

2025

CFMS Recommendations for Student Health and Wellbeing

Canadian Federation of Medical Students

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LETTER FROM THE CANADIAN FEDERATION OF MEDICAL STUDENTS

Dear Canadian medical school faculty, administrators, and students,

Since the release of the 2021 Canadian Federation of Medical Students (CFMS) *Recommendations for Student Health and Wellbeing*, there has been a growing emphasis on student wellness and culture throughout undergraduate medical education. With innovative student-driven initiatives, faculty-led committees, and dedicated task forces, advocacy for wellness and resiliency within medical education have been at the forefront of many important discussions. We are continuously inspired by the dedication of students and faculty in prioritizing student wellbeing.

Over the past four years, the landscape of medical education has evolved significantly. In accordance with this, the CFMS has sought student feedback regarding the 2021 recommendations, their implementation, and future improvements. We have also reviewed position papers, medical education literature, and engaged with student representatives and faculty across the country. Through these avenues, we have identified a need for formalized recommendations regarding wellbeing education, accessibility policies, and community-specific support.

It is our honour to share the 2025 CFMS *Recommendations for Student Health and Wellbeing* with you all, developed through a review of relevant literature, collaborations with equity-focused organizations, and environmental scans in medical education. We sincerely appreciate your time in reviewing these recommendations, and welcome further discussions regarding considerations for implementation. Together, we can foster better medical student wellbeing across the country.

Feedback regarding this document is welcome and may be directed to the CFMS Director of Student Affairs at studentaffairs@cfms.org.

Sincerely,

Brett Henderson & Bhuvna Dalal
CFMS Wellness Curriculum Leads 2024-2025

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CFMS National Officer of Wellness 2025-2026

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CFMS Director of Student Affairs 2024-2025 & 2025-2026

SUMMARY OF RECOMMENDATIONS

Student Workload and Scheduling Recommendations

1. Scheduling

- I. Schools should adhere to the following maximum hours per shift:
 - A. 11 hours per day when not on call (excluding pre-organized hospital shifts that exceed this time)
 - B. 26-hour maximum for call shifts
 - C. Weekly limit of 80 hours, including call
- II. Scheduling maximums are not intended to be the norm and should be communicated by all specialties, enforced by UGME

2. Call

- I. Call schedules should be provided at minimum two weeks before the start of rotation to facilitate personal planning
- II. Overnight call should not be scheduled before a mandatory daytime learning session
- III. Students should not be scheduled for call on assessment days, including exams or objective structured clinical examinations (OSCEs)
- IV. A guaranteed call room must be provided for overnight shifts
- V. Post-call day should be offered after in-hospital 24-26hr call shifts or if a student receives calls past midnight on overnight home call shifts

3. Travel Time

- I. Students should receive designated travel time before and after rural rotations
 - A. A minimum of 24 hours should be provided for travel and settling time for all rural rotations
 - B. For rotations requiring more than eight hours of driving time, students should receive up to 48 hours for travel and adjustment
- II. Students should be excused from clinical duties with adequate time to commute for examinations and assessments during both urban or rural rotations.

4. Policy Accountability

- I. Workload guidelines should be disseminated in an accessible and easily understandable format to all preceptors and students
- II. An anonymous reporting mechanism should be available to report breaches in workload and scheduling policies

Attendance and Absences Recommendations

5. Personal or Flex Days

- I. Guaranteed personal days for all students

- A. Pre-clinical students should receive at least three personal days, or half-day equivalents per year to take at their own discretion
 - B. Clinical students should receive one personal day per 12 weeks of clinical time (e.g., four days for a 48-week clerkship)
- II. No-reason-needed absences with minimal restrictions
 - A. Personal and sick days should not require justification to encourage well-being and reduce stigma
 - B. Minimal blackout periods should be enforced
- III. Timely approval and student autonomy
 - A. Absences related to mental health should be considered as sick days rather than personal days
 - B. When possible, clerkship students should provide four to six weeks advance notice for personal days, and pre-clerkship students should provide two weeks advance notice for personal days. Approval should be given within a one week or a reasonable timeframe.

6. Negotiated Absences

- I. Eligibility for a negotiated absence should be expanded to reflect the diversity of life events with strong importance to students
- II. The four to six week advance notice requirement should be flexible, allowing for urgent or unforeseen events

Clinical Environment Recommendations

7. Mistreatment

- I. Schools should implement anonymous online mistreatment reporting systems to ensure student confidentiality
- II. Mistreatment committees should be diverse and distinct from academic administration
- III. Students should receive education on what constitutes mistreatment, how to submit reports, and how reports are handled
- IV. Schools should offer visiting elective students a portal with access to local wellness resources and mistreatment reporting forms for their respective schools

8. Safety

- I. Every clinical rotation should provide a designated, secure storage area for students' personal belongings, such as lockers or student lounges

Administrative Recommendations

9. Communication

- I. Medical schools should ensure respectful and collaborative email communications with students. Punitive or threatening tones should never be used

- II. Efforts should be made to decrease email burden, and make electronic communication with students more efficient

10. Site Administration

- I. Site administrative staff for clinical rotations should communicate with students at least two weeks in advance, providing the following essential information:
 - A. Reporting location, time, and contact information for the first day
 - B. Shift or call schedule
 - C. Location to store belongings and instructions for obtaining scrubs if applicable, including necessary access codes

Curriculum Recommendations

11. Wellbeing Education

- I. Schools should include dedicated in-curriculum sessions for wellness education
- II. Since students have varying opinions regarding whether wellness sessions should be mandatory, school-specific discussions with students and faculty are needed to balance structured wellness activities with protected personal time
- III. Wellness education should be evidence-based and highlight key topics such as burnout, time management, resilience, school policies that protect and promote wellness, and the culture of medicine
- IV. Schools should explore anonymous and objective assessment methods to measure the impact of wellness initiatives

Pre-clinical/Pre-clerkship Recommendations

12. Scheduling of Classes

- I. Students should have sufficient time allotted to move between rooms within the same campus
- II. If students must travel to a different site, at least one hour of commute time should be provided
 - A. No lesson, assigned study, or service learning should be scheduled during this time
- III. Predicted changes to class schedules should be communicated as early as possible to allow for adequate student planning

13. Clinical Skills

- I. Training should incorporate diverse skin images and culturally sensitive approaches to promote inclusive, comprehensive medical education

- II. Training should be in small groups (two to four students per instructor) with pre-session materials, step-by-step instruction, and practice using standardized patients and synthetic models
- III. Students should have opportunities to practice in clinical settings under supervision. Peer or family practice should be encouraged but not mandatory
- IV. OSCEs should use a reasonable grading system (considering the benefits of pass/fail vs. curved grading carefully), with transparent grading criteria and standardized rubrics

14. Examinations

- I. The frequency of examinations should be reasonable, allowing for time to adequately learn the material and to attend to one's personal well-being and activities outside medicine

Community-Specific Recommendations

15. Supports Available for Underrepresented Groups

- I. Schools should establish formal diversity mentorship programs to support students
- II. Schools should provide funding and resources to create a Diversity and Inclusion Office or committee
- III. Schools and clinical sites should provide comprehensive and ongoing cultural competency training for students, residents, and staff

16. Indigenous Medical Students

- I. Schools should implement a Cultural Leave Policy for Indigenous students. This policy should support leave for culturally significant practices such as hunting, fishing, gathering, ceremony, and other land-based or community obligations**
 - A. Schools should allow cultural leave for Indigenous students (up to 5 days in addition to standard leave policies)
 - B. Flexibility: Students should give their school as much notice as possible. For events that take part on a regular basis (i.e., powwow), students are expected to submit their leave request as soon as the event date has been determined. For other leave requests that cannot be predetermined (i.e., fishing, hunting, gathering, celebration of life), students should provide as much notice as possible, and schools should be aware of the need for flexibility in some cases
 - C. Supporting documents: Schools can request supporting documents to prove Indigeneity as needed. Schools can also request information pertaining to the event leave request detailing the type of event and the importance of the students' attendance
 - D. Learning opportunity: Cultural events should count towards Indigenous students' learning hours towards the school's Indigenous health curriculum. Schools can request a short reflection essay from the students after the event has

taken place if appropriate (i.e., not after a celebration of life ceremony) and deemed necessary

II. Indigenous health session opt-out and support:

- A. Indigenous students should have the option to attend or opt-out of lectures focused on Indigenous health, Indigenous history, etc.
- B. If attending, Indigenous students should not be called upon by professors to offer personal opinions, insights, etc. on the content being taught. Indigenous students should be given the opportunity to opt out of sessions at least 14 days in advance
- C. If attending, Indigenous students should be made aware prior to the lecture about the content covered (i.e., discussions on residential schools, mistreatment, etc.)
- D. Indigenous support staff or elders should be available to Indigenous students if they wish to debrief after an attended lecture
- E. Indigenous students should be able to substitute Indigenous health sessions with cultural events/land based activities per the cultural leave recommendation
- F. Whenever possible, Indigenous health sessions should be scheduled at the end of the school day

III. Schools should ensure Indigenous medical students have access to at least two Indigenous preceptors in clinical rotations and at least one clinical learning opportunity in Indigenous communities, including opportunities within their own home communities when appropriate

IV. Schools should provide Indigenous medical students with consistent access to cultural supports, including:

- A. Indigenous Elders and Knowledge Keepers for guidance, ceremony, and mentorship;
- B. Dedicated gathering spaces where Indigenous medical students can connect, reflect, and engage in cultural practices safely;
- C. Dedicated Indigenous medical student support staff or navigators who understand the unique experiences of Indigenous medical learners and can offer academic, personal, and cultural support

17. Black Medical Students

I. Providing support for Black community building:

- A. Schools should provide sustainable support for Black Student-Led groups like the BMSAs as these can serve as spaces on campus that foster belonging, peer support, and advocacy among Black students. Sustainable funding, administrative assistance, and spatial resources allow these groups to continue without overburdening students
- B. Schools should provide sustainable support for Black students to attend culturally significant conferences and events, such as BMSAC, BPAO, BPC, and CANPAD, that promote mentorship, belonging, and professional

development. Funding and schedule flexibility for course work will allow students to have equitable access

- C. Schools should invest in engagement and representation within Black communities by supporting Black-led community initiatives and involving Black leaders through the curriculum and institutional programming

