Aesculapian Society | Queen's University

Report and Demands to the School of Medicine Admissions Committee

Introduction to the Report

This report contains a series of demands put forth by the Aesculapian Society to advocate for greater equity, diversity, and inclusion in admissions practices at Queen's University School of Medicine. The development of these demands and recommended steps for implementation has been guided by two goals:

1. To strengthen the overall admissions process through a renewed focus on equity, diversity, and inclusion practices;
2. To examine and improve admissions practices specifically for Black and Indigenous applicants, in order to increase their representation at Queen's University School of Medicine.

This report has been developed by Queen's medical students, informed by changes to admissions processes taking place across Canada, and supported by research on strategies to achieve diversity in admissions. The full list of students who have written and provided their support for this report can be found at the end.

Equity, Diversity, and Inclusion in Medical School Admissions Practices

The Consequences of a Diversity Gap in the Physician Workforce

Equity, diversity, and inclusion are vital to the medical profession. Increasing the diversity of the physician workforce directly benefits patient care, improves patient outcomes, and reduces healthcare disparities (1-2).

Despite these well-known benefits, a diversity gap – including barriers to the acceptance and underrepresentation of students who are Black, Indigenous, Filipino, and Francophone, and from rural and low socioeconomic backgrounds – exists at all stages of medical training (3-7). This is driven by structural, top-down factors that successively reduce the proportion of marginalized and racialized students who gain access to medical education. These factors include: 1) upstream exclusion of marginalized and racialized students from institutions of higher education; 2) admissions-related factors that reduce the acceptance rate of applicants from underrepresented backgrounds into medical schools; and 3) a resulting lack of diverse representation among medical students and faculty.

Several Canadian medical schools have developed practices to increase the recruitment of applicants from underrepresented backgrounds. However, admissions practices for Black and Indigenous applicants are largely unchanged, and these groups remain significantly underrepresented in medical school classes. Moreover, these changes have not been quantified or published for public knowledge, so there is little public data available to track them. Even for those accepted to medical school, structural racism entrenched in the medical training system hinders trainees' success, advancement, and promotion throughout their medical careers. In order to fulfill their social accountability mandates and meet the needs of an increasingly diverse society, medical schools must intentionally deconstruct these barriers, both the macro and micro, and actively focus on the recruitment and retention of Black and Indigenous students and, ultimately, physicians (4).

To address racial inequities in the admissions process, it is critical to understand the considerable barriers that racialized minorities face before applying to medical school. From a young age, students from Black and Indigenous communities are negatively impacted by structural racism (8-9). As a consequence, these individuals have less access to higher education and healthcare, poorer health outcomes, over-representation in low socioeconomic classes and incarcerated populations, and experience frequent instances of overt discrimination and harassment (10-14). For Black and Indigenous students who pursue post-secondary education, their experiences as racialized minorities negatively impact their academic success (15). Lack of mentorship, less access

to support, and experiences of discrimination and harassment are among the many barriers that Black and Indigenous students face to achieving success. For those who do go on to enter careers in medicine and biomedical fields, the same discrepancies in academic attainment can be seen (16-18).

The medical school admissions process is not immune to the harmful effects of racism. Without implementing equity-based practices, the admissions process disadvantages applicants who are racialized and from lower socioeconomic backgrounds. Several factors perpetuate racism within the medical school admissions process, including:

- **Cost**
  The cost of applying to and attending medical school is prohibitively expensive for many potential applicants (19). These costs include MCAT registration (beginning at $430), school-specific application fees (ranging from $70-$180 per school), one-time application service fees (ranging from $125-$220 per service), travel and accommodation costs for interviews, as well as the many hidden costs that are necessary to accomplish these steps (20). Additionally, many applicants who gain admission benefit from being able to afford MCAT preparatory courses, typically beginning at $2,000. Altogether, these expenses rapidly amount to thousands of dollars, and contribute to the immense financial burden of applying to medical school. Individuals from low socioeconomic backgrounds are known to be underrepresented in medicine. In addition, Black and Indigenous Canadians are overrepresented in low socioeconomic classes. Thus, action must be taken to uniformly reduce the cost of applying to medical school, and to provide aid for applicants with demonstrated financial need.

- **Academic Metrics in File Review**
  The metrics that are traditionally used to evaluate applicants have been shown to limit diversity and disadvantage applicants from marginalized backgrounds. GPA has been shown to correlate positively with higher reported income level and negatively with self-identification as Black or Indigenous (21-22). Black and Indigenous applicants also report lower average MCAT scores, leading medical schools to underpredict these applicants' academic abilities and offer them fewer acceptances (22-23). These academic differences are best explained by long-standing systemic inequities that students face prior to applying to medical school (23). Thus, the emphasis placed on academic attainment and lack of affirmative action processes for those from underrepresented backgrounds has slowed efforts to increase proportional representation of medical students (24).

