

# **Chapter 15: The Clerkship Director and the Accreditation Process**

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## **Introduction**

Clerkship directors may think the process of accrediting a medical school is far removed from their typical responsibilities. However, clerkship director responsibilities are aligned closely with the goals of accreditation and, therefore, understanding the system is essential. The accreditation process is designed to ensure that the school has goals and objectives regarding the education of medical students and that a process is in place to determine whether they are met. The accreditation process and results have made American medical schools the envy of the world. Clerkship directors should understand and participate in the process.

Accreditation can be seen as a form of guarantee that a medical school is doing what it says it is, educating medical students. It is easy to forget that the primary purpose of a medical school is to teach medical students because of the competing expectations that faculty will acquire funding for and publish the results of research, provide clinical service, and strive for promotion and tenure. Accreditation has concrete benefits for a medical school and its students. Accreditation is required of US medical schools for their students to take the USMLE, enter ACGME-accredited residency programs, and obtain a license to practice medicine.

Understanding the accreditation process can help a clerkship director fulfill his/her job more effectively. Gathering the information to document the degree to which the school is meeting the LCME standards may help a clerkship director identify shortcomings and garner the resources to accomplish goals that the clerkship director, the chair, and the dean have set. This chapter describes the process of accreditation by the Liaison Committee on Medical Education (LCME), the sole authority recognized by the US Department of Education as responsible for educational programs leading to the Doctor of Medicine degree, and the place of the clerkship director in this process. Osteopathic schools are accredited by the American Osteopathic Association (AOA), rather than the LCME. The AOA accreditation process will not be covered in this chapter.

## **Medical Education before Accreditation**

To fully grasp the importance of accreditation and how it has affected medical education, it is useful to review a time before accreditation and before national standards of medical education, when American medical education was nearly non-existent. That time was not so long ago. The scientific study of medicine and the development of medical schools as we know them began in the late 19th century. Until the mid-1800s, how medicine was taught and practiced differed little from what Hippocrates taught in approximately 440 B.C.<sup>1</sup>

In the late 19th century, most US medical schools were for profit and privately owned, so many medical schools had no admission standards other than the student's ability to pay tuition. No

medical school in America required entering medical students to have a college degree or scientific knowledge, and none emphasized science.<sup>2, 3</sup> About 20% required a high school diploma for admission. No medical school in the country routinely allowed medical students to perform autopsies or see patients. Few medical schools were associated with a university and even fewer with a hospital. The founding of the medical school at Johns Hopkins University in 1893 was a turning point in American medical education. The school was modeled on German medical schools and their emphasis on scientific theory and investigation.<sup>4, 5</sup> By the outbreak of World War I, American medical science had caught up to that of Europe largely because of the success of the internationally recruited—and respected—faculty at Johns Hopkins.<sup>6</sup>

## Early Accreditation Efforts

Johns Hopkins and other institutions founded at around the same time, such as the Rockefeller Institute for Medical Research, demonstrated that the best American science and education could compete with the best in the world.<sup>3, 7, 8</sup> There was, however, a tremendous gap between this elite science and education and the way medicine was typically taught and practiced. Change was slow even after reform movements began to emerge at leading medical schools and with individual physicians. In 1904 the American Medical Association (AMA) formed a Council on Medical Education that in 1906 began inspecting all 162 medical schools in the United States at the time. These schools accounted for more than half of all medical schools in the world. The Association of American Medical Colleges (AAMC) began inspecting medical schools for membership at the same time. These two organizations later formed the Liaison Committee on Medical Education (LCME), the body that accredits medical education programs today.

