LCME®

LIAISON COMMITTEE ON MEDICAL EDUCATION

ACADEMIC QUALITY AND PUBLIC ACCOUNTABILITY IN ACADEMIC MEDICINE

The 75-Year History of the LCME

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A Research Project Led by Robert H. Eaglen, PhD

Liaison Committee on Medical Education
Washington, D.C.

The LCME is jointly sponsored by the Association of American Medical Colleges and the American Medical Association.

Founded in 1876 and based in Washington, D.C., the Association of American Medical Colleges is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 147 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 167,000 full-time faculty members, 88,000 medical students, and 124,000 resident physicians.

The American Medical Association (AMA) has promoted scientific advancement, improved public health, and protected the patient-physician relationship since its establishment in 1847. The AMA is the premier national organization dedicated to empowering the nation's physicians to continually provide safer, higher quality, and more efficient care to patients and communities.

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Preface

This publication provides an account of the antecedents and the history of the Liaison Committee on Medical Education (LCME), the organization responsible for the accreditation of educational programs leading to the MD degree in the United States and Canada. It has been the author's impression over two decades of work on behalf of the LCME that the organization continues to be largely a mystery to the medical education community as a whole, both in terms of what the organization does and why it does it. One of the main purposes in writing this document is to provide a better understanding of the inner workings of the LCME and the environment in which it operates.

The text is organized into several discrete parts. After a brief overview that reviews the nature and characteristics of accreditation, the first section provides a chronology of the events leading to the creation and subsequent development of the LCME. The sections that follow recapitulate those historical events in a thematic way, covering the development of accreditation standards, operating procedures, and relationships with other organizations. A reader who is only interested in those themes can go directly to the relevant sections or chapters for any desired information.

The author owes a sincere and unrepayable debt of gratitude to the many colleagues who have supported this work. First thanks are due to the staff of the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), and the LCME, who commissioned the work and tolerated the linguistic excesses and foibles of the author: Susan Skochelak, Barbara Barzansky, and Rob Hash from the AMA; John Prescott, Dan Hunt, Veronica Catanese, and Donna Waechter of the AAMC. No less important are the numerous individuals who assisted with the research, provided feedback, or supported the project in other ways: LCME staff from the AAMC, specifically Mike Migdal, Rachel Liska, Liz Rast, Caitlin Reicks, and Heather Lent; LCME staff from the AMA, notably Marina Ramos; Molly Alexander, archivist for the AAMC; Frank Simon, former LCME secretary who pointed out the AMA website section containing archival materials; and the highly professional staff of the AAMC's Production and Editorial Services who patiently reviewed every word of the manuscript and made the final product much more lucid and coherent.

Finally, three special women deserve recognition for their contributions to this work. The first is Susan Mortensen, former accreditation manager for the AAMC side of the LCME. Her superb administrative skills and friendly demeanor established an efficient and enjoyable work environment in the AAMC offices of the LCME, making me far more productive than I ever thought I could be after I joined the LCME staff. The second is Barbara Barzansky, current LCME secretary from the AMA, who encouraged and supported me from my first day on the job at the LCME. Her knowledge and understanding of medical education and accreditation are unparalleled, and she has been a constant source of support during and subsequent to my term of service with the LCME. Last and most importantly I thank my spouse Cathy Eaglen, who has tolerated seemingly innumerable three-to-four day absences while I was on the road as a representative of the LCME and who has been there for me always, in the good times and the bad.

A Note About References

Most of the material cited in this publication is taken from either the minutes of LCME meetings or the proceedings from the annual meetings of the AMA House of Delegates and the AAMC. Because the former documents are confidential and not accessible to the public, I have not supplied detailed reference documentation or page numbers in the text. For the latter, I have provided detailed citations, but the reader can find archives of all proceedings from the AMA and AAMC annual meetings, and much more, on their respective websites:

ama.nmtvault.com/jsp/browse.jsp
aamc.org/about/history/foundations

These online archives of the two organizations are a remarkable resource, and the reader is strongly encouraged to explore them.

Introduction

Understanding Accreditation

This is a book about higher education accreditation, specifically the accreditation of medical schools that grant the MD degree. The subject matter, accreditation, is often misunderstood and sometimes controversial. Almost everyone within the medical education community is aware of accreditation, although relatively few members of that community have firsthand experience with the activity. Most medical schools undergoing the process view it, justifiably, with quite a bit of trepidation; notwithstanding their uncertainty and anxiety, it is somewhat surprising that after the process has concluded, many schools embrace it and internalize it as part of their quality improvement efforts. (Note: The LCME has recently adopted an accreditation requirement that all medical schools conduct ongoing monitoring of their compliance with standards as an element of institutional quality improvement.)

The organization responsible for accreditation of MD-granting programs in the United States and Canada is the Liaison Committee on Medical Education (LCME®), and this is its story. The LCME was established in 1942, although the activities commonly thought of as medical education accreditation, carried out by the organizations that sponsor the LCME, go back much earlier in time. What those organizations did, how the LCME came to be, and how LCME accreditation evolved after its creation, provide most of the subject matter for this book. To recount those events meaningfully, however, requires some explanation of what accreditation is and is not, how it relates to other activities with a similar focus, and why it has lasted so long despite persistent criticisms and calls for change. Accreditation is simple in concept but remarkably complex in implementation. The reader should be forewarned that the following exegesis of the basic issues of higher education accreditation may provoke intellectual indigestion or torpor; if the next few paragraphs induce such a reaction, the reader would be well served to go directly to the next chapter, where the historical account begins.

What Exactly Is Accreditation?

The nature and scope of accreditation are nowhere near as obvious as a casual observer (or participant, for that matter) might assume. Harold Orlans' study of accreditation on behalf of the U.S. Office of Education made the point succinctly:

> A clear definition requires a clear subject, but accrediting is anything but that.[1]

Orlans included several definitions of accreditation, but one that serves particularly well as a starting point is the definition provided in 1968 by the Office of Education (which would become a cabinet-level agency in 1980):

> [Accreditation is] the voluntary process whereby an agency or association grants public recognition to a school, institute, college, university, or specialized program of study which meets certain established qualifications and educational standards, as determined through initial and periodic evaluations.[2]

Some would argue that quality improvement is an essential element of accreditation, even though it was not included in Orlans' definition. That position has merit, but the definition above is better suited for purposes of this history. It confines the scope of accreditation to educational institutions or programs, thus ruling out other types of organizations that use the term "accreditation" in a different context—such as the Joint Commission on Accreditation of Healthcare Organizations or the Association for the Accreditation of Human Research Protection Programs. It establishes a voluntary element (although the nature of such voluntariness requires clarification) and entails a status that is publicly recognized, established through an evaluation process based on established qualifications and standards, and is subject to periodic reconsideration. That covers most, if not all, of the key features of accreditation.

The precise meaning of "voluntary" in the context of accreditation does require further elaboration. The most obvious interpretation—that educational institutions or programs have a choice between seeking and maintaining accreditation or eschewing it—is sometimes, but not always, true. For licensed professions in particular, the process is anything but voluntary, since graduation from an accredited institution or program is often required by licensure bodies (but notably not by the accrediting organizations) as a condition for professional practice. Even for institutions or programs that are not involved with licensed professions, accreditation is not necessarily an optional pursuit. The U.S. Department of Education has established a "federal link," which ties access to federal student financial aid programs to those organizations and programs that submit themselves to periodic review by a department-recognized accrediting agency. Given the dependence of most higher education institutions and programs on federal financial aid to make their programs widely affordable to potential students, it becomes difficult if not impossible for higher education institutions or programs to function without successfully undergoing the accreditation process. Interestingly, the Office of Education dropped the term "voluntary" from its definition in 1974.[3]

Accreditation is simple in concept but remarkably complex in implementation.

Where the accreditation process is unquestionably voluntary, however, is in the willingness of accredited entities to be evaluated by the criteria or standards accepted or determined by themselves and by their peers. The effective functioning of accrediting organizations is largely dependent on the willingness of the organizations they accredit to commit themselves to compliance with all accreditation criteria. Such willingness to be judged by those criteria is not entirely altruistic, however, insofar as the accredited institutions or programs have a substantial say in the adoption of such criteria, both by their participation in the accrediting organizations themselves and by the widespread accreditation practice of subjecting proposed criteria to scrutiny by the public and by the accreditor's sponsoring or supporting organizations prior to their adoption.

Accreditation, Regulation, and Licensure

If accreditation is not voluntary in the usual sense of the term, is it then a form of regulation? If so, it is distinctive in being self-regulatory rather than subject to external control. The accreditation process is administered for the most part by private organizations, typically membership or professional practice groups, and rarely by governmental organizations. Thus, there is no direct accountability to the public (via governmental oversight or control) inherent in accreditation. Such accountability does take place via the chartering process for higher education institutions, however, since those institutions must be approved by an appropriate state agency in order to establish operations, and many accrediting organizations, including the LCME, have a chartering requirement as one of their criteria for accreditation. Chartering agencies typically require some form of annual reporting by educational institutions to provide a measure of public accountability.

There is often a close relationship between accreditation and licensure, although the two processes are distinct. In the case of MD-granting medical education programs, all state-level and most territorial medical licensure boards within the U.S. political jurisdiction require that medical students educated within their jurisdictions graduate from an LCME-accredited program as a condition for receiving a license to practice. This effectively precludes any higher education institution in the United States and its territories from offering an MD program without LCME accreditation since graduates of such a program would be ineligible to practice in the United States.

Another obstacle to providing an MD program without LCME accreditation is represented by the National Board of Medical Examiners (NBME), which administers the national three-part examination for licensure—the United States Medical Licensure Examination, or USMLE—required by all state and most territorial licensure boards. (Puerto Rico maintains an independent licensure examination for physicians who wish to practice on the island, although it also accepts USMLE results in lieu of its own examination.) The NBME requires that students pursuing MD study in the United States or Canada be enrolled in or have graduated from an LCME-accredited medical school to take any part of the licensure examination. Thus, medical students in a program that is not LCME accredited would not be eligible to take the USMLE and therefore would be unable to obtain a license to practice in the United States.

Types and Scope of Accreditation

The astute reader will have already noticed frequent references in this chapter to institutions and programs. Within higher education, two forms of accreditation have been recognized: institutional (with two subtypes) and programmatic.[4] Each has its own distinct history. Institutional accreditation, as the name implies, entails the evaluation of institutions of higher education. Its two subtypes reflect the geographic scope of institutional accreditation, either national or regional. Regional accreditation traces its origin to the development of regional associations of institutions of higher education. The original function of accreditation for the regional associations was to establish consistent criteria for determining membership in those associations, which is similar to the original purpose of the Association of American Medical Colleges' medical school inspection and evaluation activities. The first regional association to engage in evaluation of its existing and candidate member institutions

in relation to standards was the North Central Association, which began accrediting activities in 1910.[5] Today, there are six regional associations in the United States that undertake accreditation activities on a regular basis.

National accrediting organizations represent a relatively small subset of institutional accreditation and confine their activities to the evaluation of particular types of higher education institutions across the country (e.g., religious colleges, career schools, or trade and technical schools). The Department of Education presently recognizes six such accrediting organizations.[6]

Programmatic accreditation addresses education in specific subject areas and arose in large part through the efforts of organizations supporting those subject areas from either an educational or practice-related perspective. The LCME currently operates as a programmatic accreditor.

It is possible for an accrediting organization to be both an institutional and a programmatic accreditor; for that reason, the Department of Education refers to accrediting agencies that are either exclusively programmatic or both programmatic and institutional as "specialized" accrediting agencies. Until the late 1990s, the LCME functioned as both an institutional and programmatic accreditor. Its institutional accreditation function applied to freestanding medical schools that were not part of a university and that had not sought or obtained institutional accreditation from a regional accrediting organization. The LCME opted to become an exclusively programmatic accreditor mainly to unencumber itself from certain recognition criteria of the Department of Education.

Apart from their differentiation by type, accrediting organizations can also be characterized by the scope of their accreditation activities. An accrediting agency's scope establishes boundaries or limits on the kinds of institutions or programs it considers. The LCME restricts its scope of activity to complete MD educational programs provided within the political jurisdictions of the United States and Canada. That scope precludes LCME accreditation for programs offered in any other country (even if the institution offering the program is based in the United States), for programs that offer other types of medical degrees (such as osteopathic medical education programs), and for programs that offer partial but not complete medical education programs (such as basic science medical schools that offer the first two, nonclinical years of a medical curriculum but not the final two years of education in a clinical setting; such schools operated during much of the 20th century).

Oversight of Accreditation

Although accreditation in general is almost exclusively undertaken by private organizations, accreditation organizations are subject to substantial oversight that constrains them from actions that could be perceived as capricious, discriminatory, or contrary to the interests of the public and the institutions or programs they accredit. That oversight stems from two sources: public (the federal government by way of the Department of Education) and private (the Council on Higher Education Accreditation, an organization created by and on behalf of college and university presidents).

The federal government has been formally associated with accrediting organizations since 1952, when the Veterans Administration turned to accreditors to vouchsafe for the quality of educational programs and institutions, to ensure that federal funds provided for veterans' education through the GI Bill of Rights were being appropriately used. The legislation authorizing such activity vested authority in the commissioner of education, who was responsible for publishing a list of nationally recognized accrediting agencies and associations determined to be reliable authorities as to the quality of training offered by an educational institution.[7] This action established the federal link between the government and private accrediting organizations in which the government established a proxy role for the latter wherever federal funding programs were made available to institutions of higher education.

In the early years of this relationship, the government approach for recognizing accreditors was somewhat informal, depending in large measure on the perceived reputations of accrediting organizations by the public and the institutions or programs that were accredited. Over time, the recognition process became increasingly formalized, culminating in the establishment of the Division of Accreditation and Institutional Eligibility within the Office of Education in 1968. The role of the division was to carry out the criteria, terms, and conditions for recognition established in the Higher Education Act of 1965. To assist the secretary of education in carrying out this recognition responsibility, the Higher Education Act also established an advisory group known as the National Advisory Committee on Accreditation and Institutional Eligibility. The 1992 reauthorization of the Higher Education Act replaced that committee with another, the National Advisory Committee on Institutional Quality and Integrity (NACIQI), which has overseen the federal recognition process ever since, although it remains advisory to the secretary of education. The LCME has been recognized by the Department of Education as the national authority for the accreditation of MD-granting medical schools (later restricted to the MD educational programs of those schools) since the very beginnings of the federal recognition process in 1952.

Private oversight of accreditors came about largely because of concern and frustration on the part of college and university presidents, as the number of accrediting organizations proliferated and their demands (especially among the programmatic accreditors) were perceived as excessively burdensome for the effective functioning of the institutions as a whole.[8] The first major organization for private oversight of accreditation arose in 1938, when the National Association of State Universities joined with the American Association of Land-Grant Colleges and Universities to create the Joint Committee on Accrediting. The committee proved to be ineffective, however, and was supplanted by the National Commission on Accrediting (NCA) in 1949. NCA was established by university presidents to deal with the rapidly expanding programmatic accreditation sector. The NCA sought to delegate the primary accreditation function to the regional accreditors, with a select few programmatic accreditors to be either transferred to the regionals or invited to function under the direction of the regionals. The NCA felt that some accrediting organizations should be more concerned with educational improvement but not with accrediting per se.