II. Ensuring safety and wellbeing:

- A. Schools should implement anti-racism policies and confidential, trauma-informed reporting systems that protect the psychological safety of Black learners and address incidents involving patients, peers, and preceptors
- B. Schools should ensure cultural safety when discussing race in the learning environment, by equipping educators to lead conversations on racism without relying on Black students to share their personal experiences or act as peer educators
- C. Schools should ensure faculty provided wellness resources are culturally safe and relevant for Black Medical Students. Wellness supports must be responsive to the needs of Black medical trainees, with providers trained in cultural humility for services and resources that are accessible and effective for Black learners
- D. Schools should provide academic credit or financial compensation for students engaging in anti-racist/EDI work for the betterment of the faculty. Black students are often called upon to contribute to EDI and antiracism work. This labour is time intensive and can be emotionally draining. Offering credit or compensation recognizes and values this work appropriately

- ## **III. Schools should collect and use race-based data on admissions, progression, and attrition to identify structural barriers for Black medical students.**
- Without race-based data, inequities in the medical school experience remain hidden and are not able to be addressed. Race-based data collection must be done ethically and with collaboration with Black student groups to provide an evidence base for identifying and addressing barriers and assessing progress to overcome the barriers that are unique to Black medical students

18. 2SLGBTQIA+ Students

- I. Schools should create inclusive spaces by providing accessible gender-neutral washrooms and changerooms, and promoting visible markers of 2SLGBTQIA+ inclusivity
- II. Schools should foster a respectful learning environment by using inclusive language, ensuring students' chosen names and pronouns are recognized on profiles and attendance sheets, and providing accessible training for medical students and faculty on identifying and addressing discriminatory language and microaggressions
- III. Schools should provide 2SLGBTQIA+ competency and safety training and ensure curriculum content is taught sensitively, including guest lectures from individuals with lived experience

19. Non-Traditional Entry Students

- I. Schools should provide targeted learning guidance and academic support for non-traditional students without science backgrounds, either before the program begins or during its early stages
- II. Schools should offer educational resources or peer-tutoring sessions to help non-traditional students bridge any knowledge gaps at the start of medical school
- III. Schools should provide counseling or support sessions to address identity adjustment issues for students entering medical school from non-traditional backgrounds
- IV. Schools should foster inclusive learning environments that actively incorporate the experiences and perspectives of students from diverse backgrounds through varied case studies and group discussions

20. Students who are Caregivers

- I. Schools should provide university-affiliated childcare at a reduced rate to support student parents
- II. Schools should offer additional personal days or schedule accommodations for students with caregiving responsibilities
- III. Schools should implement a hybrid learning model to improve accessibility for student caregivers

21. Students who are Breast/Chestfeeding

- I. Schools should provide sanitary, private lactation facilities equipped with a fridge, sink, kettle, and microwave, located close to trainees' workspaces, and accessible at all hours
- II. Lactation policies should incorporate student-reported experiences and testimonials to outline common scenarios and accommodations, while maintaining flexibility for individual needs
- III. When developing lactation policies, institutions should collaborate with faculty advisors, administrative leaders, legal counsel, and medical students with lived experience of infant feeding during medical school

22. Accessibility

- I. Schools should provide closed captioning for lectures (both live and asynchronous) and accommodations for online assessments similar to in-person assessments, including: additional time, note taking, adapted proctoring, etc.
- II. Schools are encouraged to collect data at the institutional level regarding the prevalence of medical students with accessibility needs and their experiences navigating programs and policies
- III. Schools should communicate clear and concise accessibility policies and procedures, including processes of seeking and implementing accommodations, and addressing discrimination
- IV. Spaces should be adjusted for students with sensory sensitivities and challenges

I. INTRODUCTION

Medical student burnout is a significant concern within medical education. Burnout is defined as “a state of emotional, physical, and mental exhaustion resulting from prolonged stress”.¹ A recent 2022 meta-analysis estimated the prevalence of burnout among medical students at 37%, a figure consistent with findings from a 2024 Canadian Federation of Medical Students (CFMS) survey.^{2,3} Numerous factors contribute to this phenomenon, including heavy workloads, financial strain, sleep deprivation, vicarious trauma, and other psychological challenges inherent in the medical profession.^{2,3} Inadequate support systems and the constant pressure to excel further exacerbate burnout, often leading to maladaptive coping mechanisms.^{2,3}

Recognizing the importance of enhancing the well-being of medical students, Canadian medical schools have initiated efforts to address this issue. To create a supportive learning environment, it is essential to consider student perspectives in policy development. Policy changes should aim to foster a culture of support across all medical schools in Canada and ensure equitable access for all students. In 2024, the CFMS conducted a survey among Canadian medical students to assess the status of wellness policies and support systems in each medical school. This initiative is aimed at not only updating resources to better address the post-pandemic experience but also to promote transparency and dialogue among schools, facilitating the sharing of ideas for enhancing student wellness initiatives.

This document presents evidence-based policy recommendations derived from data analysis of CFMS surveys, position papers, and student consultations. These recommendations are founded on national student input and lived experience, and are intended to support medical schools and UGME in creating safer, more supportive learning environments by improving wellness policies and addressing systemic barriers across Canadian medical schools. These recommendations will be updated every four years and presented to medical schools by CFMS representatives at each institution, fostering ongoing collaboration and progress in supporting the well-being of medical students across Canada.

II. METHODS

This project was initiated by the CFMS Wellness Curriculum Task Force, and led by the National Officer of Wellness and Director of Student Affairs. The project task force first conducted a comprehensive search of previous CFMS position papers pertaining to student wellbeing through the CFMS position paper database (<https://www.cfms.org/what-we-do/advocacy/position-papers>). Position papers relevant to medical student health and wellbeing were selected for further review in order to update the CFMS Wellness Recommendations report from 2021. Additionally, a review of relevant literature was completed for additional topics. Recommendations from the selected position papers and the extant literature were compiled and assessed for utility with consideration for current medical school practices and culture.

Consultation with CFMS Stakeholders

The project task force consulted the CFMS Wellness Round Table on the utility, feasibility, and appropriateness of a new updated set of policy recommendations. Drafts were brought back to the CFMS Wellness Curriculum Task Force for review before finalizing a set of recommendations for broader CFMS consultation. Equity-focused organizations, such as the Indigenous Medical Students' Association of

Canada, the Black Medical Students Association of Canada, and the Canadian Queer Medical Students Association, were consulted to author and/or edit equity-focused sections, to ensure the prioritization of lived experiences in these recommendations. Authors and editors from these organizations were appropriately compensated.

Review of Relevant Literature

Project task force members completed a non-systematic review of literature relevant to all recommendations proposed. Evidence in the literature was used to either strengthen or eliminate recommendations.

Surveys

The CFMS circulates its *Wellness Policies at Canadian Medical Schools* to all Canadian medical students annually. The 2023 version was used to gather data on the previous iteration of the recommendations to determine if schools are meeting the recommendations. Additional sections were added to the 2024 version of the survey to include more pre-clerkship recommendations and to create further specific recommendations that apply to specific groups of students. The survey was also used in the creation of the current recommendations as another source of literature to support the recommendations. The sections of the survey include: attendance and absences recommendations, administrative policies, wellness curriculum, clinical environment, student workload and scheduling, clinical skills, examinations, BIPOC communities, students with dependents, 2SLGBTQIA+ students, students with disabilities, and students from non-traditional educational backgrounds.

Additionally, a MEDS-Well Survey was done to better understand the mental health challenges of medical students including anxiety, depression symptoms, and drug or alcohol use. These results will also be followed annually and used to inform the wellness section of the current iteration of recommendations.

CFMS Approval

The task force consulted with the Executive Board, Office of Health Policy, and the Director of Government Affairs and Advocacy at the CFMS, with feedback brought back to the Wellness Curriculum Task Force for finalization. The recommendations were then presented for approval (via a membership vote) at the 2025 CFMS Annual General Meeting.

Post-publication and Follow-up

Members of the CFMS Wellness Round Table will be connecting with Undergraduate Medical Education (UGME) student representatives or directly with relevant faculty members in each respective medical school to initiate presentation of the CFMS recommendations, and to advocate for change. Feedback will then be brought back to the CFMS for review and evolution of these recommendations.

III. RECOMMENDATIONS

Student Workload and Scheduling Recommendations

1. Scheduling

- I. *Schools should adhere to the following maximum hours per shift:*
 - A. *11 hours per day when not on call (excluding pre-organized hospital shifts that exceed this time)*
 - B. *26-hour maximum for call shifts*
 - C. *Weekly limit of 80 hours, including call*
- II. *Scheduling students at maximum limits should be an exception, not the norm*

Discussions of duty hour restrictions occur most commonly in the context of postgraduate medical education and are largely driven by patient safety concerns. In 2011, residency programs in Quebec were mandated to limit in-hospital shifts to 16 hours or less per day, following feedback from residents, stating that shifts over 24 hours were endangering patients and residents alike.⁴ The literature has also shown that factors contributing to decreased mental well-being in medical students included a perception of being controlled by the demands of the medical program, as well as concerns regarding the long hours, heavy responsibilities and patient safety concerns.³ Literature supports the idea that reducing duty hours improves both resident performance and patient outcomes; for instance, a randomized control trial in the Brigham and Women's Hospital in Boston showed a significant reduction in medical errors among residents assigned to an alternative call regime and a work-week of 63 hours, compared to those who remained on a standard call schedule, averaging 80 hours per week.⁵ Since many Canadian clerkship students often exceed 80-hour work weeks, it is likely that their performance and learning can also be enhanced by appropriate duty hours.

Literature suggests that longer clinical hours do not appear to yield higher quality learning.⁶⁻⁸ One analysis of clerkship students' performance during surgery rotations revealed that the number of hours in a given week did not correlate with any of the learning outcomes assessed.⁶ Similarly, Hinojosa-Gonzalez and colleagues report no adverse clinical or academic learning outcomes among clerkship students following a shift from a 1 in 3 (80-100 duty hours) to a 1 in 4 (70-80 duty hours) call schedule.⁷ Such findings are consistent with Moonesinghe and colleagues, whose systematic review reveals no adverse patient or trainee outcomes associated with duty hour restrictions in residency training across several US programs.⁸ Thus, it appears that in-hospital time ceases to be beneficial for medical trainees after a threshold number of hours.

