



# UGME Curriculum Renewal 2021

## Report | Phase I **Social Accountability Working Group**

\*\*\*

*University of Ottawa, Faculty of Medicine  
Undergraduate Medical Education*

July 18, 2021

## 1. Introduction

In 2010, the inaugural report on the “Future of Medical Education in Canada: A Collective Vision for MD Education” reflected the importance of social accountability in the report’s first recommendation: “Social responsibility and accountability are core values underpinning the roles of Canadian physicians and Faculties of Medicine. This commitment means that, both individually and collectively, physicians and faculties must respond to the diverse needs of individuals and communities throughout Canada, as well as meet international responsibilities to the global community”.

Given its importance, social accountability is a strategic priority for the Association of Faculties of Medicine of Canada (AFMC, 2021). Each medical school’s commitment to social accountability is expressed in part through its undergraduate medical education (UGME) curriculum: the content that is taught; the types and locations of educational experiences that are enabled; and its ability to partner with other stakeholders to identify and address the priority needs of the communities they serve. The extent of this commitment is assessed through the Committee on Accreditation of Canadian Medical Schools in Standard 1.1.1:

*A medical school is committed to address the priority health concerns of the populations it has a responsibility to serve. The medical school’s social accountability is:*

- a) articulated in its mission statement;*
- b) fulfilled in its educational program through admissions, curricular content, and types and locations of educational experiences;*
- c) evidenced by specific outcome measures.*

The Faculty of Medicine at the University of Ottawa’s 2020-2025 strategic plan “Leading Innovation for a Healthier World” includes a mandate to integrate social accountability “throughout the learning continuum”. In response to this expanded mandate, in 2020, the Faculty of Medicine established an Office of Social Accountability under the direction of a new Associate Dean, Social Accountability. This Office oversees social accountability at the UGME level as well as across the faculty.

A working group on social accountability was created as part of a broad UGME curriculum renewal process. In this report, we present the context and recommendations from our working group activities.

## Mandate of the working group

The social accountability working group was tasked with developing a set of recommendations regarding innovative ways the Faculty of Medicine can enhance social accountability including strategies, processes and opportunities to:

1. Conduct an audit of the social accountability curriculum.
2. Construct of a definition (or vision) of a University of Ottawa graduate who can respond to the current and future health needs and challenges in society.
3. Define the components of an integrated social accountability program in UGME.
4. Recommend strategies for social accountability implementation across the pre-clerkship and clerkship curricula.

At our first meeting, the working group co-chairs articulated the “given” that the work was to produce recommendations to the Curriculum Renewal Leadership Committee. We determined that the working group mandate would be communicated as a report for consideration and implementation by the Leadership Committee in conjunction with the recommendations from the other working groups. As our working group progressed, we established additional givens, including that anti-racism would be specifically addressed by a new Anti-Racism Working Group, and that while social accountability frameworks (Barber, 2020) incorporate admissions pathways, our focus would remain on curricular change.

## Process used by the working group

The Social Accountability Working group developed our recommendations through **six virtual meetings** (appendix A for individual meeting aims and objectives). One of these meetings was a community consultation with Community Service Learning placement organizations who have hosted UGME students for 30 hour placements over the past 3 academic years. We also drew on a recently conducted **audit of the UGME program** as part of a broader environmental scan of social accountability in the Faculty of Medicine, reviewed recommendations to integrate experiential learning within a spiral curriculum centred on social accountability and health advocacy in UGME that one team member developed through a recent **scoping review and environmental scan**, and conducted a **narrative literature review** of the expression and impact of social accountability in relevant UGME contexts.

## Working group members

The working group was co-led by Dr. Claire Kendall, Associate Dean, Social Accountability and Dr. Laura Muldoon, Director of Social Medicine. Members included a diverse range of faculty members, students at all levels (pre-clerkship, clerkship and postgraduate) and community members. For a complete list of members and their affiliations, please see the Members of the Working Group section on page 12.