- **Non-Academic Metrics in File Review**
  In addition to academic metrics, applicants are evaluated on their volunteer experience, work experience, awards, extracurricular pursuits, and more. This supposedly meritocratic approach has been shown to advantage applicants from high-income families and disadvantages those from marginalized backgrounds, effectively acting as a bottleneck to achieving more diverse student bodies. Indeed, the myth of meritocracy in medical admissions has been well described (25). In addition, policy documents written by medical schools and medical regulatory bodies emphasize commitments to "excellence", "diversity", and "equity". However, this maintains the same power structures that the medical institution claims to tackle by sending this message (26-27). These commitments fail to recognize the systemic inequities that prevent underrepresented applicants from attaining antiquated measures of success that are derived from wealth and unfettered access to opportunities (27-28). Ultimately, medical schools must

alter their definition of "excellence" in order to accurately recognize applicants' successes and merits in their many forms.

- **MMI & Interview Practices**
  The widespread adoption of the MMI was a useful step in increasing equity in admissions, as it has been shown to be a more equitable evaluation method than traditional interviews and academic metrics (22). However, evaluation of the traditional MMI format has demonstrated that applicants who identify as Indigenous score lower than their non-Indigenous peers (21). Research on the implicit racial biases of interviewers and members of Admissions Committees has also demonstrated significant levels of implicit white preference (29). This bias is especially pronounced in men and faculty members. In the same study, drawing attention to interviewers' levels of implicit bias and its impact on their admissions decisions was associated with greater diversity in the class that subsequently matriculated.

Recognizing the considerable inequities described above, recent demographic data has shown that the Canadian medical student body is not representative of the general Canadian population. In a recent survey of medical students, Black students composed 1.7% of respondents (vs. 6.4% of the age-matched population), Indigenous students composed 3.5% of respondents (vs. 7.4% of the age-matched population), and students with an annual family income greater than $100,000 composed 62.9% of respondents (vs. 32.4% of the general population). Inequities were also seen with regards to parental education and occupation. These findings are supported by past demographic data of Canadian and US medical students (3, 30-31). This literature emphasizes the need for robust admissions practices to be developed that will lead to a physician workforce that is demographically representative of the Canadian population.

Medical Organizations' Calls to Action

Although medical schools have begun taking steps to improve this shortfall, significant work remains to be done to increase diversity and reduce barriers for Black and Indigenous applicants. In line with this, the Canadian Medical Association (CMA) recently launched its first policy on equity and diversity (32). This policy outlines guiding principles and recommendations that medical institutions can follow to achieve greater equity and diversity among their members. Among its many recommendations, the CMA calls on medical schools to "*[ensure] recruitment strategies and admissions frameworks incorporate more holistic strategies that recognize barriers faced by certain populations to enable a more diverse pool of candidates to apply and be fairly evaluated."* Additional recommendations endorsed by the policy include:

- Ensuring that data regarding the representation of underrepresented groups is being systematically and appropriately collected and analyzed;
- Using information collected to review and inform internal policy and practice, with the aim of reducing or eliminating system-level drivers of inequity; and,
- Encouraging all instructors to develop competencies, including non-discriminatory and non-stereotyping communication, awareness of intersectionality, and cultural safety.

Canadian medical organizations have previously identified the diversity gap in admissions, and made recommendations to alter the course of admissions practices. In 2010, the Association of Faculties of Medicine of Canada (AFMC) established the Future of Medical Education in Canada (FEMC) project that called on medical schools to enact ten recommendations over a 5-year period (33). Recommendation #2, *Enhance Admissions Processes,* stated: "In order to achieve the desired diversity in our physician workforce, Faculties of Medicine must recruit, select, and support a representative mix of medical students."

Subsequent to the FEMC project, in 2018 AFMC established the Future of Admissions in Canada Think Tank (FACTT) to coordinate a pan-Canadian effort to improve equity, diversity, and inclusion in admissions. In addition, medical learner organizations – including the Canadian Federation of Medical Students (CFMS) and the Ontario Medical Students Association (OMSA) – have addressed deficiencies in the medical school admissions process in several position papers (34-35). These groups recommend the development of initiatives that will increase enrollment of medical students from underrepresented and marginalized communities and increase transparency of the admissions process.