Long duty hours and frequent call shifts appear to be major barriers to trainee wellbeing during clinical education.^{7,9} A survey of US-based residents revealed that respondents perceived sleep deprivation associated with long clinical hours to be a major negative influence on their well-being and personal relationships.⁹ Furthermore, reductions in call frequency and duty hours were shown to be associated with lower self-reported burnout scores among clerkship students and residents.^{7,9} These findings suggest that scheduling in clinical training remains an important area of intervention in addressing the issues of trainee burnout and poor well-being.

Canadian medical schools often attempt to protect their students from excessive hours using standard scheduling policies. However, the weekly hourly limit is often stipulated without call hours. This distinction renders the weekly limit substantially less effective, as call can easily result in a >100-hour week. Given the extent to which excessive in-hospital hours can adversely impact trainee well-being, along with their limited value from an educational standpoint, a modest 80-hour weekly cap has the capacity to substantially improve the learning and wellbeing of medical students across the country and positively impact patient care outcomes.

2. Call

- I. Call schedules should be provided at minimum two weeks before the start of rotation to facilitate personal planning*
- II. Overnight call should not be scheduled before a mandatory daytime learning session*
- III. Student should not be scheduled for call on assessment days, including exams or objective structured clinical examinations (OSCEs)*
- IV. A guaranteed call room must be provided for overnight shifts*
- V. Post-call days should be offered after in-hospital 24-26hr call shifts or if a student receives calls past midnight on overnight home-call shifts*

Participating in on-call duties is an essential part of medical training, allowing medical students to engage in patient care while on clinical rotations. However, clear guidelines must be established to maintain a balance between educational objectives, continuity of care, patient safety, and student well-being.

We recommend that, at minimum, call schedules must be given two weeks in advance as schedules are necessary for adequate personal life planning so that clerks can more effectively balance educational needs with personal commitments. Studies have indicated that conflicts in work-life balance, time management, and inefficient scheduling are major sources of stress for medical students.¹⁰ This lack of control over schedules can contribute logistical pressure to the already compounding stress of clerkship work hours, commuting, studying, and other demands of medical education. The rare weekend getaway or special event is an important contributor to maintaining balance during medical school. As well, it is essential that medical students have adequate advance notice of schedules to plan appropriate child or family care, animal care, health appointments, and the like. Despite this, many students report receiving their schedules only days before a rotation begins, making it difficult to plan accordingly.

The negative effects of sleep deprivation following overnight call are well-documented and include reduced attention, impaired cognitive function, and lower academic performance.⁷ While many schools currently attempt to avoid scheduling overnight call prior to a daytime learning activity (academic half day or full day), we have found that this guideline is poorly enforced. We recommend that medical schools create stronger policies to address this shortcoming in policy implementation. The integration of alternative learning options such as recorded lectures or electronic learning materials could accommodate students affected by overnight call shifts.

Being scheduled for overnight call directly prior to or following an assessment is highly demoralizing in medical school. Although there is limited literature on this specific situation, we may draw from the above discussions of overnight shifts impacting cognitive function and retention. Typically, clerkship exams are lengthy and are preceded by several days, if not weeks, of arduous studying. Similar to how the evidence points to limited learning capability after overnight call, our student consultation has revealed the limited learning capability after long nights of studying and a lengthy exam. This particular situation seems to be an accelerated fodder for burnout. For these reasons, we are recommending that medical schools protect students from being scheduled for overnight call surrounding assessment days, including exams and OSCEs.

Finally, under no circumstance should a medical student be scheduled for a call shift if there is not a guaranteed sleeping room for that student. The absence of a call room removes the possibility of any rest overnight and can be quite stressful for students. Through our student consultations, we have heard countless instances of students sleeping on couches, chairs, and even vacant patient beds, which is both physically and emotionally distressing. We strongly recommend that medical schools work with administrators to ensure a safe sleeping place for each medical student on call and establish a process should they find themselves without a sleeping room for a call shift. Post-call days should be offered following in-hospital 24–26 hour call shifts, as well as after overnight home call shifts if the student receives calls past midnight. This ensures adequate rest and supports safe, effective learning.

3. Travel Time

- I. Students should receive designated travel time before and after rural rotations*
 - A. A minimum of 24 hours should be provided for travel and settling time for all rural rotations*
 - B. For rotations requiring more than eight hours of driving time, students should receive up to 48 hours for travel and adjustment*
- II. Students should be excused from clinical duties with adequate time to commute for examinations and assessments during both urban or rural rotations*

Many Canadian medical schools require students to complete mandatory rural medicine experiences during clerkship years. These enriching experiences can be substantial distances from a medical student's home site. Student consultations have identified a lack of designated travel time as a major concern.

We have found that it is not uncommon for a student to be scheduled for a call shift or regular shift the weekend before or after a rural rotation, time that would generally have been spent traveling between the rural site and the student's home site. It is generally agreeable that traveling is complex, and travel to rural sites can include multiple modalities of transport (car, train, plane, ferry, etc), along with packing for up to four weeks and adjusting to temporary housing. As such, we recommend that medical students be given designated travel time prior to and following a rural rotation.

Students should be granted, at minimum, a single full day (24 hours) to travel and settle into their rural accommodations. Examples of students scheduled for a shift on a Sunday, then expected to be at a rural

site Monday morning are logistically impossible and generally demoralizing to students. Further, some rural sites are up to >8 hours of travel time by car from a student's home site. While some students may choose to fly in these cases, it is generally not advisable for this to be the expectation for students in a rural site, where vehicles are mainstay forms of transportation. In these cases, we recommend a full 48 hours to allow for the student to travel and settle into their temporary home.

Implementation of this designated travel time for mandatory clerkship rotations should be arranged by medical school administrators, who have standard clerkship "tracks" and can foresee which students have an upcoming rural rotation. In these cases, they may arrange for call protection or to amend the shift schedule accordingly. During elective rural experiences, the designated travel time would be the responsibility of the medical student; however, school administrators should make it clear to students that this travel time is available. Administrators should also be made aware that this travel time should be accommodated.

In addition to travel time for rural rotations, students should also be excused from clinical duties with sufficient time to commute and prepare for examinations and assessments. Being scheduled for clinical duties prior to assessments or examinations can cause undue stress if travel time is not accounted for in scheduling. We recommend that students be relieved of clinical responsibilities with adequate notice and commute time ahead of examinations to ensure they can approach assessments without unnecessary stress related to travel time.

4. Policy Accountability

- I. Workload guidelines should be disseminated in an accessible and easily understandable format for all preceptors and students*
- II. An anonymous reporting mechanism should be available to report breaches in workload and scheduling policies*

The proper dissemination of guidelines pertaining to student workload, mistreatment, and other domains is essential to ensure that students, preceptors, and staff have a shared understanding of expectations, rules, and regulations.¹¹ In both undergraduate and postgraduate medical training, there often lies a "hidden curriculum", with a pressure to take on more than what is expected to demonstrate interest in the field, pursue additional learning, and clinical skills, even though no findings to support these ideas have been documented.^{6,12} In fact, research has identified that medical students often perceive higher expectations from their skills, knowledge, and preparation from their preceptors than what is reality.^{6,12} Hence, it is increasingly important that workplace guidelines be disseminated and made accessible widely.^{6,12}

Although appropriate dissemination of workload policies will not address the hidden curriculum, having all parties of the clerkship interaction made aware of the guidelines will support a strong working relationship. This may be a step towards improving medical workplace culture, with resulting positive impacts to medical student wellbeing.¹³

For further accountability, infractions of workload policy guidelines set by medical schools should be reportable through an online reporting mechanism. The faculties of medicine should be responsible to both track and monitor medical student mistreatment. The use of anonymous reporting mechanisms has been well validated for mistreatment, with most Canadian medical schools already adopting these systems. We recommend that the system for reporting infractions in workload policies should be either a separate mechanism from the now widely adopted anonymous mistreatment reporting systems, or to be integrated into the current reporting systems, so long as students are well notified that they may report workload infractions as mistreatment. Canadian medical schools should be responsible for identifying trends in medical student mistreatment in order to determine if adjustments to current policies are needed. Moreover, medical students should be educated on workload policies, when to report infractions, and how these reports are managed and acted upon. Reporting mistreatment can be intimidating; a 2018 study by Chung et al. found that intimidation was the second most often cited reason for not reporting misconduct, following that “the incident did not seem important enough to report”.¹⁴ Thus, medical schools should create systems that minimize potential barriers to workload policy overage reporting.

Attendance and Absences Recommendations

5. Personal or Flex Days

- I. Guaranteed personal days for all students*
 - A. Pre-clinical students should receive at least three personal days, or half day equivalents per year to take at their own discretion*
 - B. Clinical students should receive one personal day per 12 weeks of clinical time (e.g., four days for a 48-week clerkship)*
- II. No-reason-needed absences with minimal restrictions*
 - A. Personal and sick days should not require justification to encourage well-being and reduce stigma*
 - B. Minimal blackout periods should be enforced*
- III. Timely approval and student autonomy*
 - A. Absences related to mental health should be considered as sick days rather than personal days*
 - B. When possible, clerkship students should provide four to six weeks advance notice for personal days and pre-clerkship students should provide two weeks advance notice for personal days. Approval should be given within a 1 week or a reasonable timeframe*

Personal days, sometimes called flex days, allow students to exercise a limited degree of control over their schedules by allowing a predetermined number of discretionary days off. With the rigorous demands of a medical student schedule, these days allow students to support their wellbeing by taking a day off for reasons that may not fall under traditional absence policies, such as important life events, travel, or simply to rest and recharge.

While many Canadian medical schools already have variations of personal day policies in place, we find that they are inconsistent and often do not include clinical years. The transition to clinical learning, and a far more demanding schedule, is known to be among the most stressful times during medical school.^{10,15}

As such, we are recommending that personal days also be included for clinical students. We recommend an allotment of personal days, which are to be taken at the discretion of the student, relative to the number of clinical weeks in a year, recognizing that this may vary between schools and during specific rotations. For example, at the University of Toronto, clerkship students are permitted four personal days per year, with a maximum of one per rotation.