## 2. Key Issues

### Summary of the evidence

The Social Accountability Working Group considered data from the following sources:

#### Environmental scan of social accountability in the Faculty of Medicine at the University of Ottawa

Our curricular audit (Zhu, 2021) demonstrates that social accountability principles are addressed in several ways in the UGME curriculum (see table in appendix B). Mandatory components of the curriculum include: Society, the Individual, and Medicine (SIM) curriculum (mainly didactic lectures and panels); Community Service Learning (30 hours of community placements in year 1); Community Week (one week in rural family practice at the end of year 1). The CSL program is the main experiential curricular component. Of 560 documents that addressed social accountability collected across the Faculty of Medicine, 50.2% related to education, and 70.8% of these to the UGME program. These activities were categorized based on their location on the "Social Obligation Scale" where activities of a medical school can be graded based on whether they are socially responsible, socially responsive, or socially accountable (the highest level) (Boelen, 2016). Only 17% of items were felt to be socially accountable in that they demonstrated working in partnership with communities toward their defined needs. Most activities were socially responsive or socially responsible in that they incorporated a social determinants of health lens but were not yet widely socially accountable in nature.

#### Narrative literature review

We conducted a narrative review of the literature (Mihan, 2021, in progress) using the questions: 1) How has social accountability been expressed in undergraduate medical education curricula? 2) What is the impact of these activities in terms of outputs (e.g., medical student experience) and outcomes (e.g., community health outcomes)? We found literature from five countries that described UGME educational activities in five areas: 1) distributed medical education and community-specific placements/services, 2) community engagement and advocacy activities, 3) international elective preparation and experiences, 4) classroom-based learning of social accountability-related concepts, and 5) student engagement in social accountability UGME activities. Distributed medical education and community-specific placements/services were most frequently examined, with an emphasis on rural and remote placements. We categorized impact into four main outcomes: 1) student experience, 2) student competencies, 3) future career choice/practice setting, and 4) community feedback. Of these outcomes, student experience was most frequently examined, followed by future career choice/practice setting.

Overall, this review found that social accountability was primarily expressed in UGME activities through placement/service activities, and most frequently assessed through student experiences. Student experiences of SA UGME activities have been reported to be largely positive, with benefits also reported for student competencies and influences on future career choice/practice setting. The expression of SA through community engagement in the development of curricular activities indicates a positive shift from social responsibility to social accountability, but we noted that a highly socially accountable curriculum would increasingly consider measures of community impact.

### Scoping review and environmental scan

One of the working group members, Oliver Fung in collaboration with Dr. Yvonne Ying, had conducted a scoping review and environmental scan during the summer of 2020 and produced recommendations to integrate experiential learning within a spiral curriculum centred on social accountability and health advocacy in UGME. This process led to twelve recommendations to integrate experiential learning within a spiral curriculum.

The University of Ottawa Faculty of Medicine Undergraduate Medical Education (UGME) program should:

1. form a community-centred subcommittee to partner in medical education;
2. broaden patient partners' capacity to be educators and evaluators;
3. optimize multidisciplinary partnerships to deliver interprofessional education;
4. optimize use of learning management software and social media platforms;
5. utilize flipped classrooms;
6. expand and diversify Community Service Learning programs;
7. dedicate regularly scheduled time for social medicine during clinical training;
8. diversify clinical experiences;
9. introduce and integrate rural medicine concepts earlier;
10. develop narrative-based medicine electives;
11. optimize international partnerships and collaborations;
12. prioritize evaluating competencies in concepts of social accountability and health advocacy.

Please see the report (Fung, 2020) and related paper (Fung, 2021) for more details on the process and findings.

### Qualitative data generated from our community consultation

We held a 2-hour community consultation with Community Service Learning placement organizations who have hosted UGME students for 30 hour placements over the past 3 academic years. In this facilitated session, organizations and working group members shared their experiences hosting medical students and provided thoughts for improvement of the

program. We sorted all data arising from the meeting into themes and shared these with the working group members for input. These themes formed the basis of our first draft of recommendations. Please see the meeting report for further details (included in English, also available in French).

