CANADIAN MEDICAL EDUCATION JOURNAL | REVUE CANADIENNE DE L'ÉDUCATION MÉDICALE

2026, In Press: https://doi.org/10.36834/7mc21x18

SCIENTIFIC REPORTS

Community service learning in Canadian medical schools: a national qualitative study of implementation and evaluation

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Abstract

Background: Community Service Learning (CSL) is a required component of Canadian medical education, designed to foster social accountability and integrate community engagement into the training process. Despite widespread adoption across Canadian curricula, no study has examined CSL implementation nationally. This study provides a national snapshot of CSL as reported by program leads, describing how CSL programs are delivered across Canadian medical schools.

Methods: We conducted structured interviews (April–June 2025) with CSL leads at 16 Committee on Accreditation of Canadian Medical Schools (CACMS) accredited institutions. The interview guide was based on CACMS element 6.6 (preparation, structure, evaluation). Interviews were transcribed verbatim, managed in NVivo 15, and analyzed using conventional content analysis.

Results: Five categories were identified from 6.7 hours of interviews: (1) learning objectives, (2) implementation, (3) placement structures, (4) preparation and safety, and (5) assessment and evaluation. CSL was mandatory at 12/16 schools (mean ≈40 hours; range ≈10–80+). Fifteen out of 16 emphasized communication skills and understanding lived experiences of diverse populations. Placement models varied: 10/16 offered online or in-person options and 9/16 required work with people facing health inequities. Preparation included universal orientation (16/16), with social determinants of health emphasized at 14/16. Assessment relied on reflections (16/16; 11 end-only, five longitudinal), while only six out of 16 systematically gathered community-partner feedback.

Conclusion: This study reveals significant variability in CSL program design, placement criteria, and evaluation. Establishing benchmarks and fostering inter-institutional collaboration could strengthen CSL's impact on students, communities, and the broader goal of socially accountable medical education.

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L’apprentissage par le service communautaire dans les facultés de médecine canadiennes : une étude qualitative nationale sur la mise en œuvre et l’évaluation

Résumé

Contexte : L’apprentissage par le service communautaire (ASC) est un volet obligatoire de la formation médicale au Canada. Il vise à favoriser la responsabilité sociale et intégrer l’engagement communautaire dans le processus de formation. Malgré son adoption généralisée dans les programmes d’études canadiens, aucune étude n’a encore examiné la mise en œuvre de l’ASC à l’échelle nationale. La présente étude offre un portrait national de l’ASC tel que décrit par les responsables de programme, en détaillant la manière dont les programmes d’ASC sont mis en œuvre dans les facultés de médecine canadiennes.

Méthodes : Nous avons mené des entretiens structurés (avril-juin 2025) avec les responsables de l’ASC de 16 établissements accrédités par le Comité d’agrément des facultés de médecine du Canada (CAFMC). Le guide d’entretien s’appuyait sur l’élément 6.6 du CAFMC (préparation, structure, évaluation). Les entretiens ont été transcrits mot pour mot, gérés dans NVivo 15, puis analysés à l’aide d’une analyse de contenu conventionnelle.

Résultats : Cinq catégories ont été dégagées à partir de 6,7 heures d’entretiens : (1) les objectifs d’apprentissage, (2) la mise en œuvre, (3) les modalités de placement, (4) la préparation et la sécurité, et (5) l’évaluation. L’ASC était obligatoire dans 12 établissements sur 16 (moyenne ≈ 40 heures ; fourchette ≈ 10–80+). Quinze établissements sur 16 mettaient l’accent sur les compétences en communication et la compréhension des expériences vécues par des populations diverses. Les modalités de placement variaient : 10 établissements sur 16 proposaient des options en ligne ou en présentiel et 9 sur 16 exigeaient de travailler avec des personnes confrontées à des inégalités en matière de santé. La préparation comprenait une orientation dans toutes les facultés (16 sur 16) et les déterminants sociaux de la santé étaient mis de l’avant dans 14 établissements sur 16. L’évaluation reposait sur des réflexions (16 sur 16 ; 11 en fin de stage uniquement, 5 tout au long du parcours). Seuls six établissements sur 16 recueillaient systématiquement la rétroaction des partenaires communautaires.

Conclusion : Cette étude révèle une grande variabilité dans la conception des programmes d’ASC, les critères de placement et l’évaluation. L’établissement de critères de référence et la promotion de la collaboration interinstitutionnelle pourraient renforcer l’impact de l’ASC sur les étudiants, les communautés et l’objectif plus large d’une formation médicale socialement responsable.