Personal days have been recommended and created for the purpose of student wellbeing with the idea that they can be taken for personal reasons, decided by, and at the discretion of, the student. Students should not have to indicate a reason for taking this day off, beyond stating that they would like a personal day on a given date. Given the persistent stigma surrounding mental illness, students appreciate the availability of no-reason-needed personal and sick day absences.¹⁶ Such policies enable students to address their mental well-being without having to disclose specific reasons for their absence. Moreover, flexible absence policies play a crucial role in fostering a positive learning environment. They empower students to address their mental health needs with the same care and attention as they would their physical health, contributing to a supportive and flourishing academic community.

Additionally, while it is recognized that some limitations may be necessary (as are in place for other absences; i.e., personal days may not be taken on days with mandatory assessments), in general, there should be minimal to no limitations placed on personal day usage in order to allow students full autonomy over when they wish to take these days. Restrictions on their use may detract from the purpose of allowing students to choose when to take a personal day, and the overall aim of promoting student wellbeing.

Providing four to six weeks of advance notice during clerkship rotations, and more where possible, will allow for colleagues and medical school staff to adjust to any absences as needed. Pre-clerkship students should provide two weeks advance notice. More advance notice should not be required as this will again limit students' ability to use their personal days for reasons which may not always provide multiple months of advance notice. Students should also receive timely responses to their personal day requests so that they can inform their peers and instructors where necessary, as well as make whatever arrangements are necessary with respect to their reason for requesting the personal day. If, for some reason, a personal day request is unable to be approved, students should be respectfully provided with a reason why and should be provided with an opportunity to alter the request for a different day off, if possible.

6. Negotiated Absences

- I. Eligibility for a negotiated absence should be expanded to reflect the diversity of life events with strong importance to students*
- II. The four to six week advance notice requirement should be flexible, allowing for urgent or unforeseen events*

A negotiated absence refers to a leave from required academic activities that is granted at the discretion of the institution for reasons not explicitly outlined in existing absence policies. These are typically requested for meaningful personal, cultural, academic, or professional experiences that fall outside the scope of traditional leave categories. The absence policies of many Canadian medical schools can often

be restrictive with respect to which events and activities are considered acceptable for an absence request to be approved. For example, presentation at academic conferences is often an approved reason for absences. However, other similarly highly regarded events, such as for athletics, artistic, or entrepreneurial pursuits, are typically not listed as approved reasons for an absence. This excludes the diverse interests and experiences which were rewarded by the medical school applicant selection process.

Although personal days offer improvement in discrepancies between medical student needs with regard to absence approval and actual medical school policy, the restrictive language often used during policy writing can be alienating and exclusive to the diverse student populations that medical admissions committees strive to achieve. We recommend that eligibility for a negotiated absence be expanded to reflect the diversity of life events that hold significant personal, cultural, academic, or professional importance to students. With broader and more open language in defining allowable negotiated absences, and treating requests on a case-by-case basis, students are given the respect and autonomy to choose the life events most important to them.

In addition, the requirement for students to submit absence requests four to six weeks in advance can be impractical and restrictive, as it may not always align with the timing or urgency of certain events or circumstances. This policy may inadvertently disadvantage students who face unexpected circumstances or who need flexibility in managing their academic, extracurricular and personal responsibilities. We recommend that schools provide flexibility in terms of advance notice for absences, allowing for urgent absences to be requested within a shorter timeframe than four to six weeks.

Clinical Environment Recommendations

7. Mistreatment

- I. Schools should implement anonymous online mistreatment reporting systems to ensure student confidentiality*
- II. Mistreatment committees should be diverse and distinct from academic administration*
- III. Students should receive education on what constitutes mistreatment, how to submit reports, and how reports are handled*
- IV. Schools should offer visiting elective students a portal with access to local wellness resources and mistreatment reporting forms for their respective schools*

Medical student mistreatment significantly contributes to burnout, emotional distress, and increased rates of medical error.^{14,17} A lack of mistreatment reports, despite mistreatment occurring, likely perpetuates that these behaviours are tolerated.¹⁴ Thus, the CFMS recommends the above set of policies and student resources to address mistreatment.

Anonymity is essential to ensuring that students feel safe to report mistreatment. If there is a perception that reporting will have negative consequences on their academic performance or career trajectory and inhibit their ability to succeed in a medical environment, students are far less likely to report their experienced mistreatment, which speaks to the significance of anonymizing the reporting process.¹⁸ As supervisors have the power to influence student evaluation, reference letters, and (potentially) residency

opportunities, particularly at small campuses, it is paramount to protect the identity of the students during the reporting process. If anonymous reporting mechanisms are not possible, reporting through proxies (e.g., another person reporting mistreatment on behalf of the affected student) may be an effective strategy in reducing hesitancy in mistreatment reporting, and should be included as an option within mistreatment reporting portals.

Additionally, some mistreatment reporting systems are not easily accessible as certain schools require students to submit these reports in person, which poses a barrier due to lack of accessibility and lack of anonymity. While most Canadian medical schools have adopted anonymous online mistreatment reporting systems, we recommend that all Canadian medical schools adopt this system to ensure accessibility and anonymity.

Furthermore, mistreatment committees should be independent of academic administration to eliminate concerns of bias or retaliation. Medical schools should delegate mistreatment handling to an autonomous committee, distinct from academic affairs and trusted by the student body.¹⁸ This would provide a more confidential space, free from potential repercussions on one's career, for reporting mistreatment. It is also important to create diverse and multidisciplinary committees involving student representation to ensure that marginalized student groups, who often face unique mistreatment experiences at higher rates, are adequately represented.^{19,20}

With the normalization of these mistreatment behaviours experienced by medical students through the “hidden curriculum”, students can be desensitized to inappropriate behaviours, making it increasingly challenging for students to identify an experience as mistreatment.¹⁷ When students experience a particular behaviour repeatedly, this delineation becomes even more challenging.¹⁸ Students may become acculturated that mistreatment is a rite of passage or necessary to develop the trust and confidence of their superiors, emphasizing the importance of educating students on how they should be treated during their medical education.^{14,18} Certain types of mistreatment, such as neglecting medical students from engaging meaningfully in the clinical environment, go overlooked despite having a significant impact on learning and wellbeing.²¹ For these reasons, we recommend that students have dedicated education on what constitutes mistreatment, how to report mistreatment, and how reports are handled, both early on in medical school and again prior to clinical experiences.

Mistreatment can occur regardless of whether a student is at their home site or visiting electives. Unfortunately, most visiting elective students do not currently have adequate resources from the school they are visiting on how to report mistreatment if it happens. For this reason, we recommend that schools offer visiting students a portal or similar resource from which they may access workload scheduling policies and mistreatment reporting information. Students' home institutions should also have policies in place to support their students while on visiting electives who may experience mistreatment.

8. Safety

- I. Every clinical rotation should provide a designated, secure storage area for students' personal belongings such as lockers or student lounges*

Ensuring that medical students have access to areas for secure storage of personal belongings is an important component of an optimal clinical training environment. Lack of such accommodations has been cited as a significant stressor during clerkship training and a major contributing factor to negative student experiences.²² One study revealed that the assignment of personal lockers to clerkship students was an effective response to students' concerns regarding the lack of team integration during a surgery rotation.²³ As such, it appears that providing students with designated spaces to store personal belongings has the capacity to promote a sense of belonging within the clinical environment, in addition to the sense of security for one's personal belongings. As many students also keep valuable electronics with them during the day for studying or extracurricular purposes, such as meetings or presentations, the lack of a safe place to store belongings can be disruptive in the clinical environment. We recommend that medical schools require each clinical rotation to have a designated safe location for students to store belongings, in accordance with the Committee on Accreditation of Canadian Medical Schools standard 5.11.

Administrative Recommendations

9. Communication

- I. Medical schools should ensure respectful and collaborative email communications with students, and punitive or threatening tones should be avoided particularly when citing professionalism concerns*
- II. Efforts should be made to decrease email burden, and make electronic communication with students more efficient*

Our consultations with medical students revealed that students often make their best reasonable attempts to stay on top of administrative tasks and emails; however, between filling out evaluations, completing small assignments and modules, handling IT difficulties, answering emails, etc., the tasks add up quite quickly. Unfortunately, we have heard from several student representatives that threatening and punitive tones are often used to intimidate students to complete administrative tasks quickly. These communication strategies can often be discouraging to students, degrading the faculty-student relationship. We respectfully recommend that medical school leadership require that administrators use only respectful and professional language and tone when communicating with medical students, with a focus on understanding student perspectives rather than punishment. Further, in the climate of unmatched students and increasing competitiveness in residency applications, professionalism flags can be career and life altering and should not be used liberally, such as to motivate students to complete small administrative tasks. The student consultations revealed multiple reports of students being labeled as “non-compliant” after being late to submit an administrative task and threatened with professionalism flags, which is both concerning and discouraging. We recommend that these flags be reserved for serious offenses only.

Another way to ensure that administrative tasks are completed on time is for email communication to be as efficient as possible. The CFMS is recommending that efforts be made by administrative teams to increase the efficiency of communication to students. For example, action items or to-do's may be indicated in the subject line of an email, rather than hidden in a long attached document that may be easily missed. Students would also appreciate ample notice for administrative tasks.

As with many careers, email burden can be quite cumbersome, especially for medical students who must address emails outside of traditional (or extended) work hours. Our student consultation identified email burden as a target for wellbeing intervention. We are recommending that attempts be made to reduce email burden for students in both the number of emails sent and the number of attachments. We often hear that administrative teams send medical students numerous emails within the same day, or emails with ≥ 20 attachments, which can make it difficult to identify which attachments apply to them.

10. Site Administration

- I. Site administrative staff for clinical rotations should communicate with students at least two weeks in advance, providing the following essential information:*
 - A. Reporting location, time, and contact information for the first day*
 - B. Shift or call schedule*
 - C. Location to store belongings and instructions for obtaining scrubs if applicable, including necessary access codes*

The first day of a rotation is often stressful for students who must navigate a new hospital, medical record system, and access procedures. Our consultation identified the minimum information that students should receive to facilitate a smooth start, including where and when to arrive, preceptor or team contact information, shift/call schedule, location to store belongings, where to obtain scrubs, and any required access codes. Students often report that this information is provided late, or even not at all. Providing this information at least two weeks in advance allows students to prepare adequately, reducing unnecessary stress and the risk of negative evaluations due to a lack of preparation.