Interestingly, the NCA considered one of the LCME sponsors, the American Medical Association (AMA), as an agency whose accreditation activities could be transferred to the regionals, while the other sponsor, the Association of American Medical Colleges (AAMC), was considered an organization better suited to educational improvement than accreditation. The LCME was not considered as a distinct accrediting organization by the NCA (accreditation decisions were still made independently by the LCME's sponsors at the time), notwithstanding frequent communications between the sponsors and NCA that served as a common topic of discussion during LCME meetings in the early 1950s. The NCA's early efforts to gain leverage over medical education accreditation proved to be futile and in fact had the opposite effect of strengthening the commitment of the AMA and the AAMC to making the LCME work (described in detail in Chapter 3). Both the AMA and the AAMC informed the commission that they had no intention of discontinuing their accreditation functions, although they did express a willingness to expand cooperation with the regional accreditors. Although the NCA failed to establish substantial control over programmatic accreditors, it did manage to continue functioning as an accreditation oversight organization into the early 1970s. In 1956 the NCA initiated a recognition process for programmatic accreditors.

While the NCA was striving to address many of the challenges of accreditation posed by the programmatic accreditors, the regional associations were also attempting to improve the efficiency of the regional process. To that end, a National Committee of Regional Accrediting Agencies was established in 1949 and was superseded in 1964 with the creation of the Federation of Regional Accrediting Commissions of Higher Education (FRACHE).[9] FRACHE's main thrust was to foster greater uniformity in accreditation practices in light of the rapid growth of federal financial assistance to colleges and universities. FRACHE and the NCA shared many common goals, including limits on the proliferation of specialized accrediting organizations, coordination and simplification of accreditation processes, and preservation of their members' academic and administrative independence as a counterbalance to the increasing federal role in postsecondary education. This led ultimately to the merger of the two organizations into a new private oversight body, the Council on Postsecondary Accreditation (COPA), in 1975. Like the Office of Education and NCA, COPA created a recognition process for validating the authenticity of accrediting agencies.

COPA developed into an effective organization for recognizing and coordinating accrediting activities of both regional and programmatic agencies, and even today it is held in high regard by the leaders of many accrediting organizations. It served that function until 1993, when it took the lion's share of blame for failure to address the increasing frequency of defaults on federal loans. The demise of COPA led immediately to the establishment of a successor organization, the Commission on Recognition of Postsecondary Accreditation (CORPA), as well as the Association of Specialized and Programmatic Accreditors (ASPA). CORPA proved to be short-lived, transferring its recognition functions to a new organization created by the university presidents in 1996: the Council for Higher Education Accreditation (CHEA). The LCME is a charter member of ASPA—which has no formal recognition process for member agencies—but has declined membership in CHEA and has therefore not undergone CHEA's recognition process.

Controversies Surrounding Accreditation

For the casual reader, a formal definition of "accreditation" may provide some illumination about the process, but much greater insight can be found by exploring the adjectives used to describe the term. For much of its history, accreditation has been a heatedly debated topic within academia, especially among university leaders. It has also become a controversial issue for the federal government, most visibly during the past decade or so when political leaders have questioned whether the process provides appropriate value and accountability to the public.

There is little doubt that accreditation is, and has been for some time, controversial. There are several underlying issues that continue to fuel the debate about the value and efficacy of accreditation. One is the extent to which accreditation serves the perceived public need for educational quality assurance. The arguments against accreditation's efficacy are rooted partly in the notion of the accreditation process as being focused on meeting minimum standards of performance, which are established in large part by the institutions or programs being accredited. They are also rooted partly in the apparent ease with which such standards are met, as reflected in the rarity of accreditation denial or withdrawal by accrediting bodies. The counterarguments are that while the process employs minimum standards to be achieved to obtain or maintain accreditation, the standards themselves are high; most institutions and programs do not simply meet, but in fact substantially exceed, the minimum expectations; and the rarity of negative decisions is a reflection of the effectiveness of the process, not any inherent weaknesses or laxity in its structure or implementation. In the context of this debate, it is worth recalling the NCA's early inclination to distinguish between quality assurance and quality improvement as it examined the functioning of various accrediting organizations.

If one examines accreditation through the lens of quality assurance or quality improvement, another closely related topic emerges, namely the extent to which accreditation is focused on process rather than being grounded in outcomes analysis. The strongest critics of accreditation's efficacy in quality assurance also tend to be the most vocal proponents for greater use of outcomes in making accreditation decisions. (This is abundantly clear in the deliberations of the Department of Education's NACIQI during the past decade.) The debate is framed not simply in terms of greater use of outcomes by accreditors, but also to some extent on the development of common or national metrics that can apply across all institutions or programs, such as student success in licensure examinations or career placement. The question of whether good outcomes can be achieved in the absence of good processes is notably missing in such discussions, however. Medical education (and therefore the LCME) has been insulated from this debate for the most part because its rigorous demands can only be met successfully by the best students, and its student admissions process is correspondingly skewed in favor of high academic performers who are most likely to achieve successful outcomes. Medicine has also benefited from a unique labor market in which the number of placements (residency positions) available after graduating from medical school has greatly exceeded the total annual output of U.S. medical schools, thus ensuring success in residency placement. The recent expansion of medical school enrollments, however, without a concomitant increase in residency training opportunities, has pretty much muted the profession's advantage in career placement as an easily achievable outcome measure.

To some degree, the debate about process versus outcomes in accreditation is rather sterile since all accrediting agencies do focus attention on outcome issues as well as process. The real question for debate should therefore be whether accreditors place *sufficient* emphasis on outcomes since virtually all of them include some form of outcomes review in their process. Accreditors' attention to process is hardly accidental—the standards adopted by accrediting organizations invariably reflect what the accredited entities themselves consider to be sufficiently important to merit inclusion as criteria by which they will be judged. If those standards are mainly process oriented, it is because the accredited units consider such processes to be important markers of educational quality. Nevertheless, a focus on process entails much more documentation effort than reporting of outcomes, leading to the perception that accreditation is a cumbersome, burdensome activity representing major costs in time and effort by accredited institutions and programs. Perceptions of accreditation as being clunky have existed for a long time. Orlans cited an early study which made that precise point:

> The authors of a 1940 study wrote that, "in the short space of 30 years," accrediting had become "a cumbersome … machinery which appears greatly in need of simplification and coordination."[10]

Orlans did not mention the authors or the study by name, but perusal of the report's bibliography indicates that the author was almost certainly referring to a study by Kelly et al titled *Collegiate Accreditation by Agencies Within States*, published by the Office of Education in 1940.[11]

In addition to the focus on process, another reason for thinking of accreditation as cumbersome is the number of accreditation requirements to which most institutions and programs are subject. (It must be noted, however, that no accreditation standard or criterion can be adopted without consent of those who are most directly affected by it.) The number of accreditation standards and criteria among various accrediting organizations commonly number 100 or more when one considers nested criteria or components within "standards." When the LCME shifted to a list format for its standards in 2002, the resulting number of standards was well over 200. And that only represents the tip of the iceberg because an individual standard, criterion, or component frequently entails several specific requirements within it. Consider, for example, the LCME's current Element 8.6: "A medical school has in place a system with central oversight that monitors and ensures completion by all medical students of required clinical experiences in the medical education program and remedies any identified gaps." The reader should be able to identify at least four, and probably more, distinct requirements embedded within the element. Similar examples are easily found in the standards and criteria of any other accrediting organization. The proliferation of accreditation requirements, spanning virtually every nook and cranny of an institution or program's operation and function, begs for criticism of the accreditation process as burdensome or cumbersome when each specific accreditation requirement must be addressed through appropriate documentation.

One final controversial aspect of accreditation that will be mentioned here is the perception that the enterprise is secretive and mysterious. Certainly, not all of accreditation is shrouded in mystery.

Without exception, accreditors go out of their way to make their standards and processes as accessible as possible to the entities they accredit, as well as to the public, through websites, regional meetings, and other communication strategies. The decision-making process itself, however, as well as the evidence upon which it is based, is in most cases shielded from outside view. The typical accreditation process entails an on-site evaluation by a survey team, whose composition is known only to the institution or program and to the accreditor. The survey team prepares a report of its findings that is held in strict confidence by most accreditors. The report and any other relevant information are then reviewed and an accreditation decision is made by a select group of individuals who meet behind closed doors.

The key element in all of these aspects of accreditation is confidentiality. While accreditors accumulate remarkably vast amounts of information about the entities they accredit, very little of it finds its way into the public domain. The rationale for not making such information more readily available is confidentiality. Accreditation data and findings are considered by accrediting organizations as strictly confidential information between themselves and the institutions or programs they accredit. Because of the breadth and complexity of the information and the processes used to interpret it, accreditors are justifiably concerned that making such information public can easily lead to misinterpretation or distortion, thus causing undue harm to the institutions or programs being evaluated. Accreditors are also concerned that publicizing the identity of evaluation teams poses a risk of inhibiting the ability of those teams to conduct an exhaustive and unbiased analysis of institutional or programmatic information, free of external pressures or influences. To date, accreditors have been successful in preserving their perspective on this issue in their dealings with oversight organizations such as the Department of Education, but the pressures for greater transparency persist.

There are certainly a number of other controversial issues surrounding accreditation, but space limitations (and the author's concern that this book maintains its focus on the LCME) preclude exhaustive review of all of them. The interested reader should consult the websites of specific accrediting organizations, or the agencies responsible for oversight of accreditation, for additional information and discussion.

Looking Ahead

Hopefully, anyone who has managed to muddle through this divergence into the nature and scope of accreditation has not given up hope of learning about the history of the LCME and medical education accreditation in general. That is the central topic of this book, after all. The remaining chapters cover several aspects of medical school accreditation from a historical perspective. The first part provides an overview of the major historical events in medical school accreditation, tracing back to the origins of the AAMC and the AMA. Succeeding sections of the book address the evolution of accreditation standards, the development of LCME accreditation processes, and the role of other organizations, both internal and external to the medical profession, in relation to LCME function and structure. Let the tale now begin.

PART I

From Inspections to Surveys: The Origins and Evolution of the LCME

Chapter 1

Germination of an Accreditation System: Inspection of Medical Schools Before the Flexner Era

The LCME was founded in 1942, but if one adopts the definition of accreditation cited in the preceding chapter, it is possible to trace the origins of medical school accreditation processes much earlier. To briefly recapitulate the key elements of that definition, accreditation requires (1) a voluntary process, however defined; (2) public recognition of an institution or program's status; (3) established qualifications or standards by which to determine an institution's or program's status; and (4) initial and periodic evaluations based on established qualifications or standards. Although not part of the definition, it is also worthwhile to consider is the purpose of organizations in undertaking accreditation activities, whether for quality assurance or quality improvement, as a contributing historical factor in the development of accreditation.

Major historical events of the period included the following:

- Origin of the American Medical Association (1847)
- Creation of the Provisional Association of American Medical Colleges (1876)
- Provisional Association of American Medical Colleges renamed as the American Medical College Association (1877)
- First publication of the *Journal of the American Medical Association* (1883)
- Establishment of the National Confederation of State Medical Examining and Licensing Boards (1890)
- Origin of the modern Association of American Medical Colleges (1890)
- Formation of the American Medical Association Council on Medical Education (1904)

1847–1854: Formation of the American Medical Association and Its Commitment to Educational Quality

The American Medical Association (AMA) was established in May of 1847 as a voluntary organization. As Nathan Davis pointed out in his 1855 *History of the American Medical Association*, the number of U.S. medical colleges, which also had authority to grant licenses to practice, had more than doubled between 1830 and 1845, creating among those colleges "… a competition unrestrained by any mutual intercourse with each other, or social connection with the profession at large."[12] At the time, the typical duration of a program to obtain a medical degree was 16 weeks. The competitive pressures for short courses of study, combined with easily met requirements for graduation, engendered a growing concern among medical societies and some medical colleges about the quality of medical education in such an environment. The first concrete manifestations of that concern emerged in the form of resolutions presented at the 1844 meeting of the Medical Society of the State of New York. Those resolutions identified three essential concerns regarding medical education. The first was that a four-month course

of study (lectures) was too short to include all the branches of medical science. The second was that the standard of education (both premedical and medical) required for the granting of diplomas was altogether too low. Finally, the resolutions declared that the union of teaching and licensing powers within medical college faculties was easily susceptible to abuse.

While these resolutions produced extensive discussion of medical education at subsequent meetings of the New York medical society, it was recognized that action by a single state to remedy the identified concerns would likely have little or no impact on the quality of medical education as a whole unless other states adopted a similar course of action. This led to the call for a national convention of state medical societies to consider the problems and for a permanent national medical society to speak to the needs of the profession as a whole. That national convention took place in New York in 1846.

The 1846 meeting convened in the medical department at New York University, with nearly 100 representatives attending from 16 states and from approximately one-third of the existing 36 medical colleges. Notwithstanding the apparent interest reflected in the breadth of participants, a motion was presented by a representative from New York University's medical department shortly after the meeting began, calling for the convention to adjourn for lack of adequate representation from half of the states and from a majority of the medical colleges. The resolution was quickly voted down, however, and the delegates proceeded to establish a series of committees to address specific issues and report on them at a subsequent meeting in 1847. The issues noted were as follows:

- Creation of a national medical association
- Adoption of "a uniform and elevated standard of requirements for the M.D. degree" by all U.S. medical schools
- Acquisition of a "suitable preliminary education of young men, before being received as students of medicine"
- Adoption of a single national code of ethics for the medical profession in the United States[13]

An additional resolution to separate the teaching and licensing powers of medical colleges proved to be somewhat more controversial, but it ultimately prevailed when an additional committee was approved to tackle this topic and report on it at the 1847 convention.

The proceedings of the 1846 convention were published in a variety of medical periodicals afterward, and several delegates to the convention subsequently offered addresses on the issues articulated at the convention, all of which had the effect of stimulating greater interest in the subject matter. Thus, when the 1847 convention began at the Academy of Natural Sciences in Philadelphia, Pennsylvania, participation grew to almost 250 delegates representing 22 states and the District of Columbia, as well as 28 medical colleges. The most significant outcome of the 1847 meeting was the establishment of the American Medical Association under the leadership of Davis. The constitution adopted by the fledgling association established several purposes for the organization, one of which was "elevating the standard of medical education."[14] Seven standing committees were created, including the Committee on Medical Education.

The convention delegates discussed at length the reports of the 1846 committees dealing with a uniform standard of requirements for the MD degree and the preliminary education of medical students before beginning their course of medical study. A committee on requirements for the MD degree offered a resolution, ultimately adopted, that enumerated 10 different elements (described in detail in Chapter 6). The resolution covered the recommended length of the educational program (three years), qualifications of preceptors, required subject matter, clinical education in a hospital setting, and documentation and verification of student attendance. The committee reporting on preliminary education of medical students established good moral character and documented knowledge of languages, natural philosophy, and natural sciences as essential prerequisites. These recommendations were adopted and published in the proceedings of the convention. Thus the seeds of modern accreditation standards were first sown.

