UNIVERSITY OF ALBERTA

MD Program v.220124

1-3-5 Year Strategic Roadmap | 2026

Vision: With our communities, inspired through learning, serving society.

Mission: Our Medical school develops diverse, competent, and compassionate physician leaders to serve the health needs of Alberta, Northern Communities and Canada through adaptive innovation and social accountability.

Values: In all our interactions with students, learners, staff, instructors, care providers, and patients, we value well-being, compassion, cultural safety, diverse perspectives, health equity, and growth.

Focus Areas & Definitions	1-Year Plan [by Jan 1, 2023]	3-Year Picture [by Jan 1, 2025]	5-Year Vision [by Jan 1, 2027]	Possible Metrics
People Come First Fostering a learning community where interactions amongst learners, staff, faculty, patients, families and community members are grounded in compassion, dignity, and mutual respect.	a. "People Come First" principles are defined and socialized using the FoMD descriptions of psychological safety, equity, diversity, & inclusion. b. A framework for education and training of People Come First is implemented. c. Annual metrics are published for review by students, staff, and faculty.	a. A process of consultation to revise People Come First based on the wisdom of the communities with whom we interact is implemented. b. Individuals and teams that demonstrate People Come First principles are publicly recognized. c. Program evaluation and review processes include front-line administrators, coordinators, and teachers. d. Professional development opportunities for undergraduate administrators are provided each year.	**a. Medical students, staff and faculty in the MD program experience a common sense of psychological safety and belonging that lives within and extends beyond the medical school and university.**	■ Annual MSF on medical students by class re People Come First principles. ■ Percentage of graduates rating the quality of their education as high on Alumni survey. ■ Retention of graduates as licensed physicians in Northern Alberta (5 year). ■ Annual staff engagement surveys.
Generalism & Adaptive Practice Redefining how medical education is delivered so that our graduates exemplify the profession identity formation, adaptability, and readiness for clinical practice in the varied settings encountered by generalists.	a. Longitudinal integrated themes are moved into curricular blocks to promote appropriate rendering of knowledge into clinical decision-making. b. Medical students use early self-assessment and adaptive learning strategies to address personal learning needs. c. Expand to three longitudinal Communities of Learning including Research. d. Program Learning objectives to emphasize generalism and adaptive practice.	a. Pre-clinical courses are organized by themes rather than by professional disciplines, and reflected in the course leadership model. b. Pre-clinical course objectives and content is revised through the lens of generalism and enhanced experiential learning. c. A new clinical skills course element, encompassing physical exam and communications content, is established. d. Competency-based medical education in clerkship, with appropriate faculty development, is fully implemented.	**b. University of Alberta graduates are grounded in generalist training as caring, collaborative, and adaptable physicians.**	■ Participation rates in Communities of Learning. ■ Student reporting on adaptive learning strategies. ■ CaRMS Match Results including proportion choosing generalist careers. ■ Proportion of generalists in clinical practice who participate as teachers in the MD program.
Social Accountability Building on the values, strengths, and wisdom of the communities we serve, particularly the systemically excluded and underserved, to better understand and respond to what they expect from the MD Program.	a. A Social Accountability Lead is appointed and the Advisory Council on Social Accountability is established. b. A new, effective model of ongoing community engagement and accountability is implemented.	a. Diversity in admissions patterns anticipates systemically excluded and underserved populations. b. Mandatory, skills-based curriculum and assessment practices address the self-identified needs of systemically excluded and underserved communities. c. An Indigeneous Education Framework is implemented to address the recommendations from the TRC Calls to Actions, UNDRIP, MMIWG2+, and In Plain Sight report. d. The BMSA calls to Action are fully implemented. e. The Rural Pathways vision as endorsed by the FoMD and Rural Council is fully implemented.	**c. Communities of Alberta and Northern Canada are equitably represented in the students and curriculum of the MD Program with similar trending for staff and faculty.**	■ Admissions of students under-represented in Medicine. ■ Number of students training in rural Alberta ■ Number of students participating in opportunities related to social accountability. ■ Number of graduates practicing in inner city settings, rural Alberta, First Nations reserves and Métis settlements. ■ Number of teachers and leaders in the MD program who are under-represented in Medicine.