These calls to action are evidence that the diversity gap in medicine is a problem recognized at all tiers of the Canadian medical education system – from medical students to senior administrators. Research has emphasized the need for a diverse, representative physician workforce to serve an increasingly diverse population, and simultaneously has shown that Canadian medical schools are falling short of the target. Backed by the aforementioned research and recommendations, it is critical that we evaluate how we are addressing these collective goals. It is only by acting on these collective recommendations that we can begin to see changes in the demographic composition of our matriculating classes at Queen's.

Diversity Within Queen's University School of Medicine

Queen's University School of Medicine has a particularly troubling history of ill-treatment of Black medical students. One of the most egregious examples of this was a ban on Black students at the Queen's University School of Medicine that was instituted as a formal policy in 1918. As uncovered by Mr. Edward Thomas, a PhD candidate at Queen's, this policy had been created to align Queen's with the discriminatory practices being endorsed by other medical schools in Canada and the US, in a bid to improve the institution's reputation with the American Medical Association (41-43). However, the explanation given to the students and the greater public was that veteran soldiers returning to Kingston following World War I had insisted that they not be treated by Black medical students and doctors (42-43). There was no evidence that this had been the case. At this point in time, Queen's had been a center of medical learning for Black Caribbean students; 15 men had been enrolled in the program, which was among the highest numbers in Canada (41). Students and administrators actively worked to get the students to leave; the students were even promised program transfers to other schools that likely never materialized (41). Queen's Medicine refused to consider the applications of Black students until 1965, after an anti-discrimination committee formed by the graduate students' society began inquiring about admissions practices at the School of Medicine. After pressuring the faculty to allow them access to the file review process, a Black medical student was admitted (42).

Queen's University misrepresented the ban on numerous occasions, and the Queen's encyclopedia entry for this event (titled "Black students, expulsion from medical school") is yet to be aptly updated to reflect our new understanding of the event (44-45). What is perhaps even more shocking is the fact that this policy was not formally rescinded until 2018, when the issue was raised by Mr. Thomas and descendants of Ethelbert Bartholomew, one of the students impacted by the ban (41-42). A formal apology was issued to his family in April 2019, and a posthumous degree was awarded to Ethelbert Bartholomew at the Faculty of Health Sciences convocation in May 2019 (45-47).

Currently, Queen's University School of Medicine does not publicly report demographic data of its applicants or matriculating students, preventing accurate tracking of the proportion of students who identify as Black, Indigenous, or with other underrepresented identities in medicine. The Queen's Enrolment Report 2019-2020 shows that 2.65% of Queen's medical students identify as Indigenous, compared to 7.4% of the age-matched

Canadian population (48). Though official statistics are not available, Black students are also significantly underrepresented in the Classes of 2021-2024. Voluntary reporting of this information, along with other indicators of diversity, such as gender identity, sexual orientation, socioeconomic status, ethnicity, and disability, would empower the admissions process to strive for diversity and inclusivity in its practices.

The remainder of this report is divided into two parts. In the first, we review admissions practices at Canadian medical schools that have been established to recruit applicants from underrepresented backgrounds in medicine. In the second, we outline our demands and recommendations to the Queen's University School of Medicine Admissions Committee that integrate measures of equity, diversity, and inclusion into the admissions process. This non-exhaustive list should be evaluated on a regular basis to ensure that its implementation aligns with the UGME's evolving mandate for social accountability.

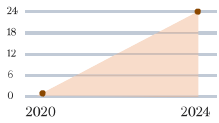
Canadian Medical School Admissions Practices Supporting Equity, Diversity, and Inclusion

In recent years, an increasing number of Canadian medical schools have formally established equity-advancing practices in their admissions processes. A summary of the reported data and outcomes associated with several of these programs is presented in the figure below. Refer to the Appendix to view a detailed table of the various application streams that currently exist for Black, Indigenous, and other underrepresented applicants to Canadian medical schools.

3/17

Canadian medical schools have created application programs for Black students.

UofT Black Student Application Program leads to **2300% increase** in Black Medical Students in Class of 2024



Increased number of Black Medical Students from 1 in the 2020 graduating class to 24 in the newest admitted class of 2024.

University of Alberta Black Medical Student Applicant Admissions Process:

As of the 2020-2021 application cycle, Black students can voluntarily self-identify on their application.These students will have Black representation as a part of their file review, interview, as well as on the MD Admission Committee.

Dalhousie University, Promoting Leadership in Health for African Nova Scotians Program (PLANS)

Mentorship and interview prep program for applicants.