## Student and Faculty Survey

The Curriculum Renewal Leadership Committee conducted a survey of UGME students and faculty in the fall of 2020. We extracted findings and comments germane to social accountability from this survey. SIM, which is where most social accountability curricular content resides, was only identified as a “top 3” strength of the MD Program by 2% of faculty and 3% of student respondents. When asked what aspirations the MD Program at the University of Ottawa should have with respect to medical student graduates, we were surprised that socially accountable attributes did not emerge as priority aspirations. While faculty respondents prioritized professional behaviours including empathy (44%), patient-centeredness (29%), other attributes ranked less highly (“socially accountable” (15%), advocate (12%), community oriented (6%), team-oriented (6%), generalist (3%) and communication skills (3%)). While students respondents also prioritized professional behaviours including empathy (28%) highly, other attributes again were ranked less highly (social accountable (8%), team-oriented (8%), patient-centred (7%), culturally sensitive/community-oriented (collapsed as 7%)). For faculty members, the top 5 priorities for curriculum renewal included racism, bias and health inequities (32%) but students didn’t reflect these areas (aside from case-based learning). SIM was identified as a gap for students and faculty (17%, 24% of respondents respectively). Equity, diversity and inclusivity was ranked as a gap by student respondents at 18%. There was an emphasis on SIM evaluation as an area of action.

## Additional references

Please see the reference section on page 13 for a list of references related to the above data sources as well as other documents we reviewed during our activities.

## Narrative description of the issue related to the recommendations arising

**There is the potential for mutual transformation between the Faculty of Medicine’s undergraduate students and communities.** Learning in and with communities opens the possibility for reciprocally beneficial relationships for students, organizations, and those they serve. Our recommendations are oriented towards fostering a culture in which social accountability is prioritized and valued as equal to all aspects of the curriculum and in which meaningful engagement with our communities is at the heart of preparing our graduates to address the most pressing needs of society. This commitment acknowledges that physicians deliver care in communities and view their work through a population health lens, understanding that they are part of a health care system where they work in partnership with

other professionals, patients, families, and communities. Socially accountable medical schools ensure that care is equitable, that community needs and priorities are acknowledged and addressed, and that no one is left behind. Graduates of a socially accountable medical school are “health system change agents” (Boelen, 2016).

We identified several innate **characteristics** of medical students who are likely to embody social accountability, most importantly the capacity for open-mindedness, but also curiosity, creativity, respect, humility, and organization and time management. While not the mandate of our working group, we felt these could be considered during the admissions process. We also identified priority areas for harnessing these attributes by developing student knowledge, attitudes and skills through our curricular activities, which we will describe further through our recommendations below.

Given the anticipated implementation of a competency-based curriculum grounded in entrusted professional activities, the working group felt it critical that social accountability be expressed through a **longitudinal, integrated spiral curriculum**. A spiral curriculum intentionally builds on learning and experience by iteratively revisiting topics, subjects or themes over the entire curriculum. Common features of a spiral curriculum include: i) revisiting topics on a number of occasions; ii) increasing levels of difficulty with each revision bringing in new knowledge or skills or more advanced applications of areas previously covered; iii) new learning that builds on and links directly to learning in previous phases; and iv) increasing competence of students. (Harden, 1999). We make specific recommendations for how such integration might be achieved.

**Certain processes emerged as important to the success of community service learning placements.** Community organizations and working group members questioned whether the current lottery system adequately matched students with placements. While there was recognition that students benefit from experiences towards which they have a natural affinity, concerns were raised that this could lead to early specialization and that students might grow more from opportunities where that have had less previous exposure. Adequately preparing students for placements in communities was identified as key. **We also heard that longitudinal relationships with both students and the Faculty of Medicine are important to community organizations and their clients.**

Critically, we heard that “just putting in the hours” did not contribute to value and meaning for either communities or learners. For a culture of social accountability, **community-oriented learning must be prioritized as a key component of the curriculum, integrated into the curriculum at all stages of learning, and be cohesive from design through to assessment of impact.** Placement design should facilitate mutual transformation through engagement in activities that foster for meaningful impact and interaction with students in medicine and other professions. We acknowledged that “learning is not always smooth” and students are more likely to grow and thrive if they are given the opportunity to meaningfully contribute to community-identified initiatives that will have a positive impact on the community organization and their client.