Curriculum Recommendations

11. Wellness Education

- I. Schools should include dedicated in-curriculum sessions for wellness education*
- II. Since students have varying opinions regarding whether wellness sessions should be mandatory, school-specific discussions with students and faculty are needed to balance structured wellness activities with protected personal time*
- III. Wellness education should be evidence-based, and highlight key topics such as burnout, time management, resilience, history of and state of current physician health, policy factors that influence physician health, and the culture of medicine*
- IV. Schools should explore anonymous and objective assessment methods to measure the impact of wellness initiatives*

Wellbeing is increasingly prioritized in medical education. A recent survey found that 10 of 11 responding schools dedicated time to wellness education, aligning with the CanMEDS professionalism competency. While wellness curricula vary, the CFMS supports in-curriculum sessions at all schools.

In terms of whether wellness education sessions should be mandatory, survey responses demonstrated variability in student opinion and current practices. Schools have mandatory, optional, or mixed wellness

activities. A portion of students felt mandatory sessions took away from their personal wellness time, but only half of the schools reported having protected wellness time. This suggests the issue may be a lack of protected time rather than the mandatory nature of sessions. Additionally, few schools offer resources like drop-in counseling, spiritual care, financial advising, or Indigenous Elders during protected wellness time. More research and discussions with students and faculty are needed to balance structured wellness sessions with personal time while ensuring access to support services, both during and outside these sessions.

A randomized controlled trial and other studies also suggest that structured mental health interventions (e.g., yoga, walking, meditation) significantly reduce anxiety and psychological distress, with benefits consistent across students, regardless of voluntary participation. These interventions also do not negatively impact academic performance, supporting the value of mandatory sessions with flexible options.²⁴

Despite active research on wellbeing in medical education, existing sessions often feel superficial and repetitive. Student consultations revealed frustration with repeated messaging on sleep, nutrition, and fitness, which can feel patronizing. Some schools, like the University of British Columbia's Wellness Initiative Network, have successfully implemented peer-led programs covering less commonly addressed topics. While sleep, nutrition, and physical activity are important, they are often overemphasized as causes of burnout. A national wellness survey found that most of the 11 responding schools covered burnout, resilience, medical culture, and time management, while fewer addressed physician health history and policy. This suggests either adoption of previous wellness recommendations or a continued focus on lifestyle factors over systemic issues. Future surveys should assess the proportion of time dedicated to each topic to ensure a balanced, evidence-based curriculum that meets student needs.

Measuring medical student wellbeing is challenging due to various confounding factors. However, assessing the efficacy of wellness interventions is essential. While validated tools like the Maslach Burnout Inventory exist, only 3 of 11 surveyed schools collect anonymous mental health data. We recommend that medical schools explore an anonymous way to assess wellbeing outcomes to determine the impact of wellness interventions.

Pre-clinical/Pre-clerkship Recommendations

12. Scheduling of Classes

- I. Students should have sufficient time allotted to move between rooms within the same campus*
- II. If students must travel to a different site, at least one hour of commute time should be provided*
 - A. No lesson, assigned study, or service learning should be scheduled during this time*
- III. Predicted changes to class schedules should be communicated as early as possible to allow for adequate student planning*

Class scheduling significantly impacts pre-clerkship medical students, and poor scheduling can increase stress.

Students need sufficient time between sessions to navigate campus without missing important content. If time is insufficient, they may arrive late, forcing instructors to delay sessions or become frustrated. Many medical schools conduct training at different sites, adding to these challenges. Our survey found that most wellness representatives (18 of 21) believe students have enough time to move between rooms on the same campus, though three responded “Sometimes”. Small adjustments, such as adding 5 extra minutes between sessions, could significantly improve students’ ability to transition comfortably.

Pre-clerkship classes take place in various settings, including classrooms, lecture halls, hospitals, and clinics. Ensuring sufficient time between sessions is especially important when students must commute between sites. When asked whether medical students were given at least one hour of commute time between different sites, our survey found that eight wellness representatives answered “Yes”, seven answered “Sometimes”, and four answered “No”. We recommend a minimum of one hour between sessions at different sites, with no lessons, assignments, or service learning scheduled during this time. Given students’ varying access to transportation, flexibility should be prioritized if universal transport is not provided.

Communication issues from school administration are a common source of stress for medical students.^{25,26} While schedule changes are sometimes unavoidable due to instructor availability, room changes, or other unforeseen circumstances, consistency remains a top priority. Organizing numerous sessions across various locations is complex, but providing advanced notice whenever possible is essential. Predicted changes should be communicated as early as possible to help students plan accordingly. Given their demanding schedules, timely updates allow students to adjust other commitments and minimize disruptions.

13. Clinical Skills

- I. Training should incorporate diverse skin images and culturally sensitive approaches to promote inclusive, comprehensive medical education*
- II. Training should be in small groups (two to four students per instructor) with pre-session materials, step-by-step instruction, and practice using standardized patients and synthetic models*
- III. Students should have opportunities to practice in clinical settings under supervision. Peer or family practice should be encouraged but not mandatory*
- IV. OSCEs should use a reasonable grading system (considering the benefits of pass/fail vs. curved grading carefully), with transparent grading criteria and standardized rubrics*

The diverse range of patient presentations underscores the need for comprehensive medical training. There is growing awareness of the lack of diverse skin images and culturally sensitive materials in curricula.²⁵ Inclusive instruction in clinical skills helps prevent bias and stigmatization.

We advocate for small-group clinical skills training with two to four students per instructor. Content should be available beforehand for preparation, and instructors should guide students step by step, providing corrections as they practice. While learning from teaching associates is a valuable strategy, literature suggests that using simulator devices and a simulated clinical environment improves OSCE outcomes and long term skill retention.²⁶ Further evidence highlights that “acquisition and performance of

the [clinical] skill are improved when the traditional mannequin style-learning program is coupled with the principles of cognitive task analysis and mental imaging,” indicating that instructional and example-based learning alone is not sufficient for confidence and mastery of clinical skills.²⁶

Practicing in clinical settings while observing real patient interactions with role models (faculty and residents) further strengthens skills and confidence.²⁷ Immediate feedback in these environments reduces pressure on students who may otherwise feel compelled to practice on peers or family. While practice with peers, friends, or family is encouraged, we recognize it may trigger dysphoria, trauma responses, or sensory aversions. Clinical learning with role models is essential to ensuring all students can engage effectively.

Another major concern among medical students is clinical skills assessment, particularly the OSCE. Though OSCEs are standard, grading methods vary across Canada. Some schools (Western, McGill, Queen’s) use a pass/fail system, while others (Manitoba, Dalhousie, NOSM, McMaster, Ottawa, Toronto, and Saskatchewan) determine passing grades based on overall class performance, based on survey findings from 2023. McMaster grades OSCEs as complete/incomplete with a 1–7 score and a class-based Z-score.

Debate exists over relative vs. absolute grading standards.²⁸ Relative (norm-referenced) standards determine pass/fail scores based on a reference group’s performance. A key drawback is the lack of clarity on required knowledge, as passing scores fluctuate with each cohort’s performance. In contrast, absolute standards use fixed cutoffs based on test content, ensuring scores reflect student knowledge rather than cohort variability. Survey feedback supports an absolute standard pass/fail system with transparent grading guidelines, promoting fair assessment while accounting for variations in teaching and evaluation.

Students overwhelmingly requested transparency in OSCE grading. Survey data (from 2023) indicated only four schools (Dalhousie, McMaster, McGill, Toronto) provide grading rubrics or checklists. Examiner stringency varies, which should be corrected for unless enough stations exist to balance differences.²⁹ A clear rubric outlining assessment criteria would help standardize evaluations and ensure fairness.

14. Examinations

- I. The frequency of examinations should be reasonable, allowing for time to adequately learn the material and to attend to one's personal well-being and activities outside medicine*

Examinations are a major source of stress for medical students. One-third of surveyed schools reported exams every 1–2 weeks, while others have longer intervals but may schedule back-to-back exams. A study of osteopathic medical schools in the US found that exams spaced 1–2 weeks apart led to better student performance and satisfaction than back-to-back exams with only a 15-minute break.³⁰

The timing of exams also affects student well-being. A survey of 339 preclinical students found Friday to be the most preferred exam day, and Monday to be the least. For long weekends, students preferred exams on Friday before the holiday rather than the Tuesday after. Additionally, 64% of students felt new material

for a Friday exam should be presented by or before the Tuesday of the same week, and 36% preferred Wednesday. Friday exams were associated with improved mental health, work-life balance, and academic engagement.³¹ With Friday exams, students can enjoy their weekends, visit loved ones, and engage more effectively with subsequent coursework. Spaced-out, end-of-week exams may reduce stress and support academic and personal well-being.

Community Specific Recommendations

15. Supports Available for Underrepresented Groups

- I. Schools should establish formal diversity mentorship programs to support students*
- II. Schools should provide funding and resources to create a Diversity and Inclusion Office or committee*
- III. Schools and clinical sites should provide comprehensive and ongoing cultural competency training for students, residents, and staff*

In recent years, Canadian medical schools have introduced underrepresented minority (URM) application streams, such as the Black Student Application Program and Indigenous Student Application Program, to create more equitable opportunities and increase representation in the medical profession. While these initiatives work to reduce barriers to entry, students still face systemic and societal challenges within the medical education system. A CFMS survey found that half of Canadian students from separate URM streams felt there were insufficient resources and support to aid their transition into medical school and foster inclusion and belonging.

We recommend that medical schools establish formal diversity mentorship programs to help mitigate systemic barriers faced by URM students. Research indicates that 80% of Black Canadian medical students feel their race or ethnicity negatively impacts their career advancement.³² URM students often face additional challenges, such as a lack of resources, support networks, and mentors who share similar cultural, religious, or other backgrounds. These obstacles can contribute to feelings of exclusion and hinder personal, academic, and professional development. The University of Toronto Faculty of Medicine's Diversity Mentorship Program, initiated in 2018, has proven beneficial, with over 80% of students reporting positive experiences.³³ Students found it to be a safe space to discuss race-related issues, build networks, and foster a sense of belonging.³³ We recommend that medical schools across Canada adopt similar mentorship programs to support the unique needs of URM students.