Introduction

Community Service Learning (CSL) integrates meaningful community engagement with academic and clinical training, offering medical students opportunities to apply knowledge in real-world contexts while reflecting on broader social determinants of health.[1,2] It is an experiential educational approach integrated into undergraduate medical curricula that combines structured community engagement with guided reflection to achieve defined learning objectives, including developing an understanding of the social determinants of health, fostering advocacy and social accountability, strengthening communication and cultural humility, and sup-orting professional identity formation. Through CSL, medical students participate in supervised placements with community partner organizations, such as food security programs, shelters, community health centres, and outreach initiatives serving individuals, communities, and populations experiencing health inequities. These longitudinal placements enable students to contribute meaningfully to community-identified needs while developing competencies in empathy, cultural humility, professional identity formation, and a sense of responsibility toward all populations.[3-8]

Despite these benefits, little is known about how Canadian medical schools' structure CSL within undergraduate medical education to align with evolving accreditation expectations. The Committee on Accreditation of Canadian Medical Schools (CACMS) Element 6.6 requires medical programs to provide structured service-learning experiences that combine community engagement with preparation and reflection.[9,10] These standards emphasize the importance of intentional program design, including adequate preparation, meaningful engagement, structured reflection, and ongoing evaluation to support student learning and professional development. Given that CSL represents the common model through which service learning is implemented in medical education, understanding how CSL programs are structured is essential to ensuring alignment with accreditation standards and educational objectives.

To date, no national analysis has examined how CSL is operationalized across Canadian medical schools. Understanding how institutions meet accreditation requirements is critical for identifying strengths, challenges, and opportunities for shared learning. Thus, this article explores CSL implementation, delivery, and evaluation across Canadian medical schools to provide an accreditation-focused national snapshot.

Methods

We employed a generic qualitative research approach using conventional content analysis to explore how CSL is implemented, delivered, and evaluated across Canadian medical schools.[11,12]

Participants and recruitment

We invited CSL Leads from all 17 CACMS-accredited Canadian medical schools to participate. We defined CSL leads as individuals with formal responsibility for the design, implementation, or evaluation of CSL or service-learning activities within their respective undergraduate medical education programs.

We identified eligible participants using publicly available information on institutional websites and invited them to participate via email. When unable to identify a specific contact, we emailed the general Faculty of Medicine or undergraduate medical education office contact and were subsequently redirected to the appropriate individual.

Data collection

We developed a structured interview guide informed by CACMS (2025) Element 6.6 for schools undergoing accreditation evaluations in 2026-2027.[10] We organized the guide to reflect the full CSL continuum, including pre-placement preparation, placement structure, and post-placement reflection and evaluation.

Pre-placement questions explored student preparation and placement processes, including: "How does

your school prepare students for CSL activities (e.g., online modules, training, etc.)?" and "What process is used to determine students' choice of placement (e.g., lottery system, applications)?" Placement-related questions examined curricular integration and program structure, such as: "Which year(s) does CSL take place in the program?", "Is CSL a mandatory or voluntary/elective component of the program?", and "What are your CSL learning objectives?" Post-placement questions focused on reflection and assessment strategies, including: "Do you have a post-placement evaluation strategy for students and partner organizations?" and "How does your school ensure student reflection following participation in CSL activities?" Closing questions addressed broader program considerations, such as: "What have been the greatest challenges and successes of CSL at your school?" and "What are your CSL plans for the future?" The University of Ottawa Research Ethics Board granted ethical exemption prior to data collection.

The research team conducted structured interviews virtually, audio-recorded them with participant consent, and three team members (EM, RK, JT) transcribed them verbatim. Interview duration ranged from 14 to 48 minutes. We imported transcripts into NVivo (Version 15) to facilitate data management and analysis.

Data analysis

We analyzed transcripts using a conventional content analysis approach to classify the data.[12,13] Two team members reviewed and coded each transcript independently. All coders first read transcripts in full to familiarize themselves with the data before generating initial codes.[13] The research team iteratively refined codes throughout the analysis process. As analysis progressed, the research team grouped related codes into broader categories to identify recurring patterns and similarities in how institutions structured and implemented CSL programs.[13] Although CACMS Element 6.6 informed the development of the interview guide and sensitized the research team to key domains of interest (i.e., prepa-ation, placement structure, reflection, and program evaluation), it did not constrain the coding process.