Working group members acknowledged the potential for inherent bias as a limitation of our group composition. We acknowledged that we could and should not ask any member to represent an entire community. We made a conscious effort to create a safe space for all participants but noted that we would never be able to incorporate everyone's perspectives and lived experience.

### 3. Final recommendations

1. We recommend that a commitment to integrating social accountability into medical education be firmly embedded in the mission of the Faculty of Medicine and priorities for the UGME Program. This commitment should be expressed through prioritizing learning with and in communities.
2. We recommend that implementation of an entrusted professional activity-based curriculum attend carefully to the behaviours that would demonstrate that medical students are proficient in areas of socially accountable practice.
3. We recommend a longitudinal curriculum that will enhance opportunities for the integration of social accountability across all years and in different types of learning activities and settings, such as didactic lectures, community panels, experiential learning, and case-based learning. We acknowledge that different cultures and practices may warrant other forms of learning, and that our understanding of these methods continues to evolve. For example, we recognize the importance of sharing circles, land-based learning, and storytelling for Indigenous Health curriculum.
4. We recommend that the components of the various working groups be integrated such that they become *points of connection* for the curriculum renewal process. We anticipate that the recommendations from our working group will overlap with many of the themes in other working groups, requiring careful integration to achieve a cohesive curriculum.
5. We recommend developing, disseminating, and adhering to a bilingual language primer that would reflect the values of social accountability. We have included the Queen's style guide as one example in the references (<https://healthsci.queensu.ca/academics/edi/style-guide>).
6. We recommend the curriculum be designed to graduate students who demonstrate knowledge, attitudes, behaviours and skills in the following areas:
  - Active listening, empathy and person-centred care;
  - Understanding and addressing health inequities arising from the social determinants of health;
  - The practice of culturally safe care;
  - Mastery in interprofessional collaborative practice (please see recommendations from the Interprofessional Care Working Group);



- Advocacy grounded in current and future expressed community needs and a strong evidence base;
- Capacity for lifelong learning;
- Resilience, including personal wellness and attention to the wellness of colleagues.

7. While the working group members felt that culturally safe care should apply universally and across diverse groups, we recommend that the Curriculum Content Review Committee consider three additional sources of information in implementing curriculum renewal: a) recommendations from the anti-racism working group; b) findings arising from the Indigenous Program curriculum review that will incorporate our response to the Truth and Reconciliation Commission Calls to Action 22, 23 and 24\*<sup>\*</sup>; and c) recommendations arising from the planetary health curriculum review (each to be completed in August 2021).

\*22. We call upon 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.

23. We call 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.

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. (Truth and Reconciliation Commission Calls to Action, 2015)

8. We recommend that our curriculum assess students on social accountability knowledge, attitudes, behaviours and skills in several ways, with opportunities for self-reflection such as journaling and peer-to-peer assessment.

9. We recommend an integrated, dynamic, and longitudinal approach to evaluating the impact of our social accountability curriculum, including:

- Student experience of their diverse social accountability activities.
- Student achievement in social accountability activities.
- Evidence of community impact through:
  - Community organizations' assessment of their placement students;
  - Community organizations' evaluation of their collaboration with the Faculty of Medicine;
  - A robust mechanism to track student career choice and future practice setting over time, in particular for underserved populations;

- iv. Measures of community health impact that are established in partnership with our community.

10. We recommend a proposed integrated and longitudinal spiral model for community service learning placements:

- Year – Students complete 30h (or more) of community service learning, ideally extending longitudinally throughout their first year.
- Year 2 – Students mentor Year 1 students in their community service learning placements, as currently enacted in the Refugee Health Initiative.
- Year 3 – Students complete a community service learning activity that takes place in a different community or with a different population than their Year 1 placement, and could be more limited in time commitment.
- Year 4 – Students complete a self-directed social accountability activity reflecting their desired area of specialty, such as a project with digital media, a scholarly project, or an oral presentation.

11. We recommend that community service learning placements be diverse in nature, and that a process to monitor the diversity of the placements be developed and implemented.