Health Promoting Learning & Work Environments Influencing transformation in learning and work environments in pervasive ways, so that it is health-promoting for all, enabled by policies, processes, procedures, and accountabilities.	a. Current policies, processes, procedures, and accountabilities that support or endanger psychological safety and health in learning and work environments are reviewed and refined. b. Anonymous "hot spot" surveys, ad-hoc low-stakes reporting, and post-course feedback sessions monitor experiences and perspectives of all in learning and work environments that involve medical students. c. HPLWE metrics are used by the MD program and key partners to foster change based on a growth mindset.	a. An educational strategy is used effectively to promote psychological safety, enhance professionalism, deconstruct structural discrimination (esp. anti-racism), and address mistreatment for all involved in MD program contexts. b. A communication strategy is implemented for students, staff, and faculty to understand how reporting data is used, feel safe to report mistreatment without fear of repercussion, and access mechanisms for prevention and resolution. c. An HPLWE group in the MD program monitors and reports on an audit tool, annual survey and other HPLWE metrics for students, staff, and faculty.	**d. The University of Alberta MD program has a national reputation as a safe, inclusive, and supportive place for those who learn & work there.**	■ Hotspot surveys (for both concerns and accolades) and ad-hoc low-stakes reporting by location. ■ Annual survey of students, staff, and faculty re well-being, engagement, mistreatment, discrimination and burnout. ■ Learning and workplace metrics including the number of sick days, leaves of absence, and attrition. ■ Reports of mistreatment by GQ (ASQ), show steady improvement and remain lower than the national average. ■ Audits showing consistency in UA learning environments as inclusive and supportive places to learn and work.
Responsive Curriculum Ensuring our curriculum, objectives, delivery and evaluation are transparent, accessible, responsive to feedback, and undergo regular, formal review and improvement.	a. A searchable curriculum map shows relationships between session, course, and program level objectives, and the user interface and experience meets the needs of the students, staff, faculty, and community partners. b. A new integrated curriculum management unit (CMU) provides oversight of the curriculum map, and supports instructors, staff, course coordinators, and curricular committees. c. A new evaluation unit is integrated into curricular committees allowing purposeful collection of feedback, transparency in program status, and timely, data-driven decision making.	a. Curricular content in all sessions of all course is updated to reflect current evidenced-based best practices in medicine. b. A live curricular roadmap allows students, staff, and instructors to track an individual student's progress in achieving program objectives. c. Clinical and academic instructors are supported, retained and valued, based on closer engagement with the CMU, and faculty development for teaching in medical education. d. Learning spaces and curriculum delivery strategies are diversified to reflect the communities that we serve through the educational support and training of students who identify with underrepresented and marginalized populations.	**e. Medical Students, staff, faculty members and the communities that we serve report an understanding, sense of pride and ownership in the design and content of the MD program curriculum.**	■ Annual surveys of students, staff, faculty members and community partners regarding their experience with the medical school and the curricular content. ■ GQ (ASQ) & Alumni Survey regarding how their education prepared them for clerkship, residency, and career. ■ Instructor retention and turnover ■ Annual measures from Program Evaluation Framework
Educational Technology Implementing a robust and well-designed Program delivery and curriculum management system (PDCMS) that addresses the needs of all stakeholders.	a. A needs assessment with recommendations is completed, based on extensive stakeholder engagement, ensuring equitable remove access. b. The hybrid learning environment model is permanently established to address remote learning needs and enable a rich and engaging learning experience. c. Human resources are secured to build and maintain the PDCMS.	a. The PDCMS is built and implemented as a single seamless system, based first on the rural learning and work environment. b. The PDCMS has a customer-based interface, built and supported by individuals with expertise in systems analysis and software. c. Appropriate use of AI, Simulation, and Machine Learning strategies enhance learning, assessment and program evaluation. d. Digital resources enable greater engagement between the MD program, community teachers and students, especially those who face barriers.	**f. The MD Program has a highly functional, seamless, adaptive and responsive PDCMS and technology infrastructure.**	■ Baseline and annual surveys on functionality, user interface, user experience, and satisfaction.

Values

In all our interactions with students, learners, staff, instructors, care providers and patients, we share the following values

1 Well-being - Every individual is a valued and respected member of our educational community; therefore, we actively promote, support, and value well-being
2 Compassion - Exhibiting compassion will foster well-being, empathy, and understanding
3 Cultural Safety - A respectful learning and work environment supports positive collaboration and communication, addressing power imbalances in the learning and work environment
4 Diverse Perspectives - Diverse perspectives count in the partnership of all the individuals and communities; therefore, we actively practice anti-racism, anti-oppression, and decolonization principles at all levels of the program
5 Health Equity - We seek to address health inequities through active innovation in our admissions process, educational practices, and advocacy
6 Growth - We believe that our development as individuals and as an organization is essential; therefore, we learn from mistakes that embody adaptive innovation and quality improvement