Unfortunately, the recommendations of the fledgling AMA had little demonstrable impact on the educational activities of private physicians or on medical colleges, in the absence of any enforcement mechanisms to prod the colleges' compliance with the requirements. The standing Committee on Medical Education established at the 1847 convention was abolished (along with most other standing committees) four years later, although it was revived the following year. New recommendations concerning medical education were sparse during the next several years, but the AMA did approve some that foreshadowed later developments in education. In 1853 the AMA approved a resolution declaring that "a familiar knowledge with the elements of medical science should precede clinical instruction."[15] The value and quality of lectures was challenged in the following resolution presented at the 1854 meeting of the AMA (although the resolution was promptly rejected):

The committee reporting on preliminary education of medical students established good moral character and documented knowledge of languages, natural philosophy, and natural sciences as essential prerequisites.

> [T]hat the practice of professors reading lectures to their classes, no matter with how much care selected from the musty records of antiquity, is a miserable apology for teaching, is *prima facie* evidence of their inability to instruct, and is inimical to medical progress.[16]

While not directly related to medical education, one very important development took place at the 1869 meeting of the AMA: a suggestion by Samuel Gross for a weekly medical journal owned by the association. Fourteen more years would pass before the founding of the *Journal of the American Medical Association* (*JAMA*), but the journal's importance for the development of accreditation as a vehicle for public recognition of the status of medical schools and for advocacy in the improvement of medical education cannot be understated.

1876–1902: Birth and Rebirth of the American Medical College Association and Expectations for Member Medical Schools

While the AMA struggled during the 19th century to forge strong links among individual physicians and state medical societies for the common good of the medical profession, it was unable to gain much traction or support from the leaders of medical schools. The number of medical schools was growing after the AMA's creation in 1847, increasing to somewhere between 60 and 75 by the mid-1870s.[17] Although medical educators had met in 1867 and 1870 to discuss higher standards for medical schools, it was not until 1876 that a nucleus of medical school deans was able to convene a group of their peers to take the first meaningful steps to establish a provisional association with defined educational standards for membership. That year, the deans and faculty of 22 medical schools met in Philadelphia to create what would become, a year later, the American Medical College Association.

As the AMA had done previously, the medical college association proposed a three-year course of lectures over a three-year period of study as the minimum requirement for membership (which would later prove to be its undoing). It also recommended specific subjects to be included in the curriculum and conferral of diplomas only after successful completion of an examination on the required curricular subjects and evidence of attendance at the college conferring the diploma. These requirements were similar to those previously promulgated by the AMA, although lacking the AMA's inclusion of specific preadmissions requirements.[18] When the college association met the following year, a motion to approve these requirements was tabled.

It was not until 1876 that a nucleus of medical school deans was able to convene a group of their peers to take the first meaningful steps to establish a provisional association with defined educational standards for membership.

At its 1878 meeting, the American Medical College Association adopted two resolutions that addressed a second important element in the definition of accreditation, namely, the public recognition of a school's compliance with standards. Such recognition was formally expressed in two resolutions approved by the membership. The first resolution required the association to prepare a list of approved members and a list of schools that had applied for and been denied membership, with the lists to be provided to all members. The ostensible rationale for such lists was to allow member institutions to verify the credentials of students who might enroll in their courses of study. The second resolution called for a special meeting to discuss adoption of a "… uniform system of instruction of a grade fully in accord with the requirements of the age in other branches of study, and with the practice of the medical institutions in Europe." The resolution also requested that "… the medical and secular presses throughout the United States be requested to lend their aid in the dissemination and discussion of these preambles and resolutions in order to place the whole matter of medical education prominently before the profession and the people."[19]

As an aside, that second resolution is also notable for the apparent first use of the word "accredited" in the documents of the organizations that would eventually become the sponsors of the LCME. The call for a special meeting included the following statement: "*Resolved*, That this Association respectfully and earnestly request that the regularly organized and accredited medical schools of the United States hold at their earliest convenience a meeting for the purpose of adopting some definite and final action.…"[20]

The 1879 meeting of the American Medical College Association was notable with regard to two activities. First, the organization agreed to establish a three-member Committee on Medical Colleges, charged with obtaining and reviewing the circulars and announcements of all U.S. medical colleges—whether they were member organizations or not—to identify colleges that did not conform with the requirements of the association and the specific requirements that were not met by such colleges. This suggests the earliest compliance mechanism for an organization engaged in accreditation-like activities. The other notable activity at this meeting was the discussion of the three-year requirement, which occupied a full day with no resolution to the issue.

When the association met the following year, its Committee on Medical Colleges presented a report on institutions that did not meet the association's membership requirements. Violations of its requirements were attributed to "thoughtlessness on the part of those preparing the various catalogues,"[21] and therefore the organization chose not to publish the names of colleges involved but opted instead to notify such colleges privately with the hope of inducing their adoption of association standards. The members also approved a motion, tabled during the previous year's meeting, to require three courses of instruction over three years.

The three-year requirement approved at the 1880 meeting would ultimately trigger a temporary demise of the association. The membership increased the following year from 31 to 33 medical colleges, yet the number attending the 1881 meeting shrank from 25 to 18. By 1882 all the eastern medical colleges withdrew from the association, reducing the number of members to 20, and only 11 institutions sent representatives to the 1882 meeting. The negative impact of the three-year requirement was clearly articulated in the following resolution adopted at the 1882 meeting: "Whereas it has become apparent to this Association that its action in establishing a three years' course of college studies is in advance of the views of the medical profession at large, it is not supported in this movement by the profession, and especially by the older eastern schools, whose status should have made them leaders in a reform movement of this character; therefore, be it resolved that the law upon this subject be not enforced during the year required for its amendment." [22] The American Medical College Association would not meet again for the remainder of the decade.

Even though the AMA and American Medical College Association were unable to successfully promulgate the development of a three-year course of study for the medical degree, their efforts did plant the seeds in the minds of the profession, and during the 1880s that concept became more palatable to state medical societies as the number of medical schools rapidly expanded, to a total of 133 by 1890.[23] Two major events precipitated the general acceptance of standards for medical education in this

thriving environment for new medical schools: establishment of a national organization for medical licensure and revitalization of the medical college association.

The two events are closely intertwined. In March 1890 the leaders of medical schools in Baltimore, Maryland, invited their colleagues to gather at the AMA annual meeting to discuss the topic of medical education in the United States. The items expected to frame that discussion included the following:

- A three-year course of study consisting of six-month sessions
- A graded curriculum
- Written and oral examinations
- A preliminary examination of English
- Laboratory instruction in chemistry, histology, and pathology

Delegates to the 1890 AMA meeting, representing 36 medical schools, produced a report that included resolutions endorsing all of the above issues as requirements for membership in a national association of medical colleges, and the resolutions were approved by the AMA membership. One year later, medical school delegates met in Washington, D.C., to adopt a constitution and bylaws for the revitalized college association, now known as the Association of American Medical Colleges (AAMC), functioning under the leadership of the remarkable Nathan Davis. The requirements discussed at the previous meeting were approved, including a more detailed medical school entrance requirement similar to the AMA's original specifications for examinations in Latin, physics, and the mathematical sciences in addition to English.

Not long after the three-year curriculum was established as a requirement of the AAMC, it was also adopted by the fledgling National Confederation of State Medical Examining and Licensing Boards (NCSMELB), and the drumbeat began to establish a longer curriculum as the minimum requirement. The case for a four-year curriculum was made emphatically by Davis, who wrote in an 1894 letter to the AAMC that "the time to be devoted to the study of medicine must not be less than *four* years, with not less than *eight* months of each year to be spent in direct attendance on medical college instruction.… The adoption of such a standard should not be accompanied by an optional alternative one requiring but *three* years of study and *eight* months of medical college attendance each year."[24] The AAMC incorporated this suggestion in a revision to its constitution in 1894, and the amended constitution was adopted with a vote of 30 in favor and 6 opposed.

Over the next few years, pressures began building to establish much more specific requirements for the medical curriculum. This was presaged in an 1896 report to the AAMC membership prepared by an ad hoc Committee on Syllabus, which laid out extensive details of how a medical curriculum should be designed. Among its recommendations were that medical students devote 10 hours a day to their studies, consisting of 4 hours in the classroom and 6 hours of preparation.[25] The report also provided specific details for each course to be covered in the four-year curriculum. The president's report at the 1898 meeting of the AAMC described "some present tendencies of this body," including "…a uniform curriculum and a definite statement of the minimum number of hours to be allotted to each session,

if not each branch taught in that session."[26] The tendency became reality when, in 1900, the AAMC considered an amendment of its constitution to require at least 3,300 hours of "actual work" that included, in addition to lectures and recitations, 500 hours of laboratory work, 150 hours of practical work (e.g., physical diagnosis, bandaging), one or more obstetric cases to be personally attended by the student, and 750 hours of clinical instruction. The proposed amendment was not adopted, but by 1907 the association would revise its constitution to require 4,000 hours of instruction distributed across several specific subject areas.

The 1900 meeting of the AAMC was notable as well for the creation of a committee to confer with the NCSMELB regarding the advisability of adopting medical education standards acceptable to both organizations. Unfortunately, that committee reported the following year that the two bodies had no common ground for action, and thus the first effort at collaboration with another organization regarding educational requirements proved to be fruitless. Curiously, a 1901 article in the *Bulletin of the American Academy of Medicine* reported that "the joint committee of the College Association and the Confederation of Medical Examining and Licensing Boards came to the conclusion that the minimum standard for admission should be that adopted by the Confederation.…"[27] It would appear then, that there was at least some common ground between the two organizations.

Development of a National Licensure Organization

The NCSMELB was established in 1890, under the leadership of John Rauch, who had previously served as the head of the Illinois Board of Health when it began to crack down on fraudulent practitioners in the 1870s. At its meeting in 1891, NCSMELB recommended that state medical boards enforce a minimum requirement of three years of medical study. It would continue to promulgate stricter standards for premedical and medical education over the ensuing decade, in parallel with events taking place at the AAMC. In the mid-1890s it established the Committee on Minimum Standards for Admission to Medical College. By 1899 NCSMELB member boards adopted a minimum matriculation standard of a four-year high school education or passage of an examination in relevant subject matter conducted by the state board (mirroring the AAMC premedical education requirement). While the confederation acknowledged the important work of organizations like the AAMC to elevate the quality of medical education, it properly noted that only the state licensing boards possessed legal authority to set or enforce standards for medical schools.

In 1902 NCSMELB established the Committee on Uniform Curriculum for Medical Colleges, which produced annual reports for the next three years, including an exhaustive summary in 1904 based on survey reports of 124 medical colleges. The 1904 report of the committee, summarized in the proceedings of the 1905 AAMC annual meeting,[28] called for course work in four terms spanning four calendar years, at least 3,600 hours of formal instruction, additional time reserved for electives, and at least 900 hours of clinical instruction within the 3,600-hour total. The membership adopted the report, providing an enforcement mechanism to drive compliance with standards similar to those emerging from the voluntary associations.

1903–1904: The Beginning of Medical School Inspections and Creation of the AMA Council on Medical Education

By the turn of the century, most elements of a modern system of accreditation were in place. Three organizations—the AMA, AAMC, and NCSMELB—had adopted criteria or requirements deemed necessary for the proper function of an MD-granting medical school. Vehicles for publicizing schools that met those criteria were available (*JAMA* and the proceedings of the AAMC annual meeting). There was an element of voluntariness in the willingness of medical schools to subject themselves to the requirements of the AAMC or the AMA. The one missing piece in the puzzle was a system for initial and periodic evaluations. That piece would be provided independently by both the AMA and the AAMC.

Although the AMA was established to improve the quality of medical education, the focus of the organization shifted rather quickly after its first few years from education to broader practice-related issues, such as medical ethics, specialization of clinical disciplines, the establishment of state health departments, and promotion of public health. In his 1866 presidential address to the organization, Nathan Davis acknowledged the loss of focus on medical education: "Whenever medical education became the theme of discussion [at AMA meetings], those more interested in the reading and discussion of papers and reports of a direct scientific and practical character were ever ready to restrict debate, refer the subject to committees, or in some other way avoid what they regarded as a mere waste of time."[29] With the genesis and later definitive establishment of the AAMC, the AMA had largely conceded discussion of medical education issues to that organization.

Perhaps because of the emergence of the AAMC as a vocal proponent of medical education quality, the AMA recognized a need to refocus its energies on the subject and in 1902 laid the groundwork for the creation of a standing committee on medical education. At that meeting, the association's Business Committee recommended the creation of a five-member Committee on Medical Education. The recommendation was adopted, and the Committee on Medical Education was appointed forthwith.

In his report to the association in 1903, committee chair Arthur Bevan remarked on the uneven quality of medical education in the United States, which the committee considered inferior to that found in Western Europe. He also acknowledged the work done by other organizations in improving medical education quality, specifically state examining boards, the AAMC, and some "great universities with medical departments."[30] The committee recommended adoption of standards including high school graduation for the preliminary education of medical students and a four-year medical course of study consisting of at least seven months in each of the four years. The committee requested an annual budget of $5,000 for the work of the committee and space for the committee at the *JAMA* building. It also recommended that committee members "inform themselves as to the requirements and character of work done by each medical school" and provide an annual report to the AMA House of Delegates. In its 1904 report to the AMA House of Delegates, the committee recommended the creation of a permanent committee or council for "… using to the best purpose the weight and influence of the American Medical Association toward elevating medical education …," and thus the Council on Medical Education (CME)

was established.[31] (The reader should note that the name of the council was changed in 1921 to the Council on Medical Education and Hospitals but then reverted to the original in 1964.)

As Victor Johnson points out in his history of the council, interest in medical education was already on the rise well before the council's creation, as indicated by the appearance of an annual issue of *JAMA* devoted to medical education in 1901, as well as by the activities of other organizations.[32] The state of U.S. medical education formed the theme of the first conference of the council in 1905, leading the CME to adopt an "ideal standard" that would soon evolve into the *Essentials of an Acceptable Medical College*, the statement of standards that would guide the AMA for nearly 50 years in its evaluation of medical schools. The expectations of the ideal standard were similar to those being promulgated by the AAMC and NCSMELB that defined preliminary requirements for medical school entrance and a five-year medical curriculum that began with a year of chemistry, biology, and physics (which could be taken in a school of liberal arts or the medical school), followed by two years focused on basic science (including laboratory experiences), and the final two on learning about patient care.[33] The standard also advocated an additional internship year in a hospital or dispensary. The CME admitted that such an ideal standard might be difficult to achieve and therefore adopted less stringent standards comparable to those of other groups: a high school education, four years of medical education (not less than 30 weeks per year nor less than 30 hours per week), and passage of a satisfactory examination administered by a state examining board.[34] The recommended standards also included an expectation that a practitioner graduate from an "approved" medical college.