Reflexivity

Given that qualitative content-based analysis involves interpretive judgment, the authors engaged in reflexive dialogue throughout the analytical process. During meetings, they discussed discrepancies and reached consensus to finalize categories. The authors' familiarity with the academic and professional landscape of CSL, its implementation, and accreditation systems added contextual grounding and mitigated the potential for institutional bias. To enhance analytic rigor, three authors (EM, RK, JT) independently coded the data before discussion. The team used deductive classifications and justified decisions against accreditation language and categories of data found within the interview guide rather than experiential assumptions. This structured, consensus-based approach strengthened rigor and trustworthiness while preserving conceptual clarity in reporting of data classifications and categories.[12-15]

Results

Representatives from 16 CACMS-accredited Canadian medical schools participated in interviews, out of 17 institutions invited. Each institution was represented by at least one CSL Lead; two institutions had two representatives participate due to shared responsibilities or recent transitions in the role. Detailed demographic characteristics of participants were not collected as the study focused on institutional-level perspectives on CSL structure and implementation.

Five categories were developed from the analysis (Table 1): Learning Objectives, Implementation, Placement Structures, Preparation and Safety, and Assessment and Evaluation.

Table 1. Key findings from CSL implementation across Canadian medical schools

Concepts	Key Findings	Example Quotes
Category 1: Learning Objectives		
Professionalism, Interpersonal Skills and Advocacy	15 schools emphasized communication skills and understanding lived experiences Professional growth 13 schools emphasized professionalism, advocacy, and a broader sense of social responsibility	"Learn to speak without jargon." [P4] "Helps them learn how to listen… and understand the lived experience of the person they're talking to." [P8] "Gets them out of the academic bubble and into real communities." [P5] "Recognize their role beyond the clinic." [P13]
Cultural Humility and Systemic Awareness	10 schools emphasized cultural humility 12 schools highlighted awareness of systemic barriers to health Key: integration with CanMEDS	"A lesson in humility." [P7] "You can't understand health outcomes without understanding the history [of Indigenous communities]." [P1] "The first time they've had to think about privilege and systemic inequities." [P12] "The point is to operationalize the CanMEDS roles in a real community setting." [P2]
Category 2: Implementation		
Program Status	CSL was mandatory at 12 of 16 schools Average 40 hours Timing varied, with some programs beginning in Year 1 and others later in training	"We have a mandatory and an optional component" [P15] "The required hours are 30, but students sometimes exceed that." [P2]
Inclusion Criteria	10 schools offered online or in-person placements Six schools only offered in-person placements Nine schools required placements with people experiencing health inequities A minority restricted placements (e.g., excluding research or avoiding hospital-based sites)	"We don't want it to be 100% virtual." [P10] "Coming out of COVID, we just felt it was really important to get people back into the community as much as possible." [P12] "They are all in person. And then the goal is to work with vulnerable populations." [P6]
Workload Expectations	13 schools noted coordination demands Several programs employed dedicated staff to support logistics and community partnerships	"We have a full-time coordinator who works in the program." [P1] "It's difficult without any formal funding." [P9]
Category 3: Placement Structures		
Placement Access	Seven schools permitted students to propose their own placements Placements in rural settings were often prioritized	"Sometimes we let them design their own project." [P3] "There is a wide variety of options." [P9]
Matching Processes	Nine schools used preference-based matching via ranked student lists Six schools used faculty or administrative assignment Four schools used random lottery systems Some hybrid models	"Each student can express up to 20 preferences." [P2] "We have someone in our office who assigns the placements." [P8] "We have a random lottery system." [P11]
Category 4: Preparation and Safety		
Orientation and Training	All 16 schools had orientation 14 covered SDOH 11 included cultural safety	"Orientation begins with sessions on social determinants of health, equity-deserving groups, and introduction to CSL." [P6] "Off-campus safety policy series of modules." [P3]

	Seven programs included population-specific content (e.g., Indigenous health) Delivery methods varied, including pre-departure sessions, online modules, and longitudinal curricula	Monthly seminars on topics ranging from power and privilege to disability justice, and critical consciousness." [P10]
Safety Protocols	12 schools emphasized confidentiality, non-clinical scope, safety briefings Some programs incorporated training to address implicit bias	"We developed a field safety manual, recognizing some students have no experience going into the public sector or working directly with the public, let alone the vulnerable sector." [P1] "We have cultural safety and gender sensitivity training." [P7] "Provide the students with a community engaged learning field safety manual too, which is new this year." [P1]
Category 5: Assessment and Evaluation		
Student Assessment	All 16 schools used reflections 11 programs required reflections only at the end of CSL Five programs required reflections at multiple time points Mostly pass/fail Some incorporated alternative assessments such as portfolios, seminars, or infographics	"Students create a portfolio describing what they did and what they learned." [P12] "Write an outline of what stood out for them… and how that will influence their practice." [P8] "Sharing what worked, what didn't, and what they learned with others." [P3]
Community Partner Feedback	Six schools systematically incorporated feedback from community partners Others gathered informal feedback	"We do send a separate evaluation to our community partners." [P2] "Community feedback is collected through surveys and sometimes through discussions." [P14] "Somebody in our office connects with the community partners for feedback so that they might feel a little more comfortable being more candid." [P11]