12. We recommend that community service learning placements be designed to allow students to:

- Meaningfully contribute to community-identified initiatives that will have a positive impact on the community organization and their clients, e.g. through community needs assessments, projects to address gaps in health and social care, grant proposal development, and direct engagement with clients;
- Learn with others, including working in teams that include other medical students as well as other health profession students and students from other disciplines.

13. We recommend the adoption of the following processes to enhance and improve the quality of community service learning placements:

- A process through which community organizations and students can mutually determine the best match in year 1 and identify new areas for student growth in year 3.
- Enhanced training and preparation of students for community service learning placements. We envision these to be two-fold:
  - i. General, i.e., an orientation to the goals and objectives of the community service learning program;
  - ii. Placement-specific, i.e., where students learn about their community organization's needs and set placement objectives that align with these.
- Strategies to support community organizations before and during community service learning placements, including:
  - i. Enhanced communication including the synthesis of information such as the expectations of both organizations and students, details of scheduling, examples of successful projects and activities;

- ii. Learning management software that is more user-friendly for both community organizations, faculty members and students;
- iii. Opportunities for placement organizations to receive student evaluations of their experience and for students to receive feedback from the community organizations.

14. We recommend that community service learning students have dedicated academic time within the curriculum for:

- i. planning for community placements through pre-placement training and collaborative objective setting with the community organizations;
- ii. conducting their community placements through scheduling that prioritizes their community placement as a learning opportunity;
- iii. self-reflection (see recommendation 8).

## 4. Implementation

### Anticipated challenges

In our first meeting, the working group articulated the following fears, and we felt these should be included verbatim in our report as important context for our work:

- a) Concerns that the University is doing this to respond to an external stimulus. For instance, the anti-Black racism is the “cause du jour” and they are putting up all these initiatives to show that they are doing the right thing, but they don’t have the intention of having this lead on long-term and sustainable changes.
- b) How will this process address anti-Indigenous racism?
- c) Accreditation: reason for this WG is because the Faculty failed the accreditation.
- d) SA: side project included in the curriculum. We need to integrate SA better.
- e) Challenging to make that happen (lots of frameworks); great theoretical ideas may not translate into something tangible in practice – disconnect between theory and practice
- f) Timeline: 6 months is tight to accomplish the WG mandate.
- g) Disconnection from the communities: all participants bring something different; our personal frameworks and expertise are limited. How can we connect with members of the communities? Inviting at some meetings some community groups that could add helpful input.

As promised at our first meeting, these fears were revisited at our final meeting. Working group members expressed that our processes attended to the majority of these fears. However, they felt the success of the working group will only arise through **demonstrable actions** that flow from the implementation of the recommendations. For example, members felt that structures and processes, such as a UGME social accountability committee that reports to CCRC, will be required to innovate from within and sustain meaningful change that

avoids tokenism of topics and communities. There was an acknowledgment the time allocation required to implement to these recommendations will require balancing other curricular priorities and activities, and that competing interests may be a risk to successful integration.

The working group was also concerned that a transition to a curriculum based on entrusted professional activities (EPAs) may be a threat to a socially accountable curriculum. If the EPAs are the drivers of curricular change, the working group is concerned that social accountability will continue to be sidelined. The current EPAs do not reflect the depth of community orientation required to make the transition to a socially accountable curriculum. Specifically, as they stand, there is minimal reference to a patient's social context and no attention is given to concepts of social determinants of health, health equity, cultural safety, population health, and interprofessional care.

Finally, the working group struggled with the language historically used to describe social accountability in action, in particular with respect to "vulnerable" or "marginalized" populations. Recognizing that social positions arise from intersections of power and privilege and that individuals can feel part of more than one social group, the term "communities" itself was felt to be limiting.

### **Implications for faculty development**

We anticipate the need for continuing professional to support a generation of physicians who may have had less exposure to social accountability and related principles. This was identified as critical to combatting the "hidden curriculum" and should be implemented for faculty teaching at all levels of the UGME curriculum.