As the CME was developing its standards, *JAMA* in 1904 had begun publishing the performance of medical school graduates on state licensing examinations. The council used that data to develop a classification of medical schools based on licensure examination failure rates, placing schools into one of the following categories:

- Class 1, with a failure rate below 10%
- Class 2, with a failure rate from 10% to 20%
- Class 3, with failure rates above 20%
- Class 4, with less than 10 graduating students or with evidence otherwise unavailable to allow for classification in one of the other groups

According to Johnson's history, the CME recognized the limited value of a classification based exclusively on licensure results and therefore determined that it was necessary to conduct on-site inspections of medical schools to obtain sounder insights into the quality of the medical education programs they provided.[35] The inspection program employed a "10-point standard" (see Chapter 6) with each school receiving a score from 1 to 10 on each of the 10 items on the scale. The country was divided into sections, and either the CME secretary or some other member personally visited each of the 160 medical schools in the United States beginning in 1906. (The modern reader should appreciate the difficulty of this endeavor, considering the transportation system existing at the beginning of the 20th century.)

While the AMA was reasserting itself as a major force for the improvement of medical education quality by way of the CME, the AAMC continued to refine its requirements for association membership. In 1902 the AAMC approved a requirement that the standard for admissions to medical school be a full equivalent of a four-year high school course and that any examination of a student for admissions (as an alternative to a high school education) be taken entirely out of the hands of the medical school.

The rivalry among the various organizations involved in improving the quality of medical education was clearly articulated in a report of the AAMC's Committee on Revision of the Constitution filed in the 1903 proceedings.[36] In that report, the committee expressed concern about losing ground to the AMA and to the state boards. Regarding the former, the report stated, "For some reason too, the American Medical Association seems to have concluded that it ought again to take an active part in the matter of medical education, the inference being that the status of this Association [the AAMC], to which were relegated all matters of medical education at the time of its organization, is not satisfactory.… It would be humiliating, indeed, for this Association, if standards should be established by the American Medical Association considerably in advance of the standards of this body, which has posed as the particular sponsor for higher medical education in this country."

Spurred by such concerns, the AAMC adopted a series of revisions to its constitution:

- For admissions to medical school, either a diploma from a four-year high school, a bachelor's degree from an approved college or university, or successful completion of an examination in several subjects needed for medical study (e.g., English, algebra, Latin, physics)
- For graduation, completion of courses of study over four years, with at least 12 months intervening between the beginning of any course and the beginning of the preceding course

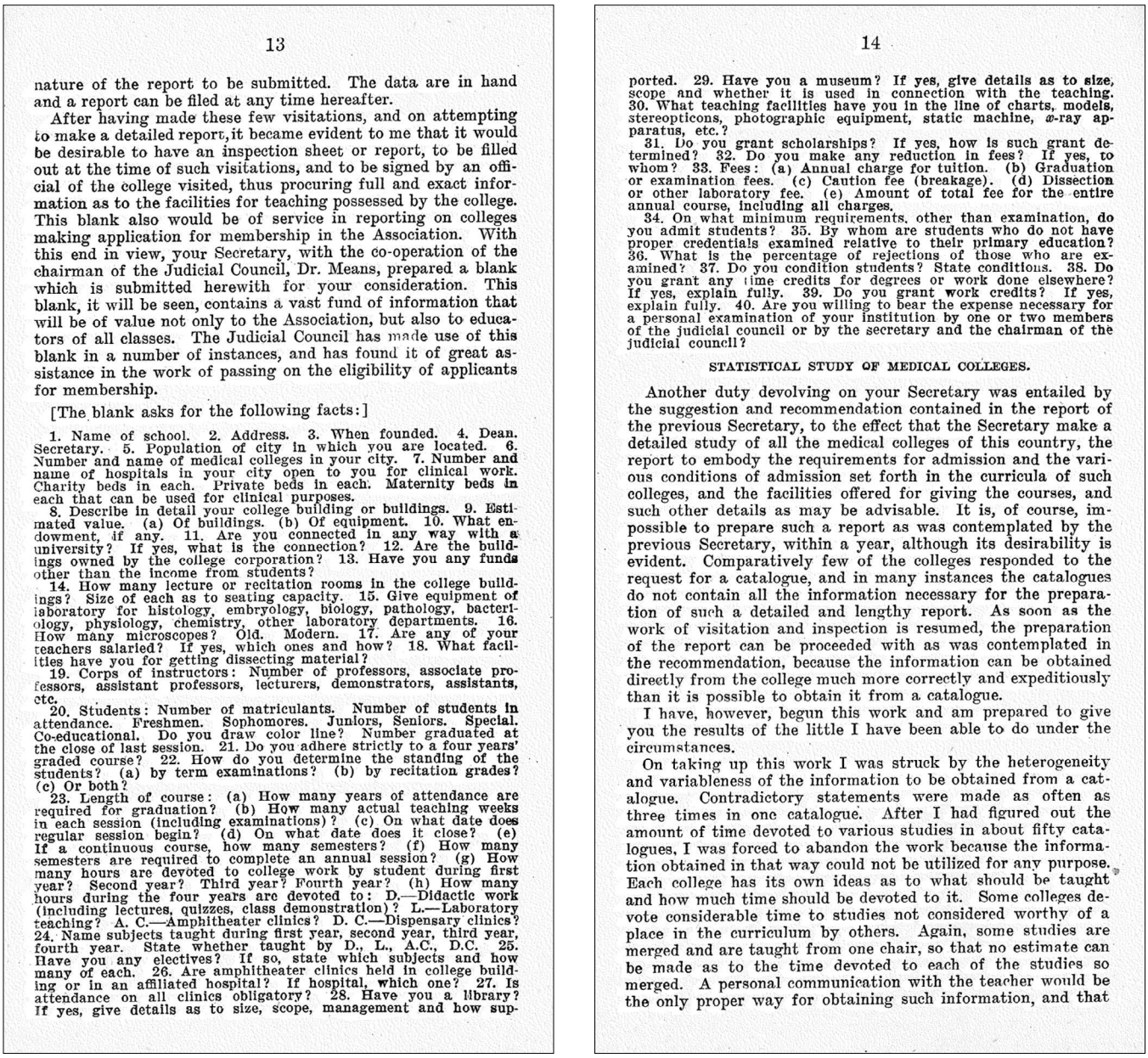
It was also at the 1903 meeting of the AAMC that its leader called for funding to support a program of inspection of member institutions. President William Rodman's address to the membership noted that "…a fund will soon be created which can be still further increased, if necessary, by direct assessment to provide for the inspection of all the schools members of the Association. Such a step now seems to me necessary, and I would recommend that the Secretary be requested to make, or cause to be made, an examination of the plants and equipments of all the colleges forming the Association, and to report thereon as soon as practicable.… Some attempt at least should be made to hold schools responsible for what they advertise. This, seemingly, is the only way of doing so."[37]

One year later, the AAMC Special Committee on By-Laws recommended the creation of a committee on visitation consisting of the association's president, secretary, and chairman of its Judicial Council to visit and investigate all schools with membership in the association, as well as any school seeking membership. Remarkably, considering the rivalries of the period, the special committee also acknowledged the possibility of a joint inspection program with other organizations. "If a plan of visitation shall be undertaken by the American Medical Association, or the Confederation of Examining Boards, or both, the above committee is authorized to confer with the representatives of these organizations in order to devise a suitable scheme of college visitation which shall be satisfactory to all three associations."[38]

The special committee's recommendation was approved, and $400 was to be appropriated to defray the costs of the visitation program for the upcoming year. The AAMC bylaws were amended in 1907 to establish a standing visitation committee charged to visit and investigate every member medical school at least once every five years to determine whether the laws of the association were being enforced.

Potential collaborations with other organizations also provided a main theme for the report of the AAMC's new secretary-treasurer, Fred Zapffe, at the 1904 meeting. He recommended a committee of one to confer with similar committees from the AMA, NCSMELB, the Southern Medical College Association, and the national associations of medical specialty societies. In his words, "The purpose of these committees is to further medical education by establishing a uniform standard of requirements for entrance to and graduation from medical schools."[39] The reasons for pursuing such collaboration are unclear, but at least one possibility is that the AAMC hoped to enhance its credibility in relation to those organizations and solidify its support in the medical education community. Zapffe was selected by the membership to serve as the committee of one that he had requested.

Zapffe also provided a surprisingly detailed report of his initial foray into medical school inspections. He had visited nine schools even though the association had not appropriated the $400 in funds that were to be allocated for the inspection program. What is most remarkable in this report is a full description of the blank form used by the association's Judicial Council for assessing the eligibility of applicants for membership. The form consisted of 40 questions covering the breadth of a medical school's operations, including its history, administration, associated hospitals, physical facilities for education, composition of the faculty, medical student class size, curriculum details across all four years, tuition, fees, scholarship support, and criteria for admission or transfer of students. For its time, the form was as detailed as the modern medical education database or data collection instrument now in use by the LCME. See Figure 1.



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nature of the report to be submitted. The data are in hand and a report can be filed at any time hereafter.

After having made these few visitations, and on attempting to make a detailed report, it became evident to me that it would be desirable to have an inspection sheet or report, to be filled out at the time of such visitations, and to be signed by an official of the college visited, thus procuring full and exact information as to the facilities for teaching possessed by the college. This blank also would be of service in reporting on colleges making application for membership in the Association. With this end in view, your Secretary, with the co-operation of the chairman of the Judicial Council, Dr. Means, prepared a blank which is submitted herewith for your consideration. This blank, it will be seen, contains a vast fund of information that will be of value not only to the Association, but also to educators of all classes. The Judicial Council has made use of this blank in a number of instances, and has found it of great assistance in the work of passing on the eligibility of applicants for membership.

[The blank asks for the following facts:]

1. Name of school. 2. Address. 3. When founded. 4. Dean. Secretary. 5. Population of city in which you are located. 6. Number and name of medical colleges in your city. 7. Number and name of hospitals in your city open to you for clinical work. Charity beds in each. Private beds in each. Maternity beds in each that can be used for clinical purposes.

8. Describe in detail your college building or buildings. 9. Estimated value. (a) Of buildings. (b) Of equipment. 10. What endowment, if any. 11. Are you connected in any way with a university? If yes, what is the connection? 12. Are the buildings owned by the college corporation? 13. Have you any funds other than the income from students?

14. How many lecture or recitation rooms in the college buildings? Size of each as to seating capacity. 15. Give equipment of laboratory for histology, embryology, biology, pathology, bacteriology, physiology, chemistry, other laboratory departments. 16. How many microscopes? Old. Modern. 17. Are any of your teachers salaried? If yes, which ones and how? 18. What facilities have you for getting dissecting material?

19. Corps of instructors: Number of professors, associate professors, assistant professors, lecturers, demonstrators, assistants, etc.

20. Students: Number of matriculants. Number of students in attendance. Freshmen. Sophomores. Juniors. Seniors. Special. Co-educational. Do you draw color line? Number graduated at the close of last session. 21. Do you adhere strictly to a four years' graded course? 22. How do you determine the standing of the students? (a) by term examinations? (b) by recitation grades? (c) Or both?

23. Length of course: (a) How many years of attendance are required for graduation? (b) How many actual teaching weeks in each session (including examinations)? (c) On what date does regular session begin? (d) On what date does it close? (e) If a continuous course, how many semesters? (f) How many semesters are required to complete an annual session? (g) How many hours are devoted to college work by student during first year? Second year? Third year? Fourth year? (h) How many hours during the four years are devoted to: D.—Didactic work (including lectures, quizzes, class demonstration)? L.—Laboratory teaching? A. C.—Amphitheater clinics? D. C.—Dispensary clinics? 24. Name subjects taught during first year, second year, third year, fourth year. State whether taught by D., L., A.C., D.C. 25. Have you any electives? If so, state which subjects and how many of each. 26. Are amphitheater clinics held in college building or in an affiliated hospital? If hospital, which one? 27. Is attendance on all clinics obligatory? 28. Have you a library? If yes, give details as to size, scope, management and how supported. 29. Have you a museum? If yes, give details as to size, scope and whether it is used in connection with the teaching. 30. What teaching facilities have you in the line of charts, models, stereopticons, photographic equipment, static machine, *x*-ray apparatus, etc.?

31. Do you grant scholarships? If yes, how is such grant determined? 32. Do you make any reduction in fees? If yes, to whom? 33. Fees: (a) Annual charge for tuition. (b) Graduation or examination fees. (c) Caution fee (breakage). (d) Dissection or other laboratory fee. (e) Amount of total fee for the entire annual course, including all charges.

34. On what minimum requirements, other than examination, do you admit students? 35. By whom are students who do not have proper credentials examined relative to their primary education? 36. What is the percentage of rejections of those who are examined? 37. Do you condition students? State conditions. 38. Do you grant any time credits for degrees or work done elsewhere? If yes, explain fully. 39. Do you grant work credits? If yes, explain fully. 40. Are you willing to bear the expense necessary for a personal examination of your institution by one or two members of the judicial council or by the secretary and the chairman of the judicial council?

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STATISTICAL STUDY OF MEDICAL COLLEGES.

Another duty devolving on your Secretary was entailed by the suggestion and recommendation contained in the report of the previous Secretary, to the effect that the Secretary make a detailed study of all the medical colleges of this country, the report to embody the requirements for admission and the various conditions of admission set forth in the curricula of such colleges, and the facilities offered for giving the courses, and such other details as may be advisable. It is, of course, impossible to prepare such a report as was contemplated by the previous Secretary, within a year, although its desirability is evident. Comparatively few of the colleges responded to the request for a catalogue, and in many instances the catalogues do not contain all the information necessary for the preparation of such a detailed and lengthy report. As soon as the work of visitation and inspection is resumed, the preparation of the report can be proceeded with as was contemplated in the recommendation, because the information can be obtained directly from the college much more correctly and expeditiously than it is possible to obtain it from a catalogue.

I have, however, begun this work and am prepared to give you the results of the little I have been able to do under the circumstances.

On taking up this work I was struck by the heterogeneity and variableness of the information to be obtained from a catalogue. Contradictory statements were made as often as three times in one catalogue. After I had figured out the amount of time devoted to various studies in about fifty catalogues, I was forced to abandon the work because the information obtained in that way could not be utilized for any purpose. Each college has its own ideas as to what should be taught and how much time should be devoted to it. Some colleges devote considerable time to studies not considered worthy of a place in the curriculum by others. Again, some studies are merged and are taught from one chair, so that no estimate can be made as to the time devoted to each of the studies so merged. A personal communication with the teacher would be the only proper way for obtaining such information, and that

Figure 1. Blank form used by AAMC Judicial Council for medical school visitations.
The data collection instrument used by the AAMC for its medical school visitation program, circa 1904. Schools were expected to complete the 40-item questionnaire when undergoing an inspection from the AAMC. Source: *Association of American Medical Colleges Minutes of the Fourteenth Annual Meeting* (Chicago, IL: American Medical Association Press, 1904).