No data published

Image credit to Oban Jones

Seats* reserved for Indigenous students by medical school:

- **14** University of British Columbia, *Indigenous Admissions Pathway*
- **10** University of Saskatchewan, *Indigenous Admissions Program*
- **5** Western University, *Indigenous Student Program*
- **4** Northern Ontario School of Medicine, *Indigenous Admissions Stream*
- **3** Memorial University of Newfoundland, *Indigenous Student Pool*

*Note: These are seats, not students; these seats are not required to be filled.

6/17

Canadian medical schools* have listed officially reserved seats for Indigenous students.

* An additional dispersed program exists in Quebec

Limited diversity programs in place

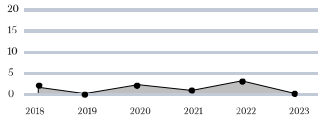
Many medical schools have limited streams or programs available to medical students.

42 reserved seats for Indigenous medical students across Canada

Queen's University has 4 reserved seats, and these are not all filled mandatorily.

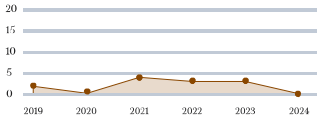
How does Queen's compare?

9 Black medical students admitted over six years



	2018	2019	2020	2021	2022	2023
Black students	2	0	2	1	4	0
Class size	102	106	108	105	104	108

13 Indigenous medical students admitted over six years



	2019	2020	2021	2022	2023	2024
Indigenous students	2	1	4	3	3	0
Class size	106	108	105	104	108	100

There is little-to-no data present on whether or not these programs are working in numerically increasing the number of BIPOC students in subsequent classes. The limited research points out this same gap:

Demographic and socioeconomic characteristics of Canadian medical students: a cross-sectional study, 2020
Rishad Khan, Tavis Apramian, Joel Hosung Kang, Jeffrey Gustafson & Shannon Sibbald

In a survey that was conducted to assess the demographic and socioeconomic characteristics of Canadian medical students, only 16.6% of currently enrolled Canadian medical students responded. Of those, it was determined (while accounting for non-response bias) that "respondents were less likely, compared to the Canadian Census population, to identify as black (1.7% vs 6.4%) ($P < 0.001$) or Aboriginal (3.5% vs. 7.4%) ($P < 0.001$)."

Diversity in medical education: data drought and socioeconomic barriers, 2015
Moneeza Walji MD MPH

"Meaningful increases in the diversity of our physician workforce require interventions that target and address each of these barriers to ensure we are not making medicine a profession that is attainable to only a select few. We need to be rigorous about collecting data on diversity in the physician workforce and to develop programs to support those who are underrepresented"

Characteristics of first-year students in Canadian medical schools, 2002
Irfan A. Dhalla, Jeff C. Kwong, David L. Streiner, Ralph E. Baddour, Andrea E. Waddell, Ian L. Johnson

"We found that Canadian medical students are not representative of the Canadian population. Medical students are much more likely than the general Canadian population to come from urban areas, come from neighbourhoods with high median family incomes and be children of well-educated, professional parents. Medical students are also far less likely the general Canadian population to be black or Aboriginal."

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Equitable, inclusive, and just admissions policies, practices, and programs are varied across Canada, and fall behind much of the progress made in the United States and elsewhere. It is notable that the Queen's University School of Medicine has many opportunities to become an equitable and inclusive institution.

Of the 17 Canadian medical schools, only 3 have application streams for Black applicants. Most schools do not have published data about the effectiveness of these programs (notably they are quite new; the University of Alberta program is set to begin in the upcoming 2020-2021 application stream). However, the success of the University of Toronto's Black Student Application Program (UofT BSAP) shows that the implementation of such a program can have drastically positive effects on the demographics of matriculating classes. In just four years, the UofT BSAP saw a 2,300% increase in the number of Black medical student matriculants, with 24 Black students in its Class of 2024 compared with 1 student in its Class of 2020. By comparison, Queen's University had zero matriculating Black medical students in the Class of 2023. Though Queen's Medicine instituted the "Medicine Admission Award for Black Canadians," it is imperative that the proper supportive programming is created, such that Black-identifying students apply, are accepted, and accept their offers to Queen's. It is also critical to collect the demographic data to investigate at what points applicants face barriers.

In contrast to Black Student Application Programs, more Canadian medical schools have programs for Indigenous students; 6 of the 17 Canadian medical schools (and an additional dispersed program in Québec) list officially reserved seats for Indigenous applicants. However, reserved seats are not required to be filled, and these, indeed, are not all filled. For instance, the Class of 2023 at Queen's Medicine had only three matriculants from the Indigenous Student Application stream, despite the presence of four seats.