### **Implications for educational technology**

We heard from both community members and students that the current software used to manage the CSL program needs to be improved and updated, including (in year 1) adding a feature that allows students to be matched with community agencies that align with their interests. We also recommend (recommendation 13) mechanisms for communication between students, the Faculty and community organizations that are more user-friendly, and acts as a one-stop shop for information sharing, scheduling, and providing and receiving feedback from students and organizations.

### **Implications for piloting**

The working group co-chairs feel we need to defer specific recommendations for piloting until we can liaise with other working groups whose recommendations impact curricular design and evaluation. We envision PDSA cycles of modest changes in the first year, such as to the year 1

community service learning placement structure, as a first step towards an integrated curriculum.

## *5. Conclusions*

An increasing emphasis on social accountability in UGME is evident across Canadian faculties of medicine, including at the University of Ottawa. Our working group engaged communities, faculty members and students to co-create a set of recommendations based on the literature and community feedback. Our working group has identified several structures, processes, and values that we feel critical to orient our Faculty's activities towards the most pressing needs of our society and to ensure our UGME students graduate with the knowledge, attitudes, behaviours and skills to practise as socially accountable physicians. Key to this success is aligning with the recommendations from other working groups to establish an integrated, longitudinal spiral curriculum that embeds social accountability curricula, including experiential learning, over all four years of UGME. However, this success will only arise through demonstrable actions that flow from the implementation of the recommendations. It will be important to measure the impact of this implementation through student experience, competencies, and feedback from communities, but we should also seek to measure our impact through ascertainment of our graduates' future practice settings and measures of community health. In collaboration with our community partners, we look forward to being part of next steps in the renewal process.

## ***6. Members of the working group***

The working group was co-led by Dr. Claire Kendall, MD, PhD, Associate Dean, Social Accountability and Dr. Laura Muldoon (MD MPH), Director of Social Medicine. Additional working group members included:

### **Formal working group members**

1. Aliza Moledina, Department of Medicine, The Ottawa Hospital, University of Ottawa Faculty of Medicine (postgraduate member).
2. Celina Debiasio, Medical student, University of Ottawa, Faculty of Medicine.
3. Chuck Su, Director, Pre-Clerkship Anglophone Stream, Leader, UGME Leadership Curriculum, Director, Distributed Medical Education, Assistant Professor, Dept. of Emergency Medicine, Assistant Professor, Dept of Family Medicine, University of Ottawa, Faculty of Medicine.
4. Craig Campbell, MD, UGME Curriculum Director, The Ottawa Hospital, Internal Medicine, University of Ottawa, Faculty of Medicine.
5. Daniel Hubert, Francophone Affairs Program Manager, University of Ottawa, Faculty of Medicine.
6. Doug Gruner, MD, CCFP, FCFP, Associate Professor, Director and content expert, Global Health, University of Ottawa, Faculty of Medicine.
7. Ewurabena Simpson, MD, Assistant Dean, Equity, Diversity, Inclusion, University of Ottawa, Faculty of Medicine.
8. Farhan Mahmood, Medical student, University of Ottawa, Faculty of Medicine.
9. Julian Little, Professor, University of Ottawa, School of Epidemiology and Public Health.
10. Lewis Han, Medical student, University of Ottawa, Faculty of Medicine.
11. Lisa Abel, Program Manager, Strategic Planning and Implementation, University of Ottawa, Faculty of Medicine.
12. Lois Crowe, Program Manager, Office of Social Accountability, University of Ottawa, Faculty of Medicine.
13. Oliver Fung, Medical student, University of Ottawa, Faculty of Medicine.

14. Paul MacPherson, PhD, MD, FRCPC, University of Ottawa, Department of Medicine, The Ottawa Hospital, The Ottawa Hospital Research Institute.
15. Robin Kennie, MD, CCFP, FCFP, Medical Director, Eastern Regional Medical Education Program.
16. Ryan Rourke, MD, CHEO, Assistant Professor, University of Ottawa, Department of Otolaryngology Department of Surgery, Division of Pediatric Otolaryngology-Head and Neck Surgery, Clerkship Rotation Director.
17. Sean Leblanc, Board member of CAPUD (Canadian Association of People who Use Drugs), DUAL (Drug Users Advocacy League) founder, community research work at St. Michaels and Mt. Sinai.
18. Siffan Rahman, BSc, MHA, Director, Diabetes Programs, Centretown Community Health Centre.