Thus, by the middle of the first decade of the 20th century, all elements that constitute the definition of accreditation, as described in the preceding chapter, were in place: standards, a method for evaluating initial and periodic achievement of the standards, a willingness by medical schools to submit themselves to formal evaluation on the basis of those standards, and a mechanism for public recognition of the results of those evaluations. The three organizations essential to the effectiveness of any medical school accreditation effort had all stepped forward to claim a role in the process.

Chapter 2

The Flexner Report and Its Aftermath

By the beginning of the 20th century, both the AMA and AAMC had stabilized organizationally to the point where their efforts to improve the quality of medical education were much more likely to find a receptive audience. The rapid growth of medical schools in the preceding decades seemed to have saturated the marketplace for medical education, as the number of U.S. medical schools began a long decline from a peak of 166 in 1904. The attrition in the number of medical schools very likely accelerated as a consequence of two major events: the first classification of medical schools by the AMA and the publication of *Medical Education in the United States and Canada* (hereafter referred to as the Flexner Report) in 1910. The immediate post-Flexner period saw continuing reductions in the number of medical schools. Furthermore, the curriculum of the surviving medical schools became increasingly homogenized by the stringent requirements of the AMA and the AAMC, and more rigorous admissions criteria promulgated by those organizations resulted in smaller enrollments.

Major historical events of the period were as follows:

- Council on Medical Education produced its first classification of medical schools (1907)
- Flexner Report published (1910)
- North Central Association became first regional association to accredit colleges and universities (1910)
- Creation of the Federation of State Medical Boards (1912)
- Council on Medical Education produced its first classification of hospitals (1914)
- Founding of the National Board of Medical Examiners (1915)
- Establishment of the Commission on Medical Education (1925)
- Development of the Scholastic Aptitude Test for Medical Schools (1930)
- Creation of the National Institute of Health (1930)
- Publication of the *Final Report of the Commission on Medical Education* (1932)
- Formation of the Advisory Board for Medical Specialties (1933)
- Creation of the Advisory Council on Medical Education, Licensure, and Hospitals (1938)

1907: Commissioning of the Flexner Report

As noted earlier, representatives of the Council on Medical Education (CME) began on-site inspections of 160 U.S. medical schools in 1906, using a 10-point standard (described in Chapter 6), with each school receiving a rating from 1 to 10 on each of the 10 items on the scale. In addition to inspections of MD-granting institutions, the CME also included 20 homeopathic and 10 eclectic institutions in its survey. (Eclectic medicine emphasized use of botanical remedies and physical therapy for the treatment of medical conditions.) The schools were grouped into categories from A through F, with A-level schools receiving scores from 90 to 100 and F-level schools receiving scores below 50. Schools in groups A–C, with scores above 70, were considered worthy of acceptance by state medical boards. Schools scoring from 50 to 70 (Levels D and E) were deemed worth recognizing if they made improvements

that would elevate their score above 70. Category F schools did not merit acceptance by state boards. Slightly over half (82) of the surveyed schools received scores above 70, with 46 in the marginal D and E groups and 32 in the F group.

The results of the inspection program were shared with the AMA membership in the CME report at the 1907 annual meeting. The overall ratings of individual schools were not published, but the CME did produce a table showing the failure rates of 149 schools on state board examinations. The board examination data were used to classify schools into three groups according to failure rates: those with rates below 10%, those with rates from 10% to20%, and those with rates greater than 20%. An additional category captured schools with insufficient data. In this classification, 62 schools (slightly over 40%) had failure rates below 10%, with 24 schools (16%) between 10% and 20% and 43 schools (29% of the total) with a failure rate greater than 20%. In accepting the CME report, the Reference Committee on Medical Education recommended that the CME undertake annual inspections of all medical schools for a period of three years, beginning in June 1907.

Although the composite ratings of medical schools were not made public, each school was notified of the rating it had received, leading to rapid change in some cases and to considerable resentment in others. To validate its work and bring public pressure to bear on the schools with marginal or unacceptable educational programs, the CME subsequently sought the assistance of the Carnegie Foundation for the Advancement of Teaching. The Carnegie Foundation had already expressed concerns about the quality of education in several professions, including law and theology as well as medicine, and was thus quite receptive to the invitation from the CME. After meeting with the council in December 1908, the foundation agreed to conduct an independent program of evaluation for U.S. medical schools, under the leadership of Abraham Flexner.

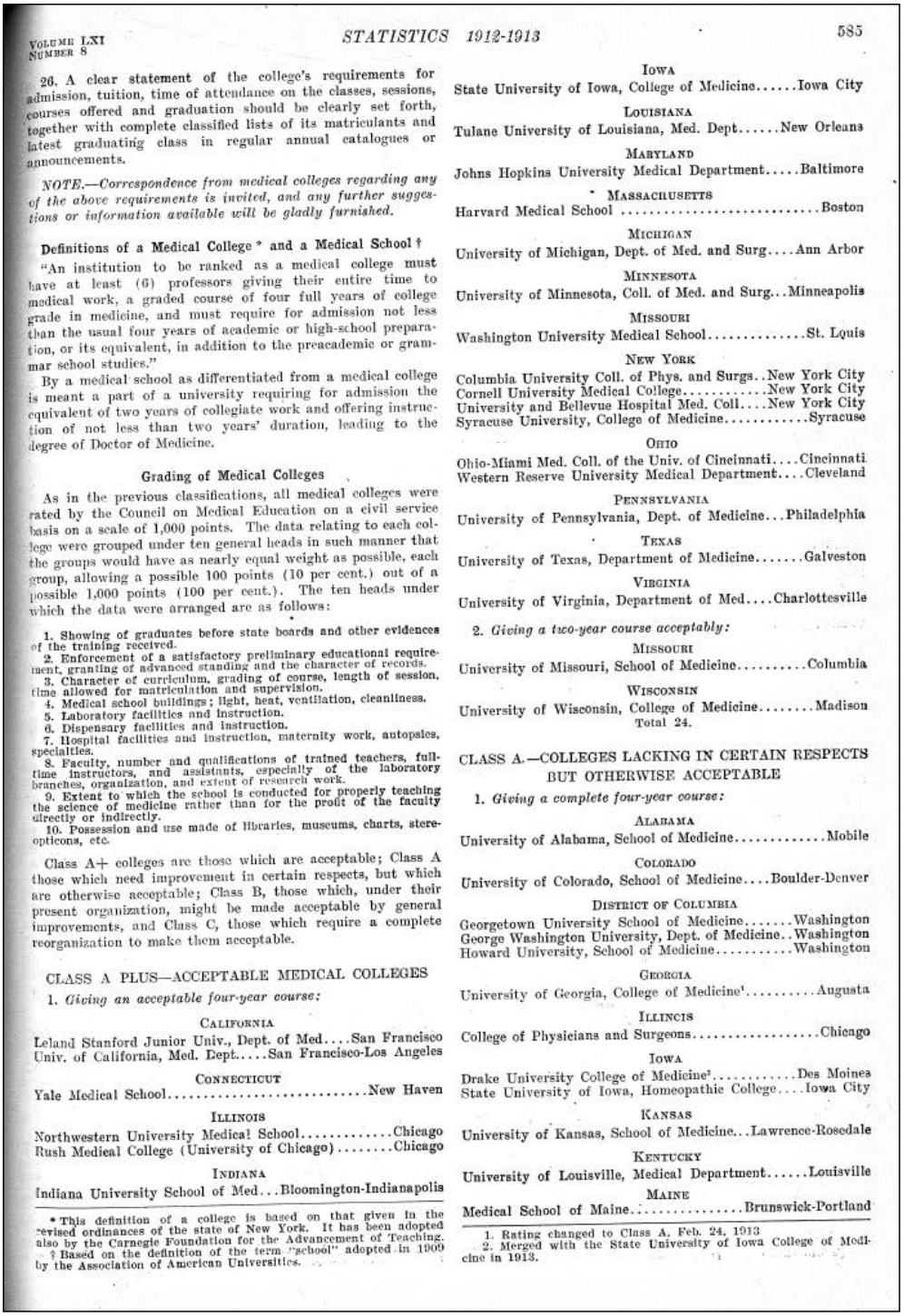
Abraham Flexner was not associated with the medical profession. His brother Simon, however, was a pathologist who was known by AMA leadership and active in AMA affairs. Indeed, he had been invited to give an illustrated lecture on his field to the AMA's General Executive Committee in 1901 (although he declined the invitation at the last moment, leading to cancellation of the lecture). He also served as a member on the AMA Council on Defense of Medical Research. Abraham Flexner, despite his lack of expertise in medical education, was able to draw on his brother's knowledge, frequent consultations with medical school faculty from Johns Hopkins, and his own studies to have the understanding necessary to evaluate medical education in the United States.[40] During his inspections of medical schools in 1909, he was accompanied by one or more members of the CME on each visit. The report of those inspections was published in the following year.[41]

1910: The Immediate Impact of the Flexner Report on AMA and AAMC Requirements

The publication of the Flexner Report itself had no visible, immediate impact on the activities of either the CME or the AAMC in relation to medical school inspections or standards. The second round of CME inspections, conducted by Flexner and council members, served as the basis for the adoption of the first version of the AMA's compendium of evaluation criteria, *Essentials of an Acceptable Medical School* (*Essentials*), as well as providing the raw material for the content of the Flexner Report.[42] The criteria outlined in *Essentials* were also used to develop a definition of a medical college and a medical school, as follows:

> An institution to be ranked as a medical college must have at least six (6) professors giving their entire time to medical work, a graded course of four full years of college grade in medicine, and must require for admission not less than the usual four years of academic or high school preparation, or its equivalent, in addition to the pre-academic or grammar school studies.
>
> By a medical school as differentiated from a medical college is meant a part of a university requiring for admission the equivalent of two years of collegiate work and which offers instruction of not less than two years' duration, leading to the degree of Doctor of Medicine.[43]

The 10-point scale used to rate medical schools in the first round of inspections was employed again for the second round, and this time the resulting classification was published as part of the AMA proceedings in the June 18, 1910, issue of *JAMA*. In contrast to the first, unpublished classifications, the ratings were simplified to an ABC system in lieu of the previous A–F categories; the interpretation remained the same, however, with A schools scoring above 70 and considered acceptable, B schools scoring between 50 and 70 and considered marginal, and C schools scoring below 50 and judged to be unacceptable. As a result of the second round of inspections, 70 U.S. medical schools achieved an A rating, 29 schools achieved a B rating, and 27 schools received a C rating. "Medical schools for colored students" were listed as a separate category, "not on the ground of any racial difference, but on account of peculiar educational conditions."[44] Canadian schools were also listed separately, with four in the A group, three in the B group, and one in the C group. See Figure 2.



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26. A clear statement of the college's requirements for admission, tuition, time of attendance on the classes, sessions, courses offered and graduation should be clearly set forth, together with complete classified lists of its matriculants and latest graduating class in regular annual catalogues or announcements.

NOTE.—Correspondence from medical colleges regarding any of the above requirements is invited, and any further suggestions or information available will be gladly furnished.

Definitions of a Medical College * and a Medical School †

"An institution to be ranked as a medical college must have at least (6) professors giving their entire time to medical work, a graded course of four full years of college grade in medicine, and must require for admission not less than the usual four years of academic or high-school preparation, or its equivalent, in addition to the preacademic or grammar school studies."

By a medical school as differentiated from a medical college is meant a part of a university requiring for admission the equivalent of two years of collegiate work and offering instruction of not less than two years' duration, leading to the degree of Doctor of Medicine.

Grading of Medical Colleges

As in the previous classifications, all medical colleges were rated by the Council on Medical Education on a civil service basis on a scale of 1,000 points. The data relating to each college were grouped under ten general heads in such manner that the groups would have as nearly equal weight as possible, each group, allowing a possible 100 points (10 per cent.) out of a possible 1,000 points (100 per cent.). The ten heads under which the data were arranged are as follows:

1. Showing of graduates before state boards and other evidences of the training received.
2. Enforcement of a satisfactory preliminary educational requirement, granting of advanced standing and the character of records.
3. Character of curriculum, grading of course, length of session, time allowed for matriculation and supervision.
4. Medical school buildings; light, heat, ventilation, cleanliness.
5. Laboratory facilities and instruction.
6. Dispensary facilities and instruction.
7. Hospital facilities and instruction, maternity work, autopsies, specialties.
8. Faculty, number and qualifications of trained teachers, full-time instructors, and assistants, especially of the laboratory branches, organization, and extent of research work.
9. Extent to which the school is conducted for properly teaching the science of medicine rather than for the profit of the faculty directly or indirectly.
10. Possession and use made of libraries, museums, charts, stereopticons, etc.

Class A+ colleges are those which are acceptable; Class A those which need improvement in certain respects, but which are otherwise acceptable; Class B, those which, under their present organization, might be made acceptable by general improvements, and Class C, those which require a complete reorganization to make them acceptable.

CLASS A PLUS—ACCEPTABLE MEDICAL COLLEGES

1. *Giving an acceptable four-year course:*

CALIFORNIA
Leland Stanford Junior Univ., Dept. of Med....San Francisco
Univ. of California, Med. Dept.....San Francisco-Los Angeles

CONNECTICUT
Yale Medical School.....New Haven

ILLINOIS
Northwestern University Medical School.....Chicago
Rush Medical College (University of Chicago).....Chicago

INDIANA
Indiana University School of Med...Bloomington-Indianapolis

IOWA
State University of Iowa, College of Medicine.....Iowa City

LOUISIANA
Tulane University of Louisiana, Med. Dept.....New Orleans

MARYLAND
Johns Hopkins University Medical Department.....Baltimore

MASSACHUSETTS
Harvard Medical School .....Boston

MICHIGAN
University of Michigan, Dept. of Med. and Surg....Ann Arbor

MINNESOTA
University of Minnesota, Coll. of Med. and Surg...Minneapolis

MISSOURI
Washington University Medical School.....St. Louis

NEW YORK
Columbia University Coll. of Phys. and Surgs..New York City
Cornell University Medical College.....New York City
University and Bellevue Hospital Med. Coll....New York City
Syracuse University, College of Medicine.....Syracuse

OHIO
Ohio-Miami Med. Coll. of the Univ. of Cincinnati....Cincinnati
Western Reserve University Medical Department....Cleveland

PENNSYLVANIA
University of Pennsylvania, Dept. of Medicine...Philadelphia

TEXAS
University of Texas, Department of Medicine.....Galveston

VIRGINIA
University of Virginia, Department of Med....Charlottesville

2. *Giving a two-year course acceptably:*

MISSOURI
University of Missouri, School of Medicine.....Columbia

WISCONSIN
University of Wisconsin, College of Medicine.....Madison
Total 24.