Overall, the data on Canadian medical schools' practices for inclusive admissions policies is sparse. Data that is publicly available often does not report respondents' race or socioeconomic status (3). Instead, these measures are often coalesced with data on geographic location, academic background, or gender, making it less clear. Furthermore, a limited amount of literature exists on diversity-related admission program success, though anecdotal evidence suggests that these programs can be extraordinarily productive and fruitful. Finally, existing programs have been shown to still include barriers for racial minorities, those from lower socioeconomic classes, and other populations otherwise marginalised in medical education. Barriers include high application fees, the requirement to 'prove' one's marginalized identity, and lack of recruitment in certain populations. The development of policies, practices, and programming at Queen's University School of Medicine must consider effective data collection, program evaluation, and barriers in the application process.

Demands to the Admissions Committee and UGME Senior Leadership of the Queen's University School of Medicine

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1. Develop a Black Student Application Program (BSAP).

Black medical students are currently underrepresented at Queen's University School of Medicine. A targeted program will allow the school to actively recruit Black students, such that the diversity of the student body is reflective of the diverse population that graduates will serve.

Recommended steps to implement this demand:

- Provide students who self-identify as Black with the option of applying through the BSAP.
- Strike a subcommittee composed of Black physicians, faculty members, medical students, and community members, which will conduct file review and interviews.
- Ensure BSAP applicants meet the same academic requirements as other applicants.
- Require BSAP applicants to submit an additional Personal Essay focused on their rationale for applying through this stream, in the context of the applicant's background.
- The program should target a minimum 3.5% (4) seats for Black students in each first-year class, in order to achieve representation proportional to the national Black population (39).

2. Create, implement, and maintain pipeline programs, to increase the number of applying and matriculating students from marginalized populations to Queen's Medicine.

A number of student-driven initiatives already exist, including the Altitude Mentorship Program and Pathways to Medicine Day, and would benefit from institutional financial and administrative support to meet their mandate. To actively recruit and retain underrepresented students, the Admissions Committee must additionally create their own programs.

Recommended steps to implement this demand:

- Develop and implement pipeline programs for students with underrepresented identities in medicine, including but not limited to, Black and Indigenous students, and students of low socioeconomic status.
- Target pipeline programs to local students at both high school and undergraduate levels.
- Include a range of services in pipeline programming, such as mentorship, fee assistance or waiving, research opportunities, and information sessions.
- Collaborate with other committees and student groups working in this area, including the Human Rights and Equity Office, Four Directions Indigenous Student Centre, Queen's Black Premedical Association (QBPA), and the Black Medical Students' Association of Canada (BMSAC).
- Collaborate with existing student initiatives, including the Pathways to Medicine Day, Altitude Mentorship Program, and Junior Medics.
- Offer pipeline program participants information about applying to the MD program, QuARMS program, MD-PhD program, and military officer program, as well as the streams and scholarships that exist, or will be developed, to support underrepresented applicants and medical students.
- Create a plan to revisit and evaluate pipeline programs that will guide improvements to the programs so that they are able to continue serving their goal of increasing the number of students from marginalized populations in medical school.

3. **Update the Queen's University School of Medicine Admissions website to include a statement and commitment to upholding equity in the admissions process and to recruiting and retaining a diverse student body.**

This will acknowledge that Queen's University School of Medicine is committed to incorporating equity-oriented strategies into its admissions process. Example statements can be found from the University of Toronto, University of British Columbia, McMaster University, Dalhousie University, New York University, and Harvard Medical School.

Recommended steps to implement this demand:

- Consult published commitments to equity, diversity, and inclusion created by other medical schools.
- Post a statement emphasizing the School of Medicine's commitment to equity and diversity on the Admissions website, developed in collaboration with the Assistant Dean of Admissions, Director of Equity and Diversity, and relevant student groups.

4. **Collect and analyze demographic data from applicants and matriculants to Queen's University School of Medicine on an annual basis.**

Routine collection and analysis of demographic data will allow us to determine: 1) whether newly implemented strategies are successful; and 2) whether certain groups continue to be underrepresented in the student body. This will align with the AFMC's goals for the future of Canadian medical admissions, specifically: "The creation of a national student diversity database is essential to meeting nationwide social accountability and collaboration goals" (4). Collection and analysis of de-identified demographic data, including data about race and ethnicity, does not create or perpetuate systems of oppression, such as racism, and can help ameliorate these social structures.