Category 1: Learning objectives

CSL was consistently described as promoting professional growth, communication skills and advocacy. Most schools emphasized cultural humility and systemic awareness, with several explicitly linking CSL to social accountability competencies.

Category 2: Implementation

Twelve of sixteen schools required CSL, averaging ~40 hours, though timing varied across curricula. Placements were largely in-person, with some hybrid options. Most schools prioritized partnerships serving individuals, communities and/or populations experiencing health inequities. Sustaining CSL required significant coordination, often supported by dedicated staff.

Category 3: Placement structures

Learner assignment models included ranked student preferences, faculty assignments, or lotteries. Some schools permitted students to propose their own placements, while others emphasized rural opportunities. Approaches reflected efforts to balance student choice with community needs.

Category 4: Preparation and safety

All schools offered orientation, typically covering social determinants of health, cultural safety and population-specific issues (e.g., Indigenous health). Safety policies included confidentiality, non-clinical role limitations and training to address bias.

Category 5: Assessment and evaluation

Reflection was the universal assessment tool, usually graded pass/fail, and was delivered through a range of modalities, including written reflections, portfolios, seminars, or other formats. Only six schools systematically incorporated community partner feedback, with others relying on informal mechanisms.

Discussion

CSL has become a widespread component of Canadian undergraduate medical education. It represents the primary mechanism through which medical schools operationalize CACMS Element 6.6, which requires structured service-learning experiences integrating community engagement with preparation and reflection.[10,16,17] Specifically, CACMS Element 6.6 defines service learning as "a structured learning experience that combines community service with preparation and reflection," establishing these components as accreditation expectations within undergraduate medical programs. Our findings suggest that Canadian medical schools broadly satisfy these expectations, with most embedding CSL early in medical training and aligning outcomes with advocacy and professional development.

Key take-home points include the fact that CSL is mandatory at most institutions, consistent with accreditation requirements for undergraduate medical education. Assessment is overwhelmingly dominated by reflective assignments, consistent with accreditation expectations, emphasizing reflection as a core component of service learning.[10,18,19] While reflective practice meets accreditation requirements and supports professional development,[18,19] limited integration of community partner perspectives suggest an opportunity to strengthen reciprocity and reinforce the collaborative intent of service learning.[17-21]

These findings highlight overall consistency in how CSL programs are structured, implemented, and evaluated across Canadian medical schools, alongside some variation in assessment approaches and partner engagement. While most institutions' implementation of CSL aligns with core accreditation expectations, opportunities remain to strengthen program evaluation and the integration of community partner perspectives. A national CSL framework or network may support benchmarking for program design, facilitate cross-institutional learning, and promote more consistent approaches to program development and evaluation.

Limitations

This research was limited to Canadian medical schools and may not be transferable to other contexts. The interview guide was structured around CACMS Element 6.6, which may have narrowed scope and interviews were relatively short, limiting depth. Perspectives of community partners were not included, which would have provided important complementary insights. Future research should strive to provide a clearer understanding of how CSL accreditation requirements are interpreted locally and identify where discrepancies lie. Future research opportunities should also delve into how CSL is contextualized or understood in other educational or accreditation frameworks.

Conclusion

This first national analysis of CSL implementation demonstrates that Canadian medical schools broadly meet accreditation requirements, though program structures remain fragmented. Reflection dominates assessment practices and systematic community partner input is limited. Establishing a national CSL network could advance accreditation goals by promoting shared standards, enhancing reciprocity with community partners and ensuring CSL achieves meaningful educational and societal outcomes.

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Published ahead of issue:

Nov 16, 2026

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Conflict of Interest:

The authors declare that they have no conflicts of interest related to this work and received no funding for this study.

Acknowledgements:

We would like to thank all participating institutions: Dalhousie University, Laval University, McMaster University, Memorial University of Newfoundland, Northern Ontario School of Medicine, Queen's University, Université de Montréal, Université de Sherbrooke, University of Alberta, University of British Columbia, University of Calgary, University of Manitoba, University of Ottawa, University of Saskatchewan, University of Toronto, the University of Western Ontario.

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