CLASS A.—COLLEGES LACKING IN CERTAIN RESPECTS BUT OTHERWISE ACCEPTABLE

1. *Giving a complete four-year course:*

ALABAMA
University of Alabama, School of Medicine.....Mobile

COLORADO
University of Colorado, School of Medicine....Boulder-Denver

DISTRICT OF COLUMBIA
Georgetown University School of Medicine.....Washington
George Washington University, Dept. of Medicine..Washington
Howard University, School of Medicine.....Washington

GEORGIA
University of Georgia, College of Medicine[1].....Augusta

ILLINOIS
College of Physicians and Surgeons.....Chicago

IOWA
Drake University College of Medicine[2].....Des Moines
State University of Iowa, Homeopathic College....Iowa City

KANSAS
University of Kansas, School of Medicine...Lawrence-Rosedale

KENTUCKY
University of Louisville, Medical Department.....Louisville

MAINE
Medical School of Maine.....Brunswick-Portland

* This definition of a college is based on that given in the revised ordinances of the state of New York. It has been adopted also by the Carnegie Foundation for the Advancement of Teaching.
† Based on the definition of the term "school" adopted in 1909 by the Association of American Universities.

1. Rating changed to Class A, Feb. 24, 1913
2. Merged with the State University of Iowa College of Medicine in 1913.

Figure 2. AMA classification of U.S. medical schools.
The ABC classification system used by the AMA to summarize the quality of U.S. medical education programs. This example from 1913 differentiated A+ grades from A grades, resulting in a four-level classification. The ABC system was discontinued by the AMA in 1932. Source: *Journal of the American Medical Association* (August 1913): 585-587.

The CME did not revise *Essentials* substantially in the immediate aftermath of the Flexner Report and the publishing of the council's classification of medical schools. The 1911 report of the CME to the AMA membership did include a number of recommendations for medical schools, such as more stringent admissions requirements (two years of college science and modern languages in addition to a complete high school education), hiring of more instructional staff (especially in the laboratory sciences), improvement of library and museum facilities, greater focus on dispensary and hospital study of patients by senior students, and adoption of a fifth, internship year.[45] These recommendations echoed expectations that had previously been established in the AMA ideal standard and in *Essentials*.

A revised *Essentials* that was presented to the AMA by the CME in 1912 did include an anticipatory requirement, to take effect as soon as circumstances permitted, that medical schools offer a fifth internship year as part of the curriculum. The new *Essentials* did not incorporate the other recommendations discussed at the 1911 AMA meeting. The CME also shared the results of its third round of medical school inspections at the 1912 meeting and introduced an A+ rating ("very acceptable") in its published list of medical schools. Issues of clinical education and the internship year were pinpointed as the next major challenge for the council. In 1913 the CME adopted a more detailed requirement for the "preliminary college year" in collaboration with the AAMC; the council's report to the AMA membership also acknowledged the recent cooperation it had enjoyed with the AAMC and with the newly created Federation of State Medical Boards (FSMB).

While Flexner's work received little direct recognition at the AMA annual meeting in 1910, its influence was much more visible at the AAMC. Flexner himself presented a paper at the AAMC's March 1910 annual meeting that discussed AAMC standards for medical school admissions; he had been commissioned earlier by the AAMC to review information on student records provided by the membership to the organization. He prefaced his remarks by acknowledging the accreditation function of the AAMC, although he did not use that specific term. "The Association of American Medical Colleges is, if I understand its purpose aright, an organization formed for the purpose of elevating and maintaining the standards in medical education through the voluntary actions of the medical colleges themselves."[46] The thrust of his comments addressed the high school admissions requirement. Flexner considered the standard itself to be reasonable, but he was harshly critical of the association's enforcement of the standard, based on information he had obtained in the course of his medical school inspections with members of the CME. His proposed solution to the challenge of enforcement was to get state medical boards to adopt and verify compliance with the admissions standard. Flexner's recommendations were referred to the association's Committee on Medical Education, with instructions to investigate and formulate an amendment to the AAMC constitution for consideration at the next annual meeting.

Although the Flexner Report had not yet been published when the AAMC met in 1910, his work and that of the CME in rating the medical schools were familiar to the membership and served as a focal point for discussion at the meeting. The report of the AAMC secretary-treasurer, Fred Zapffe, began with a broad acknowledgment of the issue: "The most important matter which presents itself at this

time is the rating of colleges. A number of organizations have for several years past been making inspections and ratings, and while these findings do not agree in all particulars, there is, in the main, a uniformity which makes these inspections valuable." Zapffe suggested that the AAMC "take up the task," although he also pointed out that he was unable to personally visit any member colleges during the preceding year for lack of funding provided by the organization. Later in his report, Zapffe specifically noted Flexner's work and its impact on medical colleges, noting that "colleges are alive to the worth of the recommendations made by the [Carnegie] Foundation …" and that conditions in medical schools had improved as a result of the foundation's work.[47]

The AAMC Judicial Council—in all likelihood sensitive to the work of the CME and Flexner and to Flexner's criticism of AAMC enforcement of its admissions standard—adopted a plan to assign different regions of the country to each of its members; the Committee on Medical Education was also asked to adopt a similar approach "to keep in touch with educational matters in the district assigned … with the view toward the recognition of the Association standards and the establishment of uniformity."[48] While Judicial Council members did not have direct access to the information collected by Flexner and the CME, they found the findings sufficiently worrisome so to recommend that the council "be given authority to order an investigation of the colleges now members of the Association that have been reported on adversely by the American Medical Association Council of Education, and to investigate any other colleges members of the Association that may be subjected to like criticism by other examining or inspecting bodies."[49]

Finally, the 1910 annual meeting also saw proposals for modification of the AAMC constitution to address several curriculum requirements. The proposals resulted from analysis of curriculum data that had been published in *JAMA* and based on CME/Flexner inspections of medical schools. The AAMC Committee on Curriculum recommended, by way of its Subcommittee on Curriculum for the Clinical Years, that the minimum length of each academic year be expanded to 32 weeks from the 30-week minimum in place; it also recommended that the curriculum encompass 1,000 hours of formal instruction in each of the four years of medical study, removing language in the existing constitution that allowed for an exception of up to 10% of the 4,000-hour requirement.[50] The subcommittee further recommended a distribution of contact hours "to conform with the American Medical Association." The membership endorsed these recommendations and referred them to the AAMC's Committee on Medical Education for the development of appropriate constitutional amendments to be presented at the next annual meeting.

1912–1920: Inspections and Listings of Approved Medical Schools

As noted earlier, the CME had already completed two rounds of medical school inspections by 1910. At the time of the CME's creation in 1904, there were 166 medical schools operating in the United States. After the council conducted its first round of inspections, it reported data for 160 U.S. schools. The CME reported to its membership in 1912 that 37 colleges had shuttered by merger or closure in the interval between the initial inspections and the completion of the second round, conducted in partnership with Abraham Flexner.[51] This outcome from the second round of inspections,

which also included Canadian medical schools, led the AMA's Reference Committee on Medical Education to recommend a third round of inspections of U.S. schools to be conducted during the 1911–1912 academic year. By the end of that third round, another 19 U.S. schools had ceased operation, bringing the total of U.S. medical schools to 124. A fourth round of inspections took place in 1913–1914 and included Canadian medical schools; further attrition yielded a total of 106 medical schools continuing to operate after those inspections.

Meanwhile, the AAMC had independently initiated a program of inspections for member medical schools when Zapffe was appointed as the AAMC secretary-treasurer in 1903; however, it took Zapffe four years to complete those inspections because of limited financial support provided by the AAMC. Although the AAMC established a visitation committee charged to inspect all member institutions in 1907, that plan did not materialize, again for lack of funding.

The AMA publication of medical school ratings and the release of the Flexner Report prompted the AAMC to take a more aggressive approach to its inspection program. At the 1910 meeting of the AAMC, Zapffe proposed that the AAMC undertake ratings of its member institutions. The AAMC's Judicial Council requested and received authorization to investigate member institutions that had been "reported on adversely" by the CME; both the AAMC president and secretary recommended that the CME be invited to participate in the next AAMC annual meeting.

The following year, the AAMC conducted its first joint inspection of a medical school with the CME. In 1912, the Judicial Council proposed, and the membership accepted, a recommendation to inspect any member deemed unacceptable by state medical boards or by "other evaluative bodies." In conjunction with the AMA's fourth round of inspections in 1913–1914, AAMC representatives jointly visited new applicants and low-rated member institutions. The chair of the AAMC Executive Council, William Means, reported to the membership in 1914 that dual inspections of colleges had proven to be very successful. Some but not all AAMC medical school inspections the following year were conducted jointly with representatives of the CME.

The surge of inspection programs at the AMA and the AAMC coincided with the emerging development of national organizations that promulgated a consistent approach to medical licensure across state boundaries. The FSMB was formed in 1912 through the merging of the National Confederation of State Medical Examining and Licensing Boards (described briefly in the preceding chapter) with the American Confederation of Reciprocating Examining and Licensing Boards. From its inception, the FSMB was strongly supportive of the standards adopted by the CME and the AAMC. The national focus on licensure was boosted further by the 1915 creation of the National Board of Medical Examiners (NBME), established "… to elevate the standard of qualification for the practice of medicine and surgery, and to provide a means for recognition of qualified persons to practice in any state, territory, or dependency of the United States without further examination by their licensing boards."[52]

According to the NBME website, one of the elements leading to its formation was the series of educational reforms proposed by Flexner. One of the requirements for eligibility to take the examination was graduation from a medical school listed in Class A by the CME.[53]

At the CME, a fifth round of inspections had been proposed after the 1913–1914 cycle but was postponed. The council planned to resume inspections in 1917–1918 and invited the participation of the AAMC in the inspections of those schools holding AAMC membership. To that end, the AAMC Executive Council presented a resolution at its 1917 meeting for a special levy of $25 per member for each of the next two years to defray the costs of participation in the joint inspection program. The membership approved the resolution, which was amended to state that the reports be constructive, include details regarding conditions found, identify deficiencies and recommend steps to address them, and be shared with the school that was inspected.[54] However, the anticipated physician manpower demands of World War I intervened, and the planned cycle of inspections did not take place. Wartime concerns quickly receded, however, and in 1919 the CME renewed its call for a program of inspections of all medical schools; that effort began in October 1919, undertaken in collaboration with the AAMC, and was completed in 1922.

The surge of inspection programs at the AMA and the AAMC coincided with the emerging development of national organizations that promulgated a consistent approach to medical licensure across state boundaries.

After the completion of the fifth round of inspections, the CME (now renamed as the Council on Medical Education and Hospitals, or CMEH) and the AAMC appeared to have gone separate ways in their inspection programs. Minutes of AAMC proceedings in the 1920s suggest that on-site inspections were being done by Executive Council appointees, without participation from the CMEH. The AAMC had also reverted to its practice of inspecting only new applicants and members with low ratings from the CMEH. There would be no further comprehensive inspections of all medical schools by either organization for more than a decade.

The CME and the AMA had prudently decided not to publish the classification of medical schools resulting from the first round of inspections conducted shortly after the council's formation. The first formal listing of medical schools, published in *JAMA* in 1910, used an ABC system to categorize schools, respectively, as acceptable, in need of substantial improvement, and unsatisfactory. Throughout the next two decades, *JAMA* continued to publish the list of council-approved medical schools using the ABC classification. It also published a list of AAMC member institutions and the AAMC membership requirements.

After the third round of inspections in 1912, the CME report to the AMA membership suggested adoption of an A– category for schools lacking in certain respects but otherwise acceptable; the published listing of schools that year, however, used A+ to designate acceptable schools and A for schools that were considered

to be almost acceptable. The distinction between A+ and A was eliminated in 1918, reverting to the simple ABC system. The definition of a C school was modified to include any of the following:

- Schools requiring a complete reorganization to make them acceptable
- Schools that fail to keep satisfactory records of students regarding entrance requirements, attendance, grades in courses, division into classes, and reasons for promotion
- Schools that do not enforce their admission, promotion, or graduation requirements
- Schools that give the major portion of instruction after 4:00 p.m.
- Schools that are privately owned and conducted for profit
- Schools that are otherwise ineligible for consideration in Class B

This system remained in place until 1928, when the CMEH discontinued the publication of Class C schools in its annual list. For all practical purposes, that decision ended the classification system as a whole, since by 1928 there was only one B school remaining on the CMEH list. One year later, all listed schools were classified in the A group, and listing of the A schools continued until 1932, when *JAMA* eliminated any reference to a school's classification and simply reported the statistics for approved programs.

As an aside, the CME (and CMEH) lists published in *JAMA* also included homeopathic and eclectic medical schools, as well as "schools for the colored race"; however, neither osteopathic nor chiropractic medical schools were listed, as they were considered medical "cults" by the AMA at that time. Canadian medical schools were first included on the published list in 1916, although *JAMA* descriptions of Canadian schools had been included with the descriptions of U.S. schools since 1909.

The AAMC listed its member institutions as part of its annual proceedings, and the list was also published in *JAMA*. In a paper presented to the AAMC in 1909, Secretary-Treasurer Zapffe suggested differentiating the membership into major and minor categories, with the former consisting of schools that substantially exceeded membership requirements and the latter including schools that met only the minimum requirements.[56] In his report to the membership the following year, Zapffe again called for the AAMC to produce a classification of medical schools, citing the rating systems that had been adopted by other organizations. The recommendation was referred to the Committee on Medical Education but was not adopted, and the AAMC continued its practice of listing all member institutions without differentiating among them.

The possibility of AAMC classification of medical schools never materialized, but the general issue of classification was revisited by the president of the Carnegie Foundation, Henry Pritchett, in a paper he presented at the 1915 meeting of the AAMC. Pritchett acknowledged the valuable work done by the CME in inspecting and grading medical schools, as well as its presumed effect in stimulating or accelerating the closure of suspect medical schools and improving the quality of medical education. He asserted, however, that the system of classification was educationally unsound, saying, "In general, it may be fairly said that these criteria [for classifying medical schools] are too many, are not comparable one with another and are not in all cases capable of practical application." Pritchett concluded that the criteria for classification needed significant reconsideration in relation to

educational quality and suggested reducing them to five core elements: soundly administered entrance requirements, an able and devoted faculty, complete scientific laboratories, modern clinical facilities, and sufficient funding. He then recommended that such criteria could be used to differentiate schools into three categories: the clearly best, the clearly worst, and everything in between. He also noted that, in regard to the CME system in place, "…to a certain extent a school considers itself recommended to the public even when it appears in Class C." In the discussion of Pritchett's paper, CME Chair Arthur Bevan foreshadowed the eventual demise of classification, asserting, "I think we can regard all of these classifications as merely temporary expedients. We all hope that the time will come when we shall have no need of any rigid classification in this country." Nevertheless, the criteria and classifications established by the CME would not undergo any substantial changes for more than a decade.[57]

1921–1940: Medical School Standards and Evaluations in the 1920s and 1930s

The success of early educational standards and medical school inspections at the beginning of the century also produced an overreaction, as medical schools conformed by adopting stricter admission standards and longer curricula. This ultimately fed a growing sense in the 1920s that more rigorous admissions standards might be closing the door to qualified applicants. There was also concern that the curriculum was becoming rigidified, exhibiting an excessive preoccupation with science at the expense of other dimensions of medical practice.

