



UGME Program Evaluation Committee

Terms of Reference

Terms of Reference # (TOR #): PEC v.1

Supersedes: None

Lead Writer: Dr. J. Drover

Approved by MD-PEC: October 15, 2014

Approved by SOMAC: [date]

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1.0 Mandate and Responsibilities

1.1. Mandate

1.1.1. The School of Medicine is committed to evaluation and providing faculty and administration with timely feedback in order to refine and improve the MD Program. The Program Evaluation Committee: collects quantitative and qualitative data on curriculum and supporting activities in order to inform decision making at all levels in the School

1.2. Major Responsibilities

1.2.1. Is advisory to the Curriculum Committee

1.2.2. Develop a set of recommendations to inform the school of medicine on how to develop a robust program evaluation system for the MD Program. To accomplish this the committee will:

- Prioritize evaluation questions for UGME program
- Ensure the MCC and CGQ results are analyzed annually and feedback provided
- Determine timelines and recommend targets to present to Curriculum Committee
- Decide on data to be included in evaluations
- Develop questions of evaluations to be pursued
- Ensure stakeholders receive evaluations

1.3. Recommendations will directly address the accreditation standards MS-46 and MS-47 (see Appendix 2)

2.0 Leadership & Membership

2.1. Membership

2.1.1. Voting Members

- 5 Faculty members, one of whom will take on the position of chair
- 2 Student representatives as appointed by the AS
- Educational staff with expertise in program evaluation
- One representative from MEdTech

2.1.2. All new members will receive the Terms of Reference and will be oriented to the position by the Chair.

2.1.3. Other stakeholders and content experts will be invited at the discretion of the Chair.

2.2. *Responsibilities of Member*

2.2.1. All members will participate actively in the committee by:

- Reviewing all pre-circulated material
- Attending at least 70% of the meetings
- Participating in working groups, as required
- Communicating committee activities and decisions as appropriate.

2.3. *Term of Membership*

2.3.1. Appointed members will normally serve a three-year term. Membership will be staggered to ensure a regular turnover.

3.0 **Meeting Procedures**

3.1. *Frequency and Duration of Meetings*

3.1.1. Meetings will occur monthly or at the call of the chair

4.0 **Conflict of Interest**

4.1. Members are expected to declare a conflict of interest if their real or perceived personal interests might be seen to influence their ability to assess any matter before the committee objectively. They can do so either by personal declaration at a meeting or in writing to the Chair. They will be excused from any discussions regarding the matter in question. The declaration and absences will be recorded in the minutes.

5.0 **Decision-Making**

5.1. Agreement on the recommendations will be reached by a process of consensus building* SEE DISCUSSION APPENDIX 1

5.2. *Quorum*

5.2.1. Quorum is achieved with a majority of voting members.

6.0 Administrative Support & Communication

6.1 Administrative Support

6.1.1 The Secretary will be a member of the staff of the Undergraduate Medical Education Office, appointed by a Manager.

6.2 Agenda & Minutes

6.2.1 Agendas and minutes of committee meetings are to be distributed to the committee members by the recording secretary.

6.2.2 Minutes are normally distributed electronically to all members within one week of meetings.

6.2.3 All minutes and supporting material will be held in confidence.

6.2.4 Dissemination of committee decisions will be made public only with the specific direction of the Chair and after discussion and approval by the committee.

6.3 Reporting Relationship

6.3.1 The committee reports to MD Program Executive Committee.

6.3.2 The committee will have an active relationship with other committees that are vital for supplying data including but not limited to the CFRC and the Admissions Committee

7.0 Evaluation

7.1 The committee will review its membership, terms of reference, rules and procedures at least every three years, and as necessary. The Chair will report the results of the review to MD program Executive Committee.

8.0 Policies

8.1 The School of Medicine's policies are posted to <http://meds.queensu.ca/undergraduate/policies>

APPENDIX 1

Consensus-Based Decision Making Rules for Building a Consensus

A consensus requires that everyone involved in the decision must agree on the individual points discussed before they become part of the decision. Not every point will meet with everyone's complete approval. Unanimity is not the goal, although it may be reached unintentionally. It is not necessary that everyone is satisfied, but everyone's ideas should be reviewed thoroughly. The goal is for individuals to understand the relevant data, and if need be, accept the logic of differing points of view.

The following rules are helpful in reaching a consensus:

- Avoid arguing over individual ranking or position. Present a position as lucidly as possible, but consider seriously what the other group members are presenting.
- Avoid "win-lose" stalemates. Discard the notion that someone must win and, therefore, someone else must lose. When an impasse occurs, look for the next most acceptable alternative for both parties.
- Avoid trying to change minds only in order to avoid conflict and achieve harmony.
- Withstand the pressure to yield to views that have no basis in logic or the supporting data.
- Avoid majority voting, averaging, bargaining or coin flipping. These techniques do not lead to a consensus. Treat differences of opinion as indicative of an incomplete sharing of information -- so keep probing.
- Keep the attitude that the holding of different views by group members is both natural and healthy. Diversity is a normal state; continuous agreement is not. *
- View initial agreement as suspect. Explore the reasons underlying apparent agreement on a decision and make sure that all members understand the implication of the decision and support it willingly.

* CONSENSUS BUILDING: To avoid silencing voices: In the event where consensus is not feasible, make decisions to proceed in a direction where data can be tracked and collected to inform, with an understanding that we are free to consider a previous approach. The process will include documentation of what is happening and testing against alternatives. Minutes become key.

APPENDIX 2

E. Evaluation of Program Effectiveness

ED-46. A medical education program must collect and use a variety of outcome data, including national norms of accomplishment, to demonstrate the extent to which its educational objectives are being met.

The medical education program should collect outcome data on medical student performance, both during program enrollment and after program completion, appropriate to document the achievement of the program's educational objectives. The kinds of outcome data that could serve this purpose include performance on national licensure examinations, performance in courses and clerkships (or, in Canada, clerkship rotations) and other internal measures related to educational program objectives, academic progress and program completion rates, acceptance into residency programs, and assessments by graduates and residency directors of graduates' preparation in areas related to medical education program objectives, including the professional behavior of its graduates.

ED-47. In evaluating program quality, a medical education program must consider medical student evaluations of their courses, clerkships (or, in Canada, clerkship rotations), and teachers, as well as a variety of other measures.

It is expected that the medical education program will have a formal process to collect and use information from medical students on the quality of courses and clerkships/clerkship rotations. The process could include such measures as questionnaires (written or online), other structured data collection tools, focus groups, peer review, and external evaluation.