## Contributors

- Roselyne Lampron, Curriculum renewal coordinator
- Bradley MacCosham, Curriculum renewal coordinator
- Ariana Mihan, Research Coordinator, Bruyère Research Institute
- Marcia Chang Tsi Shya, Project Coordinator, International and Global Health Office
- Jessica Sewase, Project Coordinator, Office of Social Accountability
- Hadi Tehfi, Community Service Learning placement student, Faculty of Medicine, University of Ottawa
- Haley Leider, Community Service Learning placement student, Faculty of Medicine, University of Ottawa

## Special thanks

To Sharmaine Nelles and Bruno Castilloux from the Michaëlle Jean Centre for Global and Community Engagement for bringing our community engagement activity to fruition and to our community service learning placement partners who brought their time and energy to the event.





## 7. References

Arora, N., Ngo, K., Weerakkody, I., Doshi, S., & Khan, R. (2017). Improving Service Learning Curricula in Medical Education. Ontario Medical Students Association.

The Association of Faculties of Medicine of Canada (AFMC) (2021). Strategic Plan: 2021-2023. [https://www.afmc.ca/web/sites/default/files/pdf/StrategicPlan\\_EN\\_FINAL.pdf](https://www.afmc.ca/web/sites/default/files/pdf/StrategicPlan_EN_FINAL.pdf)

Barber, C., Van Der Vleuten, C., Leppink, J., & Chahine, S. (2020). Social Accountability Frameworks and Their Implications for Medical Education and Program Evaluation: A Narrative Review. *Academic Medicine*, 95(12), 1945-1954. <https://doi.org/10.1097/ACM.0000000000003731>

Boelen, C., Pearson, D., Kaufman, A., Rourke, J., Woollard, R., Marsh, D. C., & Gibbs, T. (2016). Producing A Socially Accountable Medical School: AMEE Guide No. 109. *Medical Teacher*, 38(11), 1078–1091. <https://doi.org/10.1080/0142159X.2016.1219029>

Fung, O. W., & Ying, Y. (2021). Twelve Tips to Center Social Accountability in Undergraduate Medical Education. *Medical Teacher*.

Fung, O. W., & Ying, Y. (2020). Use of Experiential Learning in a Spiral Curriculum to Improve Participatory, Reflective Learning of Social Accountability, Health Equity and Global Health in Undergraduate Medical Education at the University of Ottawa: A Curriculum Proposal.

Harden, R. M. (1999). What is a Spiral Curriculum? *Medical Teacher*, 21(2), 141-143. <https://doi.org/10.1080/01421599979752>

Mangold, K. A., Bartell, T. R., Doobay-Persaud, A. A., Adler, M. D., & Sheehan, K. (2019). Expert Consensus on Inclusion of the Social Determinants of Health in Undergraduate Medical Education Curricula. *Academic Medicine*, 94(9), 1355-1360. doi: 10.1097/ACM.0000000000002593

Mihan, A et. al. (in progress). Social Accountability in Undergraduate Medical Education: A Narrative Review.

Queen's University Faculty of Health Sciences. Style Guide: Equity, Diversity and Inclusion [Internet] Kingston ON N.D. Cited July 13, 2021. Available from <https://healthsci.queensu.ca/academics/edi/style-guide>

Vasset, F., & Steinsland, H. (2021). Models for Meeting Activities in a Public Workplace: Qualitative Study in Municipalities. *International Journal of Public Sector Performance Management*, 7(3), 358-371. <https://doi.org/10.1504/IJPSPM.2021.114591> Zhu, G., Lamontagne, S., Fitzgerald, M., Kester, N.,

Campbell, C., Forgie, M., ... Kendall, C. (2021). Identifying the State of Social Accountability at the University of Ottawa Faculty of Medicine Through an Internal Environmental Scan. MedEdPublish, (23 February 2021), 1-11. <https://doi.org/10.15694/mep.2021.000054.1>

## Appendices

### Appendix A: Objectives of our working group meetings

#### Meeting 1 – 14 Dec 2020

The purpose of this first meeting is to orient ourselves and set the foundation for our work together.