The CMEH report at the 1921 meeting of the AMA called for several revisions in the MD curriculum, including earlier clinical activity; increased emphasis on the clinical application of basic sciences such as anatomy, physiology, pathology, and pharmacology; extension of anatomical and physiological topics into the third and fourth years; and greater use of generalists for clinical teaching. In its 1922 report to the AMA membership, the council attributed the following problems in some measure to the revolution in medical education that had ushered in the 20th century:

- Medical schools were finding it necessary to limit enrollments.
- The costs of medical education had increased substantially.
- Medical practice was shifting toward greater specialization and group practice.
- There was a growing scarcity of general practitioners, especially in rural areas.
- Hospitals were growing rapidly, creating a need for more interns than the medical schools were capable of providing.[58]

Similar themes were being articulated at AAMC meetings of the period. Concerns about the growing challenge of medical education costs were articulated in a paper presented at the 1922 AAMC annual meeting that noted, "There seems to be a tendency that the student, a member of a special class of society, shall pay a larger proportion of the increasing cost of medical education."[59] The 1922 meeting also included a report that began, "Perhaps the most striking thing about the curriculum of American medical colleges is its increasing tendency to rigidity of requirement."[60] The proposed solution was to eliminate contact hour requirements for numerous specific courses from AAMC membership criteria,

instead substituting percentages of broad subject areas. Schools would also have the option of instituting elective time if desired. The next year, the AAMC approved revision of its bylaws to adopt the switch to percentages as recommended by its Committee on Curriculum.

While the new membership requirements of the AAMC addressed one of the concerns about medical education, it did not address other important areas. At the 1924 annual meeting, AAMC membership approved the creation of the Commission on Requirements for the Degree of Doctor of Medicine, with participation by the CMEH and the American Council on Education. The charge to the commission was to "carry out a thorough investigation of what should be the essential requirements for the degree of Doctor of Medicine, and shall prepare a definite plan for a basic curriculum adjusted to meet present conditions."[61] A committee was appointed to initiate the process for establishing the commission.

That committee, now called the Committee on Survey of Medical Education, reported back to the membership at the 1925 meeting. The committee's first task was to appoint someone to oversee the commission's work, and it approached the highly respected educator, Richard Pearce, to accept the role. Unfortunately, Pearce's other commitments made it impossible for him to accept, and the committee then turned to Willard Rappleye to lead the group. The committee also espoused a broader membership on the commission, to include representatives from the Association of American Universities, the Association of American University Presidents, and the National Association of Medical Examining Boards. Financial support was sought from national foundations in addition to the AMA and the AAMC, and at the time of the 1925 meeting $80,000 had been procured to support the commission's work, over half of the ultimate goal of $150,000. Thus was born the Commission on Medical Education, which would function as an independent, influential organization for the remainder of the decade and continue into the next.

The first major revision of the AMA's *Essentials* was adopted in 1927. In addition to incorporating several new and more detailed requirements (see Chapter 7 for details), this version shifted from a list to a prose format. Although the CMEH continued to discuss medical school education issues, it shifted attention to other health care topics, most notably graduate medical education and growing concern about foreign medical graduates seeking U.S. licensure. At the 1927 AAMC annual meeting, Secretary Zapffe commented on this change in the CMEH's focus, reporting that "The Council on Medical Education and Hospitals of the American Medical Association has decided to leave in the hands of this group the development of the medical curriculum."[62] At the 1928 AMA meeting, the CMEH announced its intention to focus efforts on a comprehensive survey of all U.S. hospitals; it also expressed an interest in conducting a complete inspection of all "cult or otherwise Irregular" medical schools in the U.S. (including chiropractic and osteopathic schools); that plan did not materialize, however.[63]

As the CMEH undertook greater involvement in activities beyond medical school inspections, the AAMC efforts slowly dissipated. At the 1925 AAMC meeting, its secretary pointed out that funding was insufficient to fulfill the constitutional responsibility to inspect every member institution at least once every five years. The next year, the organization agreed to provide financial support for inspections of established members, with applicant institutions and schools requesting an inspection responsible

for the associated costs. Notwithstanding this financial support, inspections continued to occur sporadically and focused mainly on new members and those with serious difficulties. Indeed, Zapffe pointed out at the 1930 AAMC meeting that one member medical school had not been visited by any organization for a period of 14 years.[64] Two years later, the AAMC adopted a policy requiring Executive Council authorization before conducting any medical school "visits" (which by 1927 had become the preferred term for inspections). The presidential address to the AAMC membership in 1933 was rather critical of the organization's visit activities: "The character of the visits as at present carried out has been criticized by several member colleges. Some members say that the visits made have been too mechanical and not conducted in cooperation with the Council on Medical Education of the American Medical Association or with the Federation of State Medical Boards.… [I]t would seem advisable that in all visits to schools the secretary of this Association should be accompanied by one other member who is a dean of a member school, and if possible by the secretary of the Council on [Medical] Education of the American Medical Association."[65]

While enthusiasm for the AAMC visit program was flagging during the early 1930s, the CMEH renewed its interest in on-site inspections. The CMEH report at the 1931 AMA meeting pointed out that "although inspections of medical schools on the Council's approved list are perhaps not necessary as frequently as formerly, the Council still holds it to be one of its essential duties."[66] One year later, CMEH Chair Ray Lyman Wilbur presented a paper at the AAMC annual meeting titled "Inspection of Medical Schools and Survey of Medical Education."[67] In 1934 the CMEH called for a new survey of all medical schools in light of advances in medical education and problems that had arisen since the last comprehensive survey of 1919–1922. To assist with the conduct of that comprehensive inspection program, the CMEH appointed Herman G. Weiskotten to its staff and sought participation from both the AAMC and the FSMB. While the AAMC participated in some of the visits, most of the work was done by Weiskotten.

The last few years of the decade were characterized by increasing competition and rancor between the AAMC and the AMA, not cooperation or collaboration.

By the time of the 1935 AMA meeting, 45 medical schools had been visited; CMEH's preliminary findings of those visits suggested a need to revise educational standards, especially with regard to the growing practice of some schools to admit large numbers of students, some of whom were considered unqualified to pursue medical studies. Revised versions of *Essentials* were adopted by the AMA in 1936 and again in 1938. By the time the survey was largely completed in 1936, the major issues that emerged were the enrollment of medical students well in excess of schools' capacity, inadequacies in clinical material (i.e., patients) and/or facilities, and growing dependence on tuition as a revenue source for medical schools. Acknowledging the impact of the CMEH survey, the AAMC in 1936 approved an Executive Council resolution authorizing a joint approach to major educational problems (licensure issues, school inspections, classification of hospitals for internships, and standards for education and examination of specialists were mentioned in this regard)

involving the CMEH, the Advisory Board on Medical Specialties, the American Hospital Association, and the FSMB.[68] Two years later Rappleye proposed, and the AAMC Executive Council endorsed, the establishment of a National Council on Medical Education, Licensure, and Hospitals. This proposal was supported by the CMEH, but its participation in the venture was voted down by the AMA House of Delegates in 1939.

Perhaps spurred by the CMEH survey, the AAMC Executive Council recommended, and the membership approved, continuation of the AAMC medical school visit program, which had been "…for many years carried out periodically, but discontinued during the past few years."[69] Inspections resumed the following year, "…not as a police function but in the spirit of helpfulness."[70] CMEH members and staff did not participate in these visits.

As a result of one of those inspections in 1938, an AAMC member institution was recommended for probation. The school objected, noting that it had been previously approved in the 1934–1936 CMEH survey of medical schools, and it had received no advance warning of the proposed probation action from the AAMC. In the ensuing discussion, the dean of another medical school pointed out that regional accrediting organizations routinely informed institutions of potential adverse actions. The Executive Council responded that it was not required to share inspection reports with schools before submitting those reports for action by the council. After additional discussion, the Executive Council agreed that it would henceforth authorize AAMC inspectors to discuss their findings with the authorities of the college inspected; further, if the Executive Council approved a report that included an unfavorable recommendation, a copy of the report would be sent to the inspected college, which in turn would be invited to appear before the council at its next regular meeting to discuss the report.

The last few years of the decade were characterized by increasing competition and rancor between the AAMC and the AMA, not cooperation or collaboration. Each organization went forward with inspections of medical schools without participation by the other. With the information obtained from its national survey of medical education, the CMEH reported in 1937 that it would begin the development of a "pattern map" using about 100 items that approved medical schools could use to compare themselves with each other.[71] The AAMC moved forward with a national organization on education and licensure, rechristened in 1938 as the Advisory Council on Medical Education. This was done without the participation of the CMEH, although that body had sought unsuccessfully to convince the House of Delegates to authorize its engagement. In perhaps the most surprising development of the time, in 1939 the AAMC Executive Council sought authorization from its membership to begin a program of inspection and approval of internships, an activity that had been conducted for over a decade by the CMEH. The reaction of the CMEH to this venture was predictable: its 1940 report to the House of Delegates described "vigorous criticism of the CMEH" at the 1939 AAMC meeting and noted the AAMC decision to conduct its own investigations and classifications of internship programs and hospitals.[72] No CMEH representatives attended the AAMC meeting in 1940. At the AAMC's 1940 meeting, its Committee on Internships recommended that the organization function independently of the CMEH, with no participation by the AAMC on CMEH inspections of hospitals.

The 1940 AAMC meeting also included discussion of several motions that had emanated from the work of the recently created Advisory Council on Medical Education. A proposal to liberalize premedical course requirements and allow for greater focus on nonscience subjects was tabled. A recommendation that the AAMC adopt standards and develop a list of approved internships and hospitals was endorsed. A proposal was approved requiring that state medical boards license only graduates of approved medical schools from those states that had comparable educational standards to the state where licensure would be granted. Finally, the membership accepted a recommendation that state medical boards waive their requirement for passing a basic science examination for those licensure applicants who graduated from approved medical schools. On that latter topic, the following interesting thoughts were captured in the proceedings: "The Federation of State Medical Boards feel just as we do; they felt that the thing [i.e., the basic science examination] was a nuisance. Of course, you understand that the purpose of the basic science law is not a qualifying examination of any kind. The whole purpose is simply a hope that it may eliminate certain osteopaths and chiropractors and probably some other irregulars."[73]

Chapter 3

Origin, Early Development, and the First Decade of the LCME

As the AMA and the AAMC seemed to be drifting further apart in the late 1930s, one event began to draw them back together: the advent of World War II. Both organizations had expressed growing concerns about the potentially detrimental effect of wartime mobilization on the quality of medical education, with the possibility of shortened curricula and increased enrollments producing graduates not fully prepared for the practice of medicine. The LCME emerged in no small part because of those concerns, but the Liaison Committee of 1942, unlike today's LCME, had no visible corporate identity and functioned more as a venue for discussion of concerns shared by the AMA and the AAMC.

Major historical events of the period were as follows:

- Formation of the LCME (1942)
- Establishment of the Association of Canadian Medical Colleges (1943)
- Establishment of the National Commission on Accrediting (1949)
- Creation of the National Fund for Medical Education (1949)
- Passage of GI Bill of Rights, requiring U.S. Office of Education to publish a list of nationally recognized accrediting agencies and associations (1952)

1942: Creation of a Liaison Committee

How the LCME came into existence is well documented, notably by Donald Kassebaum's 1992 article in the AAMC journal *Academic Medicine*®.[74] The reasons for its creation are somewhat more difficult to discern.

As the article discusses in ample detail, the meeting that led to the creation of the LCME took place in Chicago, Illinois, on February 18, 1942, and included representatives of the AMA Board of Trustees, its Council on Medical Education and Hospitals (CMEH), leadership of the AAMC, and several medical school deans. According to Kassebaum, the presumed intent of the meeting was to determine how the AMA and the AAMC could avoid duplication of effort in addressing issues of medical education and workforce needs in relation to the war effort.

Although the pressures on both organizations to address wartime concerns were undoubtedly substantial, there is little evidence to suggest that such pressures specifically led the leadership of the two organizations to meet. In a review of the proceedings of AMA meetings and minutes of the CMEH in the years immediately preceding the joint session, the author of this history did not find any mention of a need or desire to gather for such a purpose. As the minutes of the October 1941 meeting of the AAMC Executive Council somewhat cryptically stated, "It was decided that the president of the Association communicate with the chairman of the Board of Trustees of the American Medical Association and

suggest a meeting of said board and the Executive Council for the purpose of discussing problems of mutual interest."[75] The nature of those problems is not mentioned.

It is worth noting that the two organizations were very different in terms of size and scope at the time. The operating budget for the AAMC at the end of 1941 was less than $32,000, and the paid staff consisted of Secretary Fred Zapffe and a part-time stenographer. The AMA, in contrast, reported expenditures of over $1.5 million (approximately two-thirds of which represented expenses associated with *JAMA*) and 636 employees. Both organizations were based in the Chicago area. Notwithstanding the differences in size, the AAMC had one distinct advantage not available to the AMA: representation of all medical school deans in the United States.

Details of that meeting have been preserved in the archives of the AMA and the AAMC.[76] At the beginning of the 1942 joint meeting, Loren Chandler, dean of Stanford's medical school, was invited to provide a foreword to the event. Chandler pointed out that there had been two or three efforts to bring the two organizations together, but such an event had not been possible in the past two years. He went on to state, "I don't know of any specific program or any specific proposal that we have in mind to discuss with agencies here interested in the same thing and at times duplicating each other. It seemed to us, particularly in a war time emergency, that we could advantageously discuss at least a program of long-term, long project to cooperate in some ways to improve medical education and keep our medical schools and our graduates coming along on a high standard and help to meet the problems that we will be faced with during this war emergency, such problems, for instance, as in surveys of medical schools and medical problems and perhaps joint action by your Council and the Association.…"

Duplication of effort was also a concern voiced by the chair of the CMEH, Ray Lyman Wilbur, in his introductory remarks at the meeting. "It seems to me that while it has been obvious for a number of years that we should have close cooperation between the Council on Medical Education and Hospitals and the Association of American Medical Colleges, that while that has been obvious and has been carried out to some extent, there has been unnecessary duplication at times and confusion because their headquarters have not had a general understanding that made it possible for us to present a united front when we went to a hospital or to a medical school or to the federal government or to a state or whatever the occasion might have been."

Wilbur's opening comments indicated the interest of the two organizations in sharing the effort of medical school inspections: "[I]t ought to be comparatively simple to come to not only a definitive agreement but an understood policy of uniting in so far as these two organizations are concerned in all surveys to be made of medical schools. There is every reason from our standpoint why when the Council makes a survey it should have also a representative of the Association available at the same time, for we have the same sort of interest." Other areas he mentioned as potential opportunities for combined efforts were the sharing of student records, use of AMA presses for publication of the AAMC's journal (the *Journal of Medical Education*), and even the sharing of space in the AMA building. It is certainly noteworthy that medical school surveys emerged as the very first area for potential collaboration.