Recommended steps to implement this demand:

- Distribute a voluntary survey to applicants, matriculating students, and graduating students on an annual basis.
    - The survey should capture demographic data about respondents including, but not limited to: race, socioeconomic status, family history, postal code, gender identity, sexual orientation, ability, and language.
- Identify a faculty member or administrative lead who will be responsible for analyzing the results of this data and generating a report of findings.
- Establish a timeline for the report's completion, ensuring sufficient time for the findings to be reviewed by the Admissions Committee and for changes to be made to the admissions process in the following year.
- Make de-identified demographic data about students publicly available through the Queen's University School of Medicine website.

5. **Implement an arithmetic modifier into the file review stage, to give consideration to the diverse attributes and experiences of applicants.**

The health care needs of Canadians are complex and diverse, and require physicians who reflect the population they support. Examples of modifiers can be seen by the Max Rady College of Medicine at the University of Manitoba, which have enhanced the diversity of their student body (40). Applicants should be provided with the opportunity to describe barriers (including, but not limited to: personal, family-related, and financial) in their autobiographical sketch that can be factored into their application score during file review.

Recommended steps to implement this demand:

- Consult existing modifiers or complexity scores utilized by other medical schools to create domains of attributes to enhance diversity.
- Incorporate modifiers into file review that increase scores for applicants who: have dependents and/or are caregivers, worked full-time during their education, participated in work-study programs, or have encountered other barriers (personal, medical, or otherwise) during their application to medical school. These should be accompanied by space for the applicant to provide verifiers for these life events.
- Ensure that equal weight and scoring is attributed to the domains of: 1) work experience; and 2) extracurriculars and volunteering. Additionally, consider providing preferential weight to the former domain to support applicants who worked throughout their education. This will ensure that applicants with significant extracurricular and volunteer experiences, who are typically of higher socioeconomic status, are not unduly favored in the admissions process.

6. Require anti-oppression and anti-racism training of all members of the Admissions Committee, and all medical students and faculty members who are part of the file review, MMI, and panel interview processes.

By participating in anti-oppression and anti-racism training, students and faculty members will actively learn about principles of equity, diversity, and inclusion and how they pertain to the assessors' roles in the admissions process.

Recommended steps to implement this demand:

- Collaborate with the Human Rights and Equity Office of Queen's University, and other groups as necessary, to create anti-oppression and anti-racism training that is specific to the admissions process.
- Coordinate the format and delivery of the newly developed workshops, such that they are amenable to the availabilities of those participating in the admissions process.
- Require all students and faculty members who are involved in the interview process to complete the newly designed workshop(s) prior to participating in file review and interviews.

7. Construct MMI stations with a framework that incorporates and values diversity in race, gender identity, sexual orientation, ability, and socioeconomic status, with holistic oversight of station design by staff and students well-versed in topics of equity, diversity, and inclusion.

The MMI has been found to be an effective indicator of future success in medicine as well as a more equitable selection method than other commonly used measures, such as GPA and MCAT scores (21-22). However, bias towards certain groups underrepresented in medicine persists within the MMI (21, 38). Addressing this bias requires the addition of diversity to the blueprint of practices throughout the admissions process.

Recommended steps to implement this demand:

- Introduce increased diversity as a goal into the blueprint used to guide MMI design.
- Conduct a literature review of best practices in developing MMI questions, stations, and procedures to minimize bias against individuals from groups which are traditionally underrepresented in medicine.
- Include staff and students well-versed in topics of equity, diversity, and inclusion in the process of MMI design.
- Review all MMI stations for potential sources of bias from the scenario, rubric, and/or interviewers prior to the interview process.
- Reserve one MMI station specifically to discuss the overcoming of barriers as a strength.

8. Coordinate MMI and panel interviews in such a way as to achieve diversity in race and gender.

Past students and interviewees have identified that interviewer pairs are frequently concordant in gender and/or race. The Admissions Committee should coordinate interviewers in the future such that there is an increased likelihood of gender and/or race concordance with interviewees. This will reduce the impact of interviewers' gender and/or racial biases affecting interviewees' scores.

Recommended steps to implement this demand:

- Collect information on interviewers' gender and racial identity, either by consulting with existing demographic data held by the UGME or by distributing a brief survey prior to the interview weekends.
- Coordinate interview pairs in MMI and panel stations such that interviewers do not identify as the same gender and race.

9. Review and revise admissions policies, practices, and programs regularly, to facilitate ongoing understanding of issues of equity, diversity, and inclusion in medicine.