Medical schools should establish diversity and inclusion offices or committees to address systemic barriers and promote equity within their institutions, if they do not already exist. In the CFMS survey, students also expressed a need for more school efforts in diversity and inclusion, highlighting gaps such as a lack of tailored support for specific backgrounds. Medical schools should invest in establishing formal offices dedicated to centralizing efforts to combat systemic barriers, promote equity, and foster inclusivity. Such offices can also help reduce the "minority tax" experienced by URM students, who often spend their own resources working toward reducing disparities for their peers.^{32,34} Successful examples, like The Office of Belonging, Equity, Diversity, and Inclusion at Brown University's Warren Alpert

Medical School, demonstrate the positive impact of dedicated offices in promoting belonging, health equity, and inclusive instruction.³⁵

Finally, medical schools and affiliated clinical sites must implement ongoing cultural competency training for students and residents to combat stigma and discrimination within the medical community. Studies show that 59% of Black Canadian students experience discrimination in medical school, primarily from peers, residents, and patients.³² Discrimination rates increase throughout medical education, from 20% in the first year to 100% in the fourth year and early residency, which underscores the need for continuous, up-to-date training initiatives.³² Medical schools should invest in these programs to ensure sustainability and prevent the burden of training from falling disproportionately on URM students.

16. Indigenous Medical Students

The CFMS thanks the Indigenous Medical Students' Association of Canada and medical students Kristine Keon and Carly Thomson for authoring this section.

I. Schools should implement a Cultural Leave Policy for Indigenous students. This policy should support leave for culturally significant practices such as hunting, fishing, gathering, ceremony, and other land-based or community obligations

- A. Schools should allow cultural leave for Indigenous students (up to 5 days in addition to standard leave policies)*
- B. Flexibility: Students should give their school as much notice as possible. For events that take part on a regular basis (i.e., powwow), students are expected to submit their leave request as soon as the event date has been determined. For other leave requests that cannot be predetermined (i.e., fishing, hunting, gathering, celebration of life), students should provide as much notice as possible, and schools should be aware of the need for flexibility in some cases*
- C. Supporting documents: Schools can request supporting documents to prove Indigeneity as needed. Schools can also request information pertaining to the event leave request detailing the type of event and the importance of the students' attendance*
- D. Learning opportunity: Cultural events should count towards Indigenous students' learning hours towards the school's Indigenous health curriculum. Schools can request a short reflection essay from the students after the event has taken place if appropriate (i.e., not after a celebration of life ceremony) and deemed necessary*

II. Indigenous health session opt-out and support:

- A. Indigenous students should have the option to attend or opt-out of lectures focused on Indigenous health, Indigenous history, etc.*
- B. If attending, Indigenous students should not be called upon by professors to offer personal opinions, insights, etc. on the content being taught*
- C. Indigenous students should be given the opportunity to opt out of sessions at least 14 days in advance*
- D. If attending, Indigenous students should be made aware prior to the lecture about the content covered (i.e., discussions on residential schools, mistreatment, etc.)*

- E. *Indigenous support staff or elders should be available to Indigenous students if they wish to debrief after an attended lecture*
 - F. *Indigenous students should be able to substitute Indigenous health sessions with cultural events/land based activities per the cultural leave recommendation*
 - G. *Whenever possible, Indigenous health sessions should be scheduled at the end of the school day*
- III. *Schools should ensure Indigenous medical students have access to at least two Indigenous preceptors in clinical rotations and at least one clinical learning opportunities in Indigenous communities, including opportunities within their own home communities when appropriate***
- IV. *Schools should provide Indigenous medical students with consistent access to cultural supports, including:***
- A. *Indigenous Elders and Knowledge Keepers for guidance, ceremony, and mentorship;*
 - B. *Dedicated gathering spaces where Indigenous medical students can connect, reflect, and engage in cultural practices safely;*
 - C. *Dedicated Indigenous medical student support staff or navigators who understand the unique experiences of Indigenous medical learners and can offer academic, personal, and cultural support*

Indigenous peoples (including First Nations, Métis, and Inuit) of Canada represent approximately 4.9% of the population.³⁶ Indigenous peoples continue to experience vast health disparities compared to non-Indigenous people in Canada as a result of current and historical effects of discrimination, racism, and other direct effects of colonialism.^{37–39} To address these disparities, the National Truth and Reconciliation Commission of Canada has called upon all levels of government to increase the number of Indigenous healthcare professionals working in the healthcare field (Truth and Reconciliation Commission [TRC] Call to Action #23 (i)).⁴⁰ Despite this Call to Action, fewer than 1% of physicians identified as Indigenous on the 2016 census, and 2.6% of students who participated in the first iteration of the 2022 R-1 main residency match identified as Indigenous, which are both below the expected number of Indigenous people relative to the population.^{41,42} Given the under-representation of Indigenous people in medicine, it is essential to support the Indigenous medical students who successfully matriculate into medical schools.

Cultural supports are essential for Indigenous medical students in Canada, as they promote well-being, identity affirmation, and retention in medical training. Indigenous medical students navigate systems that were not designed with in-line with Indigenous ways of knowing, and have lead to experiences of isolation, racism, and cultural disconnection as found by the TRC Report Card Project. Access to cultural supports reinforces a sense of belonging and allows students to engage with Indigenous ways of knowing and healing, which are critical not only to personal wellness but also to their future roles as physicians serving Indigenous communities. Data from other Indigenous communities internationally have found that cultural supports help Indigenous students in the health sciences succeed.⁴³ Furthermore, the TRC Call to Action #24 urges medical schools to value Indigenous healing practices and integrate them into health training. By providing Indigenous medical students with cultural supports, faculties support Indigenous student well-being and success, TRC Call to Action #23, and TRC Call to Action #24.

Canada is home to many distinct Indigenous cultures across. No two Indigenous groups or organizations are the same, but what is common across all is the importance of maintaining cultural connection for well-being. While medical schools recognize leave requests for professional development, bereavement, illness and personal emergencies, they often fail to formally recognize cultural leave. Cultural practices such as ceremonies, powwows, and land-based activities are essential to Indigenous ways of being.⁴⁴ Current leave policies are too rigid and non-accommodating of Indigenous cultural practices, and thus do not recognize the cultural significance for the physical, mental, and spiritual well-being of Indigenous learners to partake in these events. The dates of many cultural events cannot be predetermined, and therefore Indigenous-specific cultural leave requests should be flexible to accommodate students. For example, many cultures are deeply rooted in hunting, fishing, and gathering. Being able to harvest salmon when they are running, berries when they are ripe, and seals when they are mature is how I connect with the land and waters and those who came before me. These practices are fluid, and—as climate change progresses—more unpredictable. It would not be possible to pre-book these events months in advance, but students would be able to give their schools approximately one to two weeks' notice. This is one example of how important it is to allow students this flexibility. Other events, such as annual gatherings, would likely have lots of notice. At the discretion of the school, they may also request supporting documents. This could look like a letter from a community Elder or band council detailing the importance of the medical students' attendance. In the spirit of reconciliation, it is recommended that medical students have the option to substitute Indigenous health specific lectures with cultural events as reflected in this policy (please refer to the Indigenous health opt-out recommendation, Recommendation 16II). There is no better learning opportunity than firsthand knowledge and experience. Therefore, cultural events attended by Indigenous medical students should also count towards credit hours towards Indigenous health. Indigenous students should be supported in their cultural wellness including: connection to land and water, land-based practices, Indigenous languages and knowledge systems, and the right to meaningful participation in decision-making.⁴⁴

Indigenous students should have the option whether or not they attend Indigenous health lectures. Lectures do not take the place of lived experiences, and oftentimes, these sessions can be re-traumatizing to students. A better learning experience is the substitution of Indigenous health lectures for cultural events and practices (please see the cultural leave recommendation, Recommendation 16I). For those who choose to attend the session, students should be informed at least one week in advance about what content will be covered to avoid any unsuspecting triggers, and possibly contribute to the students' decision of if they will attend or not. Importantly, Indigenous students should not be called upon by professors or peers to provide opinion, insight, or experiences, unless they choose to do so willingly. It is not the responsibility of Indigenous learners to educate others on Indigenous health issues, unless desired to do so. Much of the content that is covered in Indigenous health learning sessions can be very difficult and re-traumatizing. Students should be properly connected to appropriate supports before and after the session. This might look like community, Elders, Indigenous social workers, or other appropriate personnel. Because the content can be heavy for all students, it is recommended that whenever possible, these sessions take place at the end of the school day. This is to allow students time to debrief without having to focus on another learning topic.

Mentorship has long been used in the health professions to provide students with professional and personal development.⁴⁵ At the medical student level, mentorship in general is associated with improved

satisfaction in medical school, career development, and professional development as well as increasing the overall well-being, reduced burnout, and self-efficacy in trainees.^{46–50} Additionally, medical leadership by Indigenous physicians is perceived to positively impact the attitudes of Indigenous students towards studying medicine.⁵¹ We therefore strongly support the recommendation to provide Indigenous medical students with clinical experiences with Indigenous preceptors as well as Indigenous communities, including their own.

17. Black Medical Students

The CFMS thanks the Black Medical Students Association of Canada and medical students Grace Ayoo, Leila Hammond, and Lesly Joyce Nkuindja for authoring this section.