The Council on Medical Education issued its first classification of medical schools in 1907. It concluded that the better medical schools were showing slow improvement, but the worst schools were not changing at all. The worst were still privately owned, usually by the faculty, most still had no affiliations with hospitals or universities, and the revenue source was student tuition.<sup>3, 9</sup> The Council then collaborated with Abraham Flexner, a member of a famous medical family but not a physician himself, to survey medical education. His report, entitled “Medical Education in the United States and Canada”, was released in 1910. It is generally known as The Flexner Report and it is likely that every clerkship director has at least heard of it.<sup>10</sup> According to Flexner, very few of the existing medical schools met his standards for medical education. He regarded many schools as “without redeeming features of any kind ...clinical poverty...surgery taught without a patient...recitations in obstetrics without a manikin in sight—often without one in the building.” He found dissecting rooms, if there were any, squalid, with “the smell intolerable, the cadavers...putrid” and students “ignorant and clumsy...gotten through advertising (who) would make better farmers.” He recommended that more than 120 of the over 150 medical schools in operation at the time be closed.

This report electrified the nation, and catalyzed change in medical education. By the 1920s, nearly 100 medical schools had merged or closed.<sup>9</sup> Flexner’s report accelerated the flow of donated funds to medical schools and states began to apportion money to the medical schools that became affiliated with, or were developed by, state universities. Eventually, the federal government would become the largest source of funds for medical education and research. In 1942, the accreditation activities of the AMA were merged with those of the AAMC to form the LCME.<sup>11, 12</sup>

Clerkships, and with their clerkship directors, emerged from this background of tremendous change and achievement. Today, clerkship directors play a pivotal role in the education of medical students and should play a major role in the process of accreditation.

## **Liaison Committee on Medical Education**

The LCME is the guardian of the educational process for US medical schools. Its structure and process will be described in the following section. LCME accreditation focuses on the medical school education program leading to the MD degree. If a medical school fails to demonstrate that its educational process and product meet accreditation standards, it will fail the LCME accreditation process regardless of the prestige of the school's research reputation, hospital affiliations, or competitiveness of its affiliated residency programs. Despite the magnitude of the work in preparing for an LCME site visit, hopefully the clerkship directors will ultimately see the LCME as a friend, an objective source of support and guidance in the teaching of medical students.

### **LCME Accreditation: United States and Canadian Medical Schools**

The LCME makes regular, timely evaluations of medical education programs in the United States, its territories, and in Canada (in association with the Committee on Accreditation of Canadian Medical Schools, or CACMS). Medical school programs must meet national standards of quality to be accredited. The maximum duration of full accreditation is 8 years. Programs that are not in substantial compliance with LCME standards can be accredited, but placed on probation until identified concerns have been corrected. Programs that fail to meet standards, schools that apply for accreditation and fail to meet the standards, or those that have never applied for accreditation are not accredited. Approved new medical school programs under development are designated as provisionally accredited until the charter class graduates. Accreditation is crucial because it means that high objective standards of medical education have been met. A school that is not accredited faces losing federal and state funding for itself and its students, without which it cannot survive.

### **Composition of the LCME**

The LCME is composed of 12 US and 1 Canadian professional members who are appointed for terms of up to 6 years. The members must have an MD or other advanced degree, be actively practicing medicine, have or have held an academic faculty appointment, and be knowledgeable about the process of medical education. Two public members, chosen by virtue of education, public service, or experience, also serve for 6 years. Two student members who have demonstrated an interest in medical education complete the committee. One is chosen by the AMA, the other by the AAMC.

The LCME has two co-chairs, one selected from the AMA appointees and one from the AAMC appointees, who preside alternately at meetings. There also are two LCME secretaries, again one for each organization. In alternate years they manage the LCME, including record keeping, accreditation scheduling, communication with schools, preparation of the agenda for LCME meetings, and choosing the site visit teams. An assistant secretary supports each secretary.

## Accreditation Process

The LCME gathers information and makes its judgment through a survey process. The medical school begins preparation for a site visit by conducting an institutional self-study. This includes completing an extensive Medical Education Database, which is a comprehensive collection of data about every facet of the educational program, from medical school funding to information on specific courses and clerkships. Task forces and committees within the institution analyze the database and write reports. The reports are synthesized into an institutional self-study report that includes the school's assessment of its compliance with accreditation standards. The LCME, in the person of an *ad hoc* survey team, then visits the school and prepares a survey report. Finally, the LCME makes a decision on accreditation.