Recognizing that neither societal conditions, nor social and cultural environments in medicine, are static, the Admissions Committee should, at regular and predetermined terms, re-evaluate and revise admissions policies and practices. The Committee should also commit time and resources (including funding) to this goal, including the recruitment and compensation of faculty members and/or administrative personnel. This will additionally act in concordance with the final report of the Queen's University Truth and Reconciliation Commission Task Force to review current admissions pathways (37).

Recommended steps to implement this demand:

- Ensure a regular review of Committee policies and practices, with a focus on equity, diversity and inclusion. This should include literature reviews, examination of other schools' policies, and internal review.
- Develop a practice of explicitly discussing diversity-related issues, goals, and action items at each meeting, particularly at the start of each stage of the admissions process.
- Conduct a regularly scheduled large-scale review and revision of policies and practices at a set term (for example, every 2 years).
- Ensure the Committee includes a dedicated staff or faculty member whose responsibility it is to:
    - Review the Committee's policies and practices, with a focus on equity, diversity and inclusion.
    - Conduct literature reviews in medical school admissions best practices, particularly with respect to equity, diversity, and inclusion.
    - Lead the larger-scale review and revision of policies and practices every 2 years.
    - *NB.* The presence of this staff member should not preclude the continual education and labour of all members of the Admissions Committee, including and especially by its Chair and faculty members.

10. Develop a mandate to strive for diverse representation among its membership, and include this mandate in the online Terms of Reference of the Admissions Committee.

This would ensure that the Committee includes representation in race, gender identity, sexual orientation, ability, rural background, and other identities. In doing so, annual evaluation and input on the admissions process will be inclusive of diverse perspectives. This will ultimately be reflected in the diversity of matriculating students and has previously been recommended as a strategy for achieving diversity in admissions (36).

Recommended steps to implement this demand:

- Delineate set terms for the Admissions Committee's leadership and membership, to ensure increased opportunities for participation.
- Determine set criteria for the renewal and hiring of the Committee's leadership and membership. These should include an evaluation of potential members' commitment to upholding principles of equity and diversity in the admissions process.
- Develop a mandate that the Admissions Committee will reserve a proportion of its seats for faculty members who identify as an underrepresented minority in medicine and/or who have expertise in matters of equity and diversity.
- Include greater community representation on the Admissions Committee; these community members should be representative of underrepresented populations in medicine.
- Actively recruit members from underrepresented populations, beyond the aforementioned reserved seats.
- Revise the Admissions Committee Terms of Reference to maintain the institutional memory of these practices.
- *NB.* The inclusion of traditionally underrepresented individuals on the committee should not preclude the continuing training and education of all members of the Admissions Committee, and of all individuals performing tasks related to admissions.

11. Incorporate the steps taken to meet the demands in this report into the next Queen's University School of Medicine Strategic Plan, as a long-term commitment to equity, diversity, and inclusion.

Equity, diversity, and inclusion are a key priority in medicine. While the 2017-2021 Strategic Plan references diversity to be "of significant importance," the next Strategic Plan must include tangible and transparent items, as listed in our demands, to ensure the School of Medicine remains accountable and transparent in the years to come.

Recommended steps to implement this demand:

- The UGME leadership and administration must connect with key stakeholders to outline a multi-year plan that will advance equity, diversity, and inclusion in the School of Medicine.
- The UGME must hold a series of meetings and consultations with students, faculty members, and committees to understand their long-term priorities with respect to equity, diversity, and inclusion, to ensure these are recognized in the next Strategic Plan.

12. Demonstrate accountability to this report, and to students of the Queen's Medicine community.

This report and its demands are important to the future of all Queen's University School of Medicine students, and indeed, the future of medicine in Canada. The Admissions Committee and UGME Senior Leadership must publicly recognize and address these demands, and encourage other medical institutions to do the same.

To this end, we are demanding the following action items:

- A meeting with the students who contributed to writing this report, to discuss these demands further and outline the Admissions Committee's next steps in addressing them.
- Public recognition of this report and each of our demands.
- Regular update meetings with the AS President, AS Equity Officer, AS VP Academic, Local Officer of Indigenous Health, BMSAC Representative, and other student leadership, at least once per term, as well as written report updates provided at each meeting and made publicly available to the Queen's Medicine community.

Conclusions

This report, its demands, and its recommended action items are the result of a collaboration between the Aesculapian Society and student body. We acknowledge, and are very grateful to, the students and student groups who provided feedback, endorsed this report, and who are committed to a vision of equity, diversity, and inclusion at Queen's University School of Medicine.