As a group, we will:

1. Review the mandate for our working group
2. Reflect on our shared insights and perspectives around social accountability
3. Share our hopes and fears about our working group
4. Connect with one another in a holistic manner

#### Meeting 2 – 28 Jan 2021

The purpose of this second meeting is to organize ourselves for our next steps.

We will:

1. Provide some updates about renewal process
2. Share information about data that can inform our working group mandate
3. Use the service delivery model to enter the readiness phase of our work by reflecting on how we will organize ourselves to achieve our mandate.

#### Meeting 3 – 23 March 2021

The purpose of this third meeting is to share data we think can inform our recommendations.

We will:

1. Provide some updates about renewal process
2. Hold three presentations on data that can inform our activities
3. Describe our next meeting (community engagement)

#### Meeting 4 – 12 April 2021

An engaging and participatory guided virtual conversation with community service learning placements and working group members to help the Faculty of Medicine deepen their understanding of the following question: *"What is a medical student who is able to identify and respond to the priority needs of your community?"*

#### Meeting 5 – 11 May 2021

The purpose of this 5th meeting is to brainstorm recommendations arising from the community consultation.

- We will:
  1. Present an overview of the community engagement meeting
  2. Share the report and preliminary data analysis
  3. Refine the analysis towards recommendations

#### Meeting 6 – 24 June 2021

The purpose of the sixth meeting is to review and revise the recommendations previously circulated to the group, as well as the fears listed by the group at the first meeting.

## Appendix B: UGME Social Accountability Initiatives in the Faculty of Medicine, University of Ottawa

Undergraduate Medical Education	Social Accountability Initiatives
Admissions	<ul style="list-style-type: none"> <li>Admissions: CNFS Stream, French Stream, Indigenous Stream, and Social Accountability Initiative</li> <li>Strategic Direction: Admissions Office Mandate and Research Projects related to Diversity of Applicants/Matriculants</li> </ul>
Community Service Learning	<ul style="list-style-type: none"> <li>Community Service: Mandatory 30-Hour Community Service Placement for First-Year Medical Students</li> <li>Partnership: Community Partner Feedback</li> </ul>
Committees related to Social Accountability	<ul style="list-style-type: none"> <li>Community Service: Navigating Ottawa Resources to Improve Health (NORTH) Clinic</li> <li>Clinical Service: Social Accountability Clerkship Curriculum Development</li> <li>Partnership: Social Medicine Network</li> <li>Representation: Social Accountability Student Advisory Committee, Social Accountability Leadership Team, Community Member for the Curricular Content Review Committee</li> </ul>
Curricular Components	<ul style="list-style-type: none"> <li>Clinical Service: Community Preceptorship Program for First- and Second-Year Medical Students, ePortfolio Cultural Safety Exercise</li> <li>Partnership: Interprofessional Education Classes and Electives, Simulated and Standardized Patient Program for Physician Skills Development</li> <li>Representation: Patient Testimonials in Society, Individual, and Medicine Courses</li> <li>Strategic Direction: Case-Based Learning Project on Improving Diversity of Cases</li> </ul>
Graduate Questionnaires	<ul style="list-style-type: none"> <li>Strategic Direction: AFMC Graduate Questionnaires and National Report</li> </ul>
Policies and Procedures	<ul style="list-style-type: none"> <li>Clinical Service: Mandatory Clerkship Rural/Community Rotation Policy</li> </ul>
Scholarships and Bursaries	<ul style="list-style-type: none"> <li>Recognition: Scholarships and Bursaries based on Financial Need</li> </ul>
Student-Led Initiatives	<ul style="list-style-type: none"> <li>Community Service: Orientation Week Community Service Event</li> <li>Outreach: Black Medical Students Association, Indigenous Health Interest Group, Homeless Health Initiative</li> </ul>