Accreditation assures that medical education programs are in compliance with defined standards and it asks four questions:

- Has the institution clearly established its educational objectives?
- Are the institution's programs and resources organized to meet the objectives?
- Is the institution achieving its objectives?
- What is the proof?

### ***Types of LCME Site Visits***

The LCME can make several types of visits to a medical school: the full accreditation survey, a limited (focused) survey that looks at a few specific items, a post-probation survey, or a visit by the secretaries to investigate specific areas. The LCME might visit outside the regular 8-year accreditation cycle if it learns of major changes in the educational program, if there are major changes in educational resources, if there is a change in ownership or governance of the medical school, or if branch campuses or geographically remote programs have been established. Overall, the LCME expects that there is an appropriate balance between student enrollment and the total resources of the school, including faculty, physical facilities, and available funding.

### ***Composition and Purpose of the Site Visit Team***

Individuals who are knowledgeable about medical education comprise the site visit team. These surveyors are recruited and trained by LCME staff. Survey teams are composed of administrators, and basic science and clinical educators. A full survey involves five people: a chair, who is usually a dean or the most experienced member of the team; a secretary, who has been specially trained to coordinate the visit schedule and write the team's survey report; and two or more additional members, at least one of whom is a basic scientist and the other is a clinician. Sometimes, the team includes a Faculty Fellow, a senior faculty member or educational administrator nominated by U.S. or Canadian deans, who has not participated in LCME visits before and is a potential candidate to become a regular site visitor in the future.

The purpose of the team visit is to gather information. The team does not act in the role of a consultant. The team's task is to verify the material in the self-study database, explore areas that are unclear, and collect information on changes that have occurred since the database was submitted. To accomplish its task, the team speaks with students and representatives from each basic science and clinical department and others involved in the education of medical students. All surveys are conducted without charge to accredited schools of medicine. The LCME pays the expenses for all survey team members except for the Faculty Fellow, who self-pays or is

sponsored by his or her home institution. Schools seeking an initial accreditation pay the LCME a one-time \$25,000 fee and they reimburse the LCME for survey team expenses.

### ***Site Visit Team Report and Accreditation Decision by the LCME***

The survey report itself is the major outcome of the site (survey) visit. The draft report is submitted to each LCME secretary, to each team member, and to the dean of the surveyed school. The dean can correct errors of fact, but cannot change team findings or conclusions. Team members then make appropriate changes and the team secretary sends the final report to the LCME. The LCME considers the program's accreditation at its next regularly scheduled meeting.

Generally, the LCME bases its determination on the survey report. Each report is presented to the LCME by two committee members who were not part of the survey visit. The LCME votes regarding the accreditation status of the school and the need for follow-up, such as a progress report, limited visit, or visit by the Secretariat staff. The LCME secretary sends a letter transmitting the decision and a copy of the survey report to the president of the university, and a copy is sent to the dean of the medical school. The draft report, final report, and letter of accreditation status are held confidential by the LCME. The school may disclose the report at its own discretion, but the LCME and its survey team do not make specific information public. The LCME does, however, notify the U.S. Secretary of Education and other relevant authorities of the final accreditation status.