Black medical students frequently encounter anti-Black racism, microaggressions, and underrepresentation across Canadian medical schools. These experiences contribute to heightened imposter syndrome, mental health strain, and reduced sense of belonging, with documented links to increased burnout and distress.^{32,52,53} To safeguard the health and wellbeing of Black learners, we propose the following evidence-based recommendations tailored to the Canadian medical education context:

I. Providing support for Black community building:

- A. Schools should provide sustainable support for Black Student-Led groups like the BMSAs as these can serve as spaces on campus that foster belonging, peer support, and advocacy among Black students. Sustainable funding, administrative assistance, and spatial resources allow these groups to continue without overburdening students*
- B. Schools should provide sustainable support for Black students to attend culturally significant conferences and events, such as BMSAC, BPAO, BPC, and CANPAD, that promote mentorship, belonging, and professional development. Funding and schedule flexibility for course work will allow students to have equitable access*
- C. Schools should invest in engagement and representation within Black communities by supporting Black-led community initiatives and involving Black leaders through the curriculum and institutional programming*

II. Ensuring safety and wellbeing:

- A. Schools should implement anti-racism policies and confidential, trauma-informed reporting systems that protect the psychological safety of Black learners and address incidents involving patients, peers, and preceptors*
- B. Schools should ensure cultural safety when discussing race in the learning environment, by equipping educators to lead conversations on racism without relying on Black students to share their personal experiences or act as peer educators*
- C. Schools should ensure faculty provided wellness resources are culturally safe and relevant for Black Medical Students. Wellness supports must be responsive to the needs of Black medical trainees, with providers trained in cultural humility for services and resources that are accessible and effective for Black learners*
- D. Schools should provide academic credit or financial compensation for students engaging in anti-racist/EDI work for the betterment of the faculty. Black students are often called upon to contribute to EDI and antiracism work. This labour is time intensive and can be*

emotionally draining. Offering credit or compensation recognizes and values this work appropriately

III. Schools should collect and use race-based data on admissions, progression, and attrition to identify structural barriers for Black medical students. *Without race-based data, inequities in the medical school experience remain hidden and are not able to be addressed. Race-based data collection must be done ethically and with collaboration with Black student groups to provide an evidence base for identifying and addressing barriers and assessing progress to overcome the barriers that are unique to Black medical students*

Black medical students are underrepresented in Canadian medical schools; despite making up 4.3% of the total Canadian population, only 2.9% of medical students are Black.^{54,55} At the same time as experiencing under representation, Black and ethnic minority medical students often feel hypervisible with a decreased sense of belonging.⁵⁶ Medical schools should support activities that foster belonging among Black students which may be protective against depression in burnout and imposter syndrome.⁵⁶

Black student-led organizations are a key resource for peer support, mentorship and advocacy for Black Medical learners.⁵⁷ Despite the significant role these organizations play in medical schools they are often underfunded and under-resourced. Sustained and predictable financial and administrative support is imperative to ensuring that these groups can maximize their formal and informal supports to Black medical students.

Medical schools should also provide sustained support for Black medical students to attend events that center Black identity and professional advancement. Conferences such as the Black Medical Students' Association of Canada (BMSAC) Conference, the Canadian Association of Nigerian Physicians and Dentists (CANPAD), the Black Physicians of Canada (BPC) Conference, and events organized by the Black Physicians' Association of Ontario (BPAO) offer invaluable opportunities for mentorship, networking, and identity affirmation. These culturally affirming spaces provide students with a greater sense of community, reduce professional isolation, and contribute to long-term wellness and retention in medicine.^{32,58} We recommend that institutions allocate dedicated funding and logistical support to ensure equitable access to these events.

Black learners frequently experience microaggressions and overt discrimination from patients, peers, and even faculty or preceptors, yet many feel unsafe or unsupported when attempting to report these experiences. Traditional reporting structures are often opaque, inconsistently enforced, or retraumatizing for the individual filing the complaint.⁵³ Medical schools must implement trauma-informed, accessible, and confidential reporting mechanisms that explicitly name and address anti-Black racism. These systems must be built with input from Black learners and be responsive to the realities of racialized power dynamics in clinical and academic settings. Protecting the psychological safety of Black students throughout the reporting process is essential to ensure that incidents of racism are addressed without further marginalizing the student who has already been harmed.⁵⁹

Despite many medical faculties' efforts to increase diversity at their institutions, Black faculty and faculty with education on anti-Black racism remain unrepresented in leadership positions at many schools in the

country. As a result of this, much of the anti-Black racism work taken on by faculty falls to lack medical students.

Finally, cultural safety must be embedded in how race is discussed in both formal curriculum and informal learning spaces. Black students are often placed in the position of having to validate their lived experiences or educate their peers during discussions on race, health disparities, or structural inequity—placing an undue burden of emotional labor on learners who are already navigating minority stress.⁶⁰ Educators should receive training in anti-oppressive pedagogy and be adequately prepared to lead these conversations with care, nuance, and cultural humility. Black faculty, clinicians, and community members should be actively engaged in the design and delivery of this content. Schools must also establish clear mechanisms to address harm when it occurs and ensure that Black learners are not expected to serve as de facto representatives of their racial or cultural group.

Representation is not only important within medical cohorts, but also in the environments and communities that shape medical education. Diverse representation in teaching, mentoring, and clinical exposure can help students develop cultural humility and promote patient trust. This is especially true for patients coming from minority groups, who often feel safer and better understood when cared for by providers who share aspects of their identity.^{61,62} It is also worth highlighting that community engagement during medical training can benefit both students and the populations they serve. Involvement in Black-led health initiatives can allow students to feel connected to their communities and enhance their sense of purpose. This approach can also contribute to culturally responsive care and more equitable health outcomes.⁶³ Therefore, medical schools should formally support community-based initiatives, recognize the wellness impact of representation, and promote the leadership of Black leaders across academic and clinical spaces.

Taken together, these recommendations form a framework for promoting the wellness of Black medical students in a way that is systemic, sustainable, and culturally informed. Medical institutions have a responsibility not only to eliminate harm but to foster learning environments where Black students feel safe, valued, and supported. Creating psychologically safe, affirming, and equitable spaces is not just an act of inclusion, it is a prerequisite for excellence in medical education.

18. 2SLGBTQIA+ Students

The CFMS thanks the Canadian Queer Medical Association and medical students Yang Bo (YB) Zhang and Callum French for editing this section.

- I. Schools should create inclusive spaces by providing accessible gender-neutral washrooms and changerooms, and promoting visible markers of 2SLGBTQIA+ inclusivity*
- II. Schools should foster a respectful learning environment by using inclusive language, ensuring students' chosen names and pronouns are recognized on profiles and attendance sheets, and providing accessible training for medical students and faculty on identifying and addressing discriminatory language and microaggressions*
- III. Schools should provide 2SLGBTQIA+ competency and safety training and ensure curriculum content is taught sensitively, including guest lectures from individuals with lived experience*

The 2SLGBTQIA+ acronym represents sexual and gender-diverse communities, including Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, and more identities. As of 2021, 4.4% of Canadians aged 15 and older identify as part of this community.⁶⁴ Notably, younger Canadians contribute most to this growth—those aged 15–24 make up 14% of the general population, but 30% of the 2SLGBTQIA+ population.⁶⁵ This increasing prevalence highlights the need for greater awareness to support both students and patients.

Studies in American and Canadian medical schools reveal significant explicit (conscious) and implicit (unconscious) biases toward sexual and gender-diverse individuals, impacting patient care and student interactions.^{66–70} Addressing these biases requires a two-pronged approach. To combat explicit biases, we recommend fostering 2SLGBTQIA+ inclusive spaces. This includes accessible gender-neutral washrooms and changerooms, visible markers of inclusivity (e.g., pronoun pins, “no tolerance” policy posters, flags), and respectful uses of names, pronouns, and gender-neutral language. An effective way of including gender-neutral language in presentations and documents is to focus on the organ system itself. For example, instead of “women can become pregnant”, an alternative would be “a uterus can become pregnant”. This can also be useful in discussions around hormones and their effects on systems, for example, “estrogen is osteoprotective”, not just “being a woman is osteoprotective”. Focusing on the biochemical or social cause of medical phenomena, rather than the sex or gender of an individual, allows for deeper understanding and for interesting thoughts around the care for trans individuals. Inclusive language enhances belonging, while noninclusive language negatively affects student performance and experience.^{71–74}

Implicit biases, ingrained over time, are harder to change, but can be mitigated through awareness, perspective-taking, and education.⁷⁵ We recommend mandatory 2SLGBTQIA+ competency and safety training for all students, as studies show healthcare workers receive less training on these topics than other equity, diversity, and inclusion issues.⁷⁶ This training should be well-integrated throughout the curriculum rather than solely one point in time.

Schools should also provide faculty and student focus groups on identifying microaggressions, as well as institutional, physical, informational, and epistemological discrimination, and establishing tangible ways to address these issues.⁷⁷ The principle of addressing the above should be to emphasize safety and reconciliation. Explicitly taking a stance against punitive approaches, ensuring learner and patient safety, and framing these instances as an opportunity to growth are key to uptake and longitudinal changes.

Finally, guest speakers with lived experience should be invited to enhance student perspective-taking. Currently, only 63.4% of CFMS Wellness Survey participants agreed that appropriate guest speakers present on marginalized populations’ health. These guest speakers should also be honored appropriately, whether that means monetary honoraria, compensation for travel expenses, or professional acknowledgements.

19. Non-Traditional Entry Students

- I. Schools should provide targeted learning guidance and academic support for non-traditional students without science backgrounds, either before the program begins or during its early stages*

- II. *Schools should offer educational resources or peer-tutoring sessions to help non-traditional students bridge any knowledge gaps at the start of medical school*
- III. *Schools should provide counseling or support sessions to address identity adjustment issues for students entering medical school from non-traditional backgrounds*
- IV. *Schools should foster inclusive learning environments that actively incorporate the experiences and perspectives of students from diverse backgrounds through varied case studies and group discussions*

Medical students come from diverse cultural, experiential, employment, and academic backgrounds. This includes non-traditional students—those who have had prior careers, mature students (aged 25+), those within the Canadian Armed Forces stream, and those without a science background.

Non-traditional students are a minority in medical school, as most students come directly from undergraduate or graduate science programs. While literature on this topic is limited, medical schools are often less accessible to students from non-traditional backgrounds. Despite bringing maturity, diversity, and valuable life experiences, these students frequently encounter barriers due to their background.⁷⁸

Students from science backgrounds enter medical school with a strong foundation in core scientific concepts, allowing them to focus on new medical knowledge. In contrast, students from non-science backgrounds may struggle with the assumed scientific knowledge in the curriculum.⁷⁹ Many report needing extra study time with secondary materials to catch up, which can affect their confidence and limit their ability to engage in non-academic aspects of medical school, such as socializing, adjusting to expectations, and taking on clinical responsibilities.⁷⁹ Additionally, most career-transitioning students reported inadequate support for their transition to medical school.

Non-traditional students with prior work experience bring valuable assets, including “internal locus of control, self-esteem, a sense of purpose in life, the ability to self-actualize, and critical thinking abilities”.⁸⁰ These strengths are extremely valuable, but can also make it challenging to develop a new professional identity.⁸⁰ Research shows that many struggle to reconcile their previous identity with their role as a medical trainee, often holding back aspects of their former selves.⁸⁰ In addition, they may pose challenges to medical educators because of their self-confidence, willingness to challenge the status-quo, or hesitancy to conform to the hospital hierarchy.^{78,80} This can further contribute to their barriers when transitioning to medical school.