Social justice is not a project that can be achieved alone, or overnight. We hope this document will become a starting point for an iterative, collaborative, and meaningful process, for the creation of a more inclusive and diverse culture at Queen's University School of Medicine. We look forward to collaborating with the UGME and Admissions Committee to enact these calls to action in the months and years ahead.

This report has been written and prepared by:

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The following student leaders and student groups have reviewed this report and provided their names below in support of its demands and recommendations:

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AS Global Health Committees
Equity & Advocacy Committee
Global Health Education Committee
Indigenous Health Committee
LGBTQ+ Health Committee

Queen's Medicine Panel on Equity, Diversity, and Inclusion
Student Members

Service Learning Programs
Junior Medics
Altitude Mentorship Program

Interest Groups
Environmental Advocacy in Medicine Interest Group
Health Policy Interest Group
Medical Students for Choice
Muslim Medical Association at Queen's
Public Health & Preventive Medicine Interest Group
SexMed
Women in Medicine Interest Group

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Appendix

Black Student Application Stream	Indigenous Student Application Stream	Other/Socioeconomic Status Application Stream
University of Toronto		
Black Student Application Program: For students who self-identify as Black. Numbers: Class of 2024 = 24 Black students Class of 2020 = 1 Black student.	**Indigenous Student Application Program:** For students who self-identify as Indigenous.	
University of Manitoba		
	Canadian Indigenous Applicant Pool: Supports Indigenous students through the admissions process and gives eligible applicants the option of an MMI and Indigenous Panel interview.	**Social Accountability Mandate:** To increase representation of students from historically underrepresented backgrounds in medicine. Includes a supplementary questionnaire; applicants provide information about their family, financial, and socio-cultural background.
University of Saskatchewan		
	Indigenous Admissions Program: Reserves 10 seats for students who self-identify as Indigenous.	**Diversity and Social Accountability Admissions Program:** Reserves 6 seats for students with a five-year average gross family income less than $80,000.
University of Ottawa		
	The Indigenous Health Program: Works through the recruitment, admissions, and support of Indigenous students.	**Social Accountability Initiative:** Reserves 2 seats for students from a low socioeconomic background, supporting students with an annual family income less than $60,000.

Western University		
	5 seats reserved in the incoming class for applicants who self-identify as Indigenous**.**	**ACCESS Pathway:** For students who encounter medical, financial, or socio-cultural barriers to applying to medicine.
Dalhousie University		
Promoting Leadership in Health for African Nova Scotians Program (PLANS): Recruitment and retention of Black medical students under an Affirmative Action Statement. The PLANS program provides mentorship and interview preparation for African Nova Scotians.	**Indigenous Health Program:** Recruitment and retention of Indigenous medical students. Students are offered peer and professional mentorship and interview preparation.	
University of British Columbia		
	Indigenous Admissions Pathway: Targets 5% of seats (14) for Indigenous students to reflect British Columbia's 5% Indigenous population.	
University of Calgary		
	Indigenous Application Stream: For students who self-identify as Indigenous.	**Diversity and Adversity:** Applicants from less traditional pre-medical backgrounds and underrepresented groups are strongly encouraged both to apply and to highlight their background and experiences in their applications.

University of Alberta		
Black Applicant Admissions Process: As of the 2020-2021 application cycle, Black students can voluntarily self-identify on their application. These applicants will have Black representation as a part of their file review, interview, as well as on the MD Admissions Committee.	**Indigenous Health Initiatives Program:** All Indigenous applicants who meet the application requirements and who are successful in the Indigenous admissions process will be recommended by the Indigenous Admissions Subcommittee to the MD Admissions Committee for admission.	
Northern Ontario School of Medicine		
	Indigenous Admissions Stream: 4 reserved seats for applicants who self-identify as Indigenous. This is the minimum number the faculty intends to admit, and the seats are consistently filled. Numbers: Between 5-8 Indigenous students were admitted each year between 2015-2019.	
McMaster University		
	Facilitated Indigenous Admissions Program: Allows applicants to delay the test date for their MCAT.	
The Training Program for First Nations and Inuit Physicians of Québec: Université Laval, Université de Montréal, McGill University, and Université de Sherbrooke		
	Admissions program open to applicants from Québec with First Nations or Inuit status. There are 6 seats distributed among the Québec schools. Students accepted through this program must commit to being available for mentorship and tutoring programs provided by the Indigenous services unit of their chosen Faculty of Medicine.	

	Numbers: Since its creation in 2008, 44 First Nations and Inuit students have been admitted to one of the four schools (as of 2018).	
Memorial University of Newfoundland		
	3 seats reserved for Indigenous applicants who meet Newfoundland and Labrador residency requirements.	