If a school is put on probation or is denied accreditation, it must notify all enrolled students, those newly accepted for enrollment, and those who are seeking enrollment. Deficiencies must be corrected promptly, within 24 months, unless the LCME extends this period for good cause. The LCME discloses to the public only the accreditation status of each school and the date of its next survey. The survey process for accreditation is presented in detail in the LCME publication "Rules of Procedure" that is updated periodically.<sup>13</sup> It is available online at [www.lcme.org](http://www.lcme.org)

A clerkship director will have several roles regarding the self-study and LCME site visits. In general, the clerkship director is responsible for ensuring that the clerkship has learning objectives, which are widely disseminated to faculty, students, and residents, and that they relate to the school's educational program objectives. Moreover, there must be a way of measuring whether the objectives are being met. As part of this, there must be a structured process to determine the numbers and kinds of patients that each student must see and a mechanism to monitor whether this has occurred, (See ED-2 under Specific Education Standards later in this chapter and [www.lcme.org/functionlist.htm](http://www.lcme.org/functionlist.htm).) The clerkship director must ensure that a remediation process is in place to deal with situations where the objectives are not being met. Finally, the clerkship director must be aware of work hours of the students on the clerkship (ED-38, [www.lcme.org/standard.htm#latestadditions](http://www.lcme.org/standard.htm#latestadditions), adopted July 2005).

### **Clerkship Directors and the Accreditation Process**

A clerkship director will be asked to meet with the LCME survey team when it visits the school. In preparation for the visit, a clerkship director must be aware of LCME standards, listed in an LCME publication entitled "Functions and Structure of a Medical School," which is updated periodically.<sup>14</sup> This also is available online at [www.lcme.org](http://www.lcme.org). The standards listed in this publication can help guide a clerkship director, a departmental education committee, or a medical school's executive education committee as they develop or modify the teaching program.

Standards of particular interest to clerkship directors might be those related to:

- Comparability across clinical sites
- Preparation of residents for their roles as teachers
- Need for formal mid-clerkship feedback
- Observation of core clinical skills
- Evaluation of student achievement and due process
- Academic counseling and career guidance

Finally, clerkship directors might be interested in being nominated by their dean for a position as a Faculty Fellow on an upcoming survey team.

### **LCME Database and Institutional Self-Study**

The database and institutional self-study form the core of the survey process. This process begins with the appointment of a self-study task force about 18 months before the survey team is scheduled to visit. The database describes five main areas, and the accreditation standards contained in each of these can be found in “Functions and Structure of a Medical School.” They are institutional setting, educational program for the MD degree, medical students, faculty, and educational resources. A summary follows:

#### ***Institutional Setting***

Institutional setting includes the medical school’s planning process that sets the direction for the school and results in measurable outcomes. It includes Governance/Administration, the section where the standards are enumerated for how the medical school is organized and operated. This section also includes Academic Environment, which describes the milieu in which the student is expected to learn.

#### ***Educational Program for the MD Degree***

This area includes the requirement for educational program objectives and how they are set. This is where the team will look at the school’s educational structure, including how the teaching program is designed and what it includes. Specific content areas are required in both the basic and clinical sciences as well as in such areas as communication, societal problems that have an impact on health (such as violence), and culture and gender issues.

Teaching and evaluation standards include the role of residents in medical student teaching. Standards for the management of the curriculum include responsibility for the overall design, management, and evaluation effectiveness. Standards that describe the need for integration of geographically separated sites with the main campus are critical for schools that assign students to off-campus sites. There are also standards that require medical schools to evaluate educational program quality and to monitor the amount of time medical students spend in clinical settings.

#### ***Medical Students***

This section includes standards for admission to medical school, including premedical requirements and selection of visiting and transfer students. Standards are described for student services such as academic and career counseling, financial aid counseling and resources, and health services and personal counseling. The learning environment is addressed in standards that relate to the teacher-learner relationship, including discrimination and

disciplinary action, the confidentiality of student records, and the need for adequate study space and secure storage areas.

### ***Faculty***

Faculty standards describe the number, qualifications, and functions of the faculty. Clear personnel policies for faculty are required, including the need for regular feedback to faculty on their academic performance and progress toward promotion. Standards for faculty involvement in the educational program are elaborated.

### ***Educational Resources***

This area includes standards related to the finances of the medical school and the need to maintain adequate financial resources to sustain the school's educational program. Standards for the availability of buildings, clinical teaching facilities, and information technology and library services are in this section.