Based on these findings, we recommend targeted academic and identity-based support. To address academic barriers, medical schools should offer preparatory materials and tailored learning guidance for students from non-science backgrounds. Peer tutoring may also help bridge knowledge gaps and foster collaboration. For identity development, schools should provide counseling or support sessions. Lastly, learning environments—including lectures, case discussions, and clinical encounters—should be inclusive and welcoming to students from all backgrounds.

20. Students who are Caregivers

- I. *Schools should provide university-affiliated childcare at a reduced rate to support student parents*

- II. *Schools should offer schedule accommodations for students with caregiving responsibilities when possible*
- III. *Schools should implement a hybrid learning model to improve accessibility for student caregivers*

Being a parent or caregiver adds significant responsibility for medical students, who must balance education with family needs. Despite this, gaps in support persist. Caregivers often need childcare to attend classes and clinical training. Canadian medical schools have some of the highest tuition fees compared to other programs in the country, yet students have limited income, making childcare a major expense.⁸¹ Affordable childcare is essential to alleviate this financial burden. While some students access on-campus childcare, this is not universal. Many centers have long waitlists, often requiring years for a spot.⁸² Students cannot choose their school location, making it difficult to secure childcare, especially when relocating. We recommend that schools provide university-affiliated childcare at a reduced rate to support student parents.

Parents and caregivers frequently need time off for dependents, yet additional personal days are rarely granted. While parental leave exists for expecting students, those with children may need extra days for illness or appointments.⁸³ Without flexibility, balancing school and family becomes harder. These students often require more personal days than their peers but are not provided them, adding another hurdle. We recommend that schools offer schedule accommodations for student caregivers, and establish a clear policy to define and recognize caregiver status, ensuring that eligible students can access appropriate accommodations and support

Attending classes can be difficult when childcare falls through. A hybrid model—allowing virtual attendance for lectures while requiring in-person labs, small groups, and clinicals—would improve accessibility. Student parents have limited study time, often working late at night or early morning, impacting motivation.⁸⁴ Research shows they are more likely to prefer online options, yet hybrid learning remains rare in Canadian medical schools. We recommend that schools implement a hybrid model to improve accessibility for student caregivers.⁸⁵

21. Students who are Breast/Chestfeeding

- I. *Schools should provide sanitary, private lactation facilities equipped with a fridge, sink, kettle, and microwave, located close to trainees' workspaces, and accessible at all hours*
- II. *Lactation policies should incorporate student-reported experiences and testimonials to outline common scenarios and accommodations, while maintaining flexibility for individual needs*
- III. *When developing lactation policies, institutions should collaborate with faculty advisors, administrative leaders, legal counsel, and medical students with lived experience of infant feeding during medical school*

Breast/chestfeeding is widely recognized as the optimal method of infant nutrition, with extensive benefits for both mother and child. It reduces the risk of chronic diseases, supports healthy development, and fosters mother–infant bonding, lowering rates of postpartum depression.^{86–97} It is upheld as a human right by both the United Nations and the Canadian Charter of Rights and Freedoms.^{98,99} The WHO recommends exclusive breast/chestfeeding for the first six months and continued breast/chestfeeding for two years or more, underscoring its importance.^{86,91–93}

Medical students are taught the benefits of breast/chestfeeding and encouraged to promote it to patients.^{100–102} Yet, many schools lack policies that support breast/chestfeeding among students themselves, creating an environment misaligned with their own educational messages.^{100–102} Providing designated lactation spaces, flexible scheduling, and protected time for milk expression during rotations or academic activities can promote student well-being and reinforce the values they are expected to champion as physicians.⁹³

Inadequate support may force students to make difficult choices—taking extended leave to meet feeding goals or stopping breast/chestfeeding earlier than desired. Time away from training can delay graduation, harm career opportunities, and worsen financial burdens, while early weaning can negatively affect maternal and infant health. Such decisions create unnecessary stress, disrupt educational progress, and can have lasting professional and personal consequences. This highlights the urgent need for institutional policies that allow students to meet both their academic and infant-feeding goals without compromise.

22. Accessibility

- I. Schools should provide closed captioning for lectures (both live and asynchronous) and accommodations for online assessments similar to in-person assessments, including: additional time, note taking, adapted proctoring, etc.*
- II. Schools are encouraged to collect data at the institutional level regarding the prevalence of medical students with accessibility needs and their experiences navigating programs and policies*
- III. Schools should communicate clear and concise accessibility policies and procedures, including processes of seeking and implementing accommodations, and addressing discrimination*
- IV. Spaces should be adjusted for students with sensory sensitivities and challenges*

In their 2010 report on the Future of Medical Education in Canada (FMEC), the Association of Faculties of Medicine of Canada (AFMC) recommended that Faculties of Medicine “recruit, select, and support a representative mix of medical students”.¹⁷ To support diverse student populations, accessibility must be a core pillar of medical education.

Disability is broadly defined as any impairment that can impede full societal participation.¹⁰³ Mental, physical, learning, mobility, and sensory disabilities can affect performance and participation in medical school.¹⁰³ Estimates suggest that up to 13% of medical students have disabilities, though the percentage who disclose their condition is much lower.¹⁰⁴ Students with disabilities face various barriers, such as strict attendance policies, lack of funding for transportation or dietary needs, and insufficient accommodations for sensory disabilities or pain in clinical rotations like surgery.¹⁰⁵ Some technical requirements in medical education may also be challenging for students with disabilities. For example, the ability to gather all relevant sensory information is a key skill, but auscultating lung or heart sounds may be difficult for students with hearing impairments.¹⁰³ As remarked by Gertsman et al., these “generic technical standards deny students entry into fields in which they may excel”.¹⁰³ Finally, there continues to be a pervasive hidden curriculum suggesting that students should sacrifice their health for the sake of performance and keep their conditions undisclosed, which may be a source of stigma or discrimination.¹⁰⁴

Invisible disabilities, such as chronic illnesses, mental health conditions, and neurological impairments, present unique challenges for students. Many students with invisible disabilities face a difficult decision about whether to disclose their condition after admission.¹⁰⁵ Disclosing could aid educational participation but may also compromise their privacy. In a letter published in *Medical Teacher*, for instance, Hayashi provides an anecdote of a student with alopecia who avoided the head and neck clinical examination sessions to prevent peers from noticing her wig.¹⁰⁵ It is crucial to ensure that students are aware of accessibility policies and resources, regardless of whether their disabilities are visible, specifically, how to seek accommodations, how accommodations would be implemented at various stages of training, limits of confidentiality, and processes of addressing discrimination or microaggressions. The dissemination of such information should be broad, to avoid making assumptions on dis/ability status.

The 2023-24 CFMS survey of student wellness representatives from 11 Canadian medical schools revealed that most faculties provided closed captioning for lectures, but few offered accommodations like seating for larger students or spaces without fluorescent lighting for those with sensory disabilities. One student noted that although accessibility services were helpful, wait times were long, and many students remained unaware of available resources (including examples of what accommodations would look like, additional funding opportunities, and resources for mentorship or peer support). They noted that medical students tend to feel “they will not be accommodated [or will be] viewed as weak or a poor student”. The average student rating for accessibility at their medical school was 3 out of 5, highlighting the need for improvement.

As preclinical medical education increasingly moves to online and/or asynchronous formats, medical schools should adopt standards for accessibility in online education.¹⁰⁶ This includes providing closed captioning for both live and asynchronous lectures and, where possible, offering the option to watch recorded versions at different speeds. Additionally, accommodations that were previously offered for in-person assessments, such as extra time, note-taking support, and adapted proctoring, should also be available for online assessments.¹⁰⁴

In line with the Association of American Medical Colleges (AAMC) report on accessibility, inclusion, and action in medical education (an equivalent of which does not exist for the AFMC), medical schools should provide clear and concise accessibility policies, ensuring students are aware of how to access accommodations and resources. The institutions should also regularly update these standards based on best practices.¹⁰⁷

To foster a more inclusive environment, faculties should cultivate a culture that encourages resource-seeking behavior and the use of student-focused wellness services. They should adopt universal design frameworks for both educational activities and physical spaces. Additionally, all faculty and staff should receive regular training on inclusion and accessibility, ensuring that these principles are applied in curriculum development. Finally, all Canadian medical schools are encouraged to actively recruit medical students with disabilities as their lived experiences brings both diversity and unique empathy to patient care.

IV. FUTURE DIRECTIONS

This year marks the second iteration of the CFMS Recommendations on Student Health and Wellbeing. Along with updating the recommendations, we have added several new sections to ensure that they are accessible and relevant to a diverse student body. New sections introduced in this iteration include student workload and scheduling, clinical skills, examinations, and community-specific recommendations intended to promote equity within medical student life.

Following the publication of these guidelines, CFMS representatives across Canada will advocate for the implementation of these policy changes at all member medical schools by presenting the recommendations to their respective UGME committees. Recognizing that policy changes can be a lengthy and challenging process, our representatives will collaborate with relevant committees at each UGME to assess the feasibility of these changes and track any progress made in the coming year. This will be in preparation for the following iteration of the recommendations. After the first iteration of the recommendations, we tracked progress by sending out a national survey and seeking qualitative feedback from students. These initiatives provided schools with a sense of their progress and how they compared to others. Tracking progress through these feedback mechanisms will continue each year based on the national survey responses we receive.

Every four years, a new iteration of the recommendations will be developed, informed by evolving literature and student consultation. An important addition for future recommendations will be a section on the residency match process through CaRMS. More standardized support systems should be established for students navigating CaRMS, such as making visiting electives more affordable and equitable. Additionally, other areas of focus include delivery methods for lectures and tutorials, examination-related topics such as at-home video proctoring options, and providing clearer expectations and breakdowns of exams.

V. CONCLUSION

Medical student health continues to be a significant challenge within Canadian healthcare. The targeted interventions and recommendations outlined here, grounded in both literature and consultations with Canadian medical students, aim to reduce burnout and foster a positive learning environment for medical trainees.

Importantly, creating a supportive learning environment will require actively considering student perspectives in policy development and fostering a culture of wellness that ensures equitable access to support systems across all Canadian medical schools. Ultimately, we hope these efforts will help cultivate a healthier physician trainee workforce and promote a positive cultural shift within our Canadian healthcare system.

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Most of all, we acknowledge the body of Canadian medical students whom we represent, whose voices we aim to amplify and direct toward meaningful change.

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APPENDIX 1. PREVIOUS POSITION PAPERS

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