In its institutional self-study summary, the medical school is asked to note its strengths and weaknesses and to prioritize the latter, including strategies to correct any identified problems. It is asked to analyze changes since the last LCME visit and make major recommendations for future action.

## **Specific Education Standards**

All clerkship directors should study the standards described in "Functions and Structure of a Medical School" and compare each standard to actual practice. The LCME Web site contains not only the standards, but also annotates them to facilitate compliance (see [www.lcme.org/functionslist.htm](http://www.lcme.org/functionslist.htm)). How does your department fare on the following examples?

***Standard ED-8***, "There must be comparable educational experiences and equivalent methods of evaluation across all alternative instructional sites within a given discipline."

***Standard ED-22***, "Medical students must learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery."

***Standard ED-31***, "Each student should be evaluated early enough during a unit of study to allow time for remediation."

***Standard ED-2*** exemplifies the emphasis the LCME has placed recently on the curriculum content of individual clinical courses. ED-2 states, "The objectives for clinical education must include quantified criteria for the types of patients (real or simulated), the level of student responsibility, and the appropriate settings needed for the objectives to be met." This standard indicates that a school must have a process in place to assure that students see specified numbers and types of patients to meet its objectives for clinical education. There must be a system in place that identifies student compliance with these objectives based on the recording of specific student experiences during the clerkship. Of course, this brings with it the obligation for the clerkship director or the institution as a whole to create a system to monitor experiences and remediate deficiencies of students who do not encounter the expected numbers or types of patients.

In one "best case" scenario, each student would keep case logs for review during the clerkship, perhaps using personal digital assistants (PDAs). These would detail each clinical scenario, the

type of problem encountered, and the degree of the student's participation in the encounter. The clerkship would also conduct an overall review of all student experience at mid-clerkship. Gaps in student exposure to patients could be filled by careful assignment to new patients, problem-based learning sessions (PBL), simulated patients, or paper cases. The critical features to which a clerkship director must attend to meet this standard include producing a listing of the types of patient experiences a student is to have, creation of a data collection system that measures how and where these experiences occur, elaboration of an ongoing monitoring system to identify gaps in student experience, and remediation to fill these gaps, using real or simulated patients as quickly as gaps are identified.

**Standard ED-24** states, "Residents who supervise or teach medical students, as well as graduate students and postdoctoral fellows in the biomedical sciences who serve as teachers or teaching assistants, must be familiar with the educational objectives of the course or clerkship and be prepared for their roles in teaching and evaluation." This standard includes explicit instructions that the clerkship director must have a system where residents are oriented to the objectives of the clerkship so that they know what the department expects of them as teachers. Residents must also be provided with the opportunity to learn how to teach and evaluate medical students. There must be documentation in place that resident/grad student teaching is occurring and that resident teaching ability and activity are monitored and remediated on an ongoing basis. All this work should take place in collaboration with the residency program director or other graduate medical education supervisor.

**Standard ED-8** states, "There must be comparable educational experiences and equivalent methods of evaluation across all alternative instructional sites within a given discipline." This requires that there be regular communication across all sites used for the clerkship (e.g., departmental education committee meetings, site visits by the clerkship director). There also should be analysis of student satisfaction and performance data across sites.

## Summary

Medical education has evolved considerably since the late 19th century. Students at that time were ill prepared to be physicians and the structures within which they learned were nearly devoid of education. In the early 21<sup>st</sup> century, the education of medical students is a privilege and an honor. Our medical students are exceptionally bright, energetic, and compassionate, and the educational structures within which they learn are solid, based on reason, fact, clinical experience, and the deductive method. The accreditation process and the LCME are designed to ensure that clerkship directors have the resources required to make the educational experience of a medical student productive and satisfying for everyone involved. American medical education is at a zenith and, as a clerkship director, you play a major role in this success. Your contributions are often unsung and sometimes you may feel marginalized, but you have one of the best jobs in all medicine.

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