The notion of combined medical school inspections was strongly supported by Herman G. Weiskotten, dean of Syracuse University School of Medicine, who was the major force in CMEH medical school inspections during the 1930s and would become the secretary of the CMEH on March 4, 1942. Weiskotten made the case simply by stating, "I feel very seriously the importance of the functioning of these two agencies [the AMA and AAMC], and I see no reason they could not be brought together much more closely and inspections of the medical schools be made by the two agencies together, the information secured being made available to both agencies, and there being consultation between the two agencies before any definite action is taken." That description would become the modus operandi for the LCME in the next several decades.

The impetus for conducting joint inspections of medical schools was being felt more urgently in part because medical schools were being pressured, under the Selective Service Act, to develop accelerated programs to address the needs of a military physician workforce, which was seen as a potential threat to the quality of medical education. Wilbur was certainly aware of the point when he noted that "… we have, because of this sudden responsibility forced on us by the Selective Service Act, to survey these medical schools rather promptly to be sure that if they are going to do the continuous session program they are going to do a good job."

The joint function of medical school visits, for both quality improvement and quality assurance, was noted by Chandler when he stated, "The attitude I think of the Association [AAMC] is one of helpfulness to any medical school, if it properly needs help or has a justification for being a medical school, and at the same time a guard, a sort of a watch dog attitude, which is also obviously a part of the A. M. A. Council's job, to see that no inferior programs are permitted."

After further discussion of the interests, or lack of same, in various elements of medical education on the part of the two organizations, Charles Heyd, a former AMA president, focused the discussion back on the core elements of accreditation (although he did not use the term): standards and inspections. He noted, "If I am correct that the maintenance of standards and the survey of schools are the only areas that we both canvass, then it would seem to me that approach is the way we should go.…" Wilbur then proposed a framework for achieving those ends, recommending a joint board consisting of two or three members each from the AMA Council and the AAMC "… to iron out matters of policy and make recommendations to the Council on the one hand and to the full board of the Executive Council of the Association on the other." A formal motion to create such a joint board was approved by the representatives of both organizations. The participants decided that the joint board should include three representatives from each organization. The AMA contingent immediately identified its members: Weiskotten, Heyd, and Reginald Fitz from Harvard Medical School. The AAMC deferred its selection of members when asked, but during the luncheon meeting that same day it announced that it would send Secretary Zapffe, along with Arthur Bachmeyer of the University of Chicago Medical School and Ewen MacEwen from the University of Iowa College of Medicine.

Shortly after this meeting, Weiskotten visited Zapffe at the AAMC offices, and the two discussed issues about some medical schools and the sharing of information that had been collected by the AMA regarding

accelerated programs. They agreed that the "joint committee" should meet in May, and Weiskotten reported in his notes of the meeting that "Dr. Zapffe appeared to be entirely agreeable with efforts to coordinate the work of the two agencies and to offer mutual cooperation."[77] Thus the LCME was born.

1942: The First Meeting of the LCME

The initial meeting of the committee, identified in its minutes as the Joint Committee of the Association of American Medical Colleges and the Council on Medical Education and Hospitals, took place at 10:00 a.m. on Sunday, May 17, 1942, at the Palmer House in Chicago. The agenda listed eight items for discussion. The first five items entailed discussion of specific medical schools, and the remaining three addressed accelerated educational programs, the internship, and the "statistical blank" (data collection form) for *JAMA*'s educational issue. All six of the appointees designated by the sponsoring organizations were present, and the meeting was chaired by Weiskotten, who by this time had ascended to the role of secretary to the CMEH. The minutes indicate that the conference was called at the suggestion of Weiskotten.

The five medical schools reviewed at the meeting had been visited previously by the CMEH, and reports of those inspections had been sent to Zapffe for the records of the AAMC. The first school under discussion had been visited by Weiskotten along with W.S. Leathers, the president-elect of the AAMC, at the request of a state board of medical examiners. Because the visit had not been conducted on behalf of either the AMA or the AAMC, no action was taken.

The next school had been visited by Weiskotten. At the time of the visit, the college was on private probationary status with the CMEH and had also been placed on probation by the AAMC in the past (but not at the time of the visit). Weiskotten reported a number of positive changes that had taken place at the institution. Given that information and that the college enjoyed full membership in the AAMC, the CMEH members at the meeting indicated that they would recommend to the full council at the June meeting that the college be removed from probation and full approval be restored.

Next on the agenda was a two-year basic science school. The school had been visited independently by representatives of the AMA and the AAMC in the preceding year, and the representatives from both organizations agreed that the institution was ready to develop as a four-year school.

The next school discussed was visited separately by the AAMC and the AMA earlier in 1942. Zapffe noted that when it met in February 1942, the AAMC Executive Council had already voted to recommend that the school be placed on probation when it met again in October 1942, "principally on the basis of the character of the admission of students and disharmony of the faculty and the administration of the medical school."[78] Notwithstanding this decision, the AAMC would later express optimism about the school, noting that "certain changes are going on which will undoubtedly lead to the organization of a proper medical school … they have the opportunity of having one of the greatest medical schools in the United States."[79] On the basis of the report of the school and corroborating information provided by Weiskotten, CMEH members indicated that they would also recommend probationary status to the full CMEH.

As to the final school, Zapffe informed the group that the AAMC Executive Council had voted in February to recommend at the October annual meeting that the school be dropped from the organization's membership. The AAMC subsequently heard from the university's chancellor that conditions at the medical school would be cleared up by October. The CMEH had decided at its February meeting to remove the school from its approved list, and Weiskotten indicated that the school's status would be discussed again when the council met in June. Concern was expressed that if the council altered its original decision at the June meeting, the action would be perceived as a weakening of its standards.

With the review of medical schools completed, the discussion of accelerated programs focused on problems associated with some state licensure laws regarding curriculum length, which precluded medical schools within those states from providing accelerated programs. In addition, the CMEH had informed schools on probation that they should not undertake accelerated programs. The main issue concerning the internship was a movement on the part of the federal government to reduce its minimum twelve-month length to speed up this portion of physician education so to meet military manpower needs. Canada had shortened the internship to eight months as a war emergency measure, and hospitals in one military branch were no longer offering internships while the hospitals of another branch were rumored to be discontinuing them. Representatives of both the AAMC and the AMA expressed their opposition to any efforts to shorten the internship period.

At this point, discussion turned to three medical schools that were not listed on the agenda for the meeting. The first school had proposed an increase in its freshman enrollment; both organizations had advised against it, and the plan had been dropped. No action was taken by the committee.

The impetus for conducting joint inspections of medical schools was being felt more urgently in part because medical schools were being pressured, under the Selective Service Act, to develop accelerated programs to address the needs of a military physician workforce, which was seen as a potential threat to the quality of medical education.

The next school brought forward for discussion was an unapproved U.S. medical school. The medical society in the state where the school operated sought support from the AMA and the AAMC for a state proposal that would allow the school's graduates who were licensed in the state and had completed an internship to apply for commissions in the U.S. Army as a war measure. The proposal had been presented as an alternative to a regulation being promulgated by the U.S. Surgeon General (opposed by the state) that would confer general eligibility for military commissions to graduates of "substandard" U.S. medical schools who were licensed, had completed a one-year internship, were citizens, were members of their county medical societies, and were recommended by five graduates of "standard" schools. The committee members agreed that neither the AMA nor the AAMC should approve such a request, as it would "… throw the doors wide open to graduates of all unapproved schools and would definitely weaken standards."[80]

The third school discussed had a situation similar to the preceding one. The CMEH had "removed inhibitions" for this school at its February 1942 meeting. No action or further discussion was recorded for this school.

The committee briefly discussed a statistical blank (survey form) that the AMA developed to collect information to be published in the annual medical education issue of *JAMA*. It had been shared with Zapffe, who indicated that the form would have value for the AAMC's Committee on Curriculum.

The committee proceeded to a brief discussion of the "émigré physician," that is, one who graduated from a foreign medical school and had migrated to the United States. It was pointed out that 60% of the graduates of European medical schools had failed New York state licensure examinations. Note was also taken that such physicians were eligible to enlist in the U.S. Army at the rank of private, were eligible for naturalization after three months of military service, and could then apply for a commission. No action was taken.

Most of the remaining time at the meeting was taken up by a discussion of the committee's structure and procedures, including the authority and timing of the actions for the sponsoring organizations. AAMC members of the committee were appointed by the AAMC Executive Council, which lacked independent authority to make decisions and required approval of its actions by the association as a whole. The AAMC met only once a year, while the CMEH met three times a year, creating timing problems for approval of committee recommendations. The participants agreed that frequent meetings of the committee would be necessary to mitigate the timing problem. As an operational issue, the members unanimously agreed that medical school inspections should be conducted jointly by the secretaries of the sponsoring organizations "since it places a dean in an embarrassing situation to survey a member college." Weiskotten indicated that he would invite his counterpart to participate in a recently requested inspection of a medical school that was not an AAMC member. Bachmeyer recommended that a "definite plan of study" be developed for inspectors to follow, as a guideline for preparation of a comprehensive report of the inspection; Weiskotten responded that his inspections were based on the national survey the CMEH had developed. The members agreed that if only one organization conducted an inspection of a school, the report of that inspection should be shared with the other organization. Zapffe offered to share the AAMC list of schools scheduled for inspection to facilitate CMEH participation in the surveys. The details of survey coordination were delegated to the secretaries of the sponsoring organizations to work out.

After brief discussion of possible topics for an upcoming congress on medical education and licensure, the committee members expressed their sentiment that the meeting had been very productive and emphasized the importance of frequent future meetings. After the next meeting was tentatively set to take place between the June CMEH meeting and the October AAMC meeting, the current meeting adjourned.

1942–1949: Early Years of the LCME

There was little fanfare regarding the LCME in the pronouncements of the sponsoring organizations immediately after it had been created. The report of the CMEH to the AMA House of Delegates noted simply that "… a liaison committee of the Council and the Association of American Medical Colleges has been appointed to confer on this [the problem of accelerated curricula in medical schools] and other problems of mutual interest."[81]

AAMC Secretary Zapffe provided a more detailed report of the committee's initial meeting when the AAMC met in October 1942. His remarks were emphatic about the lack of authority of the committee: "It was clearly understood, and so stated at the meeting and in the minutes which were sent to the Executive Council, that nothing that this committee did was in any way binding or would have any force, that it would simply mean concerted action, unity of thought, unity of action, and that nothing could come out of these meetings until these actions had been submitted to the parent bodies, who could take simultaneous action on recommendations if they wished to do so.… Neither the Council nor this Association is bound in any way by any discussion that might be held in the meetings of this Liaison Committee. The committee is absolutely without power. It can do nothing but talk. …"[82]

Notwithstanding the highly circumscribed role Zapffe attributed to the LCME, he was clearly enthusiastic about its potential: "Never, in my [nearly 40] years of experience [as secretary of the AAMC], has there been such a feeling of friendliness and so much cooperation between these two bodies as has existed since the establishment of this committee." At the conclusion of the report, the AAMC approved the appointment of the committee, without discussion of it or its functions.

The LCME did not meet later during 1942, and its second meeting took place at 7:00 pm on February 13, 1943. It was attended by all six of the members previously appointed by the sponsoring organizations and by CMEH Chair Wilbur. Weiskotten chaired the meeting. The minutes for the meeting recorded the name of the organization as the Liaison Committee, not the Joint Committee. Four medical schools that had been visited jointly were discussed. For two of the schools, no actions were recommended. One school was recommended for removal from probation by the CMEH and was restored to full membership by the AAMC. Continued probation was recommended for the remaining school. The committee briefly discussed medical education in the military services, with no actions or recommendations forthcoming from that discussion. Weiskotten apprised the participants about plans of the Federation of State Medical Boards (FSMB) to discuss requirements of premedical and professional education in relation to licensure and the accelerated curriculum.

The committee met twice more in 1943, at a June meeting in Chicago and an October meeting in Cleveland, Ohio. At these meetings Victor Johnson, a physiologist from the University of Chicago Medical School, replaced Reginald Fitz as a member; Johnson had also replaced Weiskotten as secretary of the CMEH. Discussion at the June meeting focused mainly on medical schools in Texas and Georgia, with no action taken for any specific school. The committee also discussed "the osteopathic situation" (presumably a reference to interest in the osteopathic community to obtain AMA approval of

osteopathic schools); however, no requests had been received from osteopathic schools by either the AMA or the AAMC, so no action was taken. The committee also considered a proposal from a physician in Los Angeles, California, to establish an American Board of Medical Educators but concluded that such an action was impractical given the wartime situation.

Only three representatives (Johnson, Zapffe, and Bachmeyer) attended the October meeting. Two medical schools were reviewed, with one of them, a two-year basic science school, recommended for approval as a four-year school and the other recommended for removal from CMEH probation and admission to full AAMC membership. There was brief discussion of osteopathic issues in Nebraska and California, although the minutes did not provide specifics of the topics discussed. The members also discussed ongoing controversy in the state of Georgia regarding one of its medical schools.

Minutes of the LCME meetings from 1944 through most of 1947 have not been preserved, although proceedings from the annual AMA and AAMC meetings during that interval indicate that the LCME met three or four times a year throughout that period. Proceedings of the 1944 AMA meeting indicate that the CMEH visited 11 medical schools during that year; two schools formerly on probation were restored to full approval, with another school receiving initial approval as a four-year medical school.[83] The CMEH also recommended, and the House of Delegates approved, revisions to *Essentials of an Acceptable Medical School* (*Essentials*) that simplified curriculum requirements and incorporated a broad description of the purposes of medical school education. Minutes of the 1944 AAMC meeting simply note that "the Liaison Committee … has held three or four meetings during the year at which we have discussed problems of mutual interest and have arrived at satisfactory solutions which were presented to the respective organizations."[84]

Over the next few years, medical school inspections continued under the auspices of the LCME. Sixteen schools were visited in 1945 and another nine the following year. In 1945 the CMEH recommended a relatively minor change in *Essentials*, replacing the premedical requirement of general chemistry with organic chemistry. At the 1945 AAMC meeting, the AAMC Executive Council adopted more stringent requirements regarding admission of or advanced standing for students from foreign universities. Interestingly, the AAMC did not at this time consider itself to be an accrediting organization. The summary of a committee established to revise the constitution and bylaws reported that among its recommendations would be recognition of the particular character of the AAMC "as an evaluating and approving organization, and, perhaps, even as an accrediting agency."[85] The basis for the distinction is, unfortunately, not recorded in the minutes.

The main theme of the CMEH report to the AMA House of Delegates in 1946 concerned postwar physician supply; the council anticipated an increasing number of women and veterans would be entering medical schools. The CMEH report also acknowledged the continued effectiveness of the LCME, noting, "Each body has been considerably strengthened by this arrangement."[86] The council raised the issue of credentialing for graduates of foreign medical schools and informed the AMA that a committee had been formed to explore this issue, with representation from the CMEH, AAMC, FSMB, Advisory Board for Medical Specialties, and the U.S. Office of Education.

AAMC Secretary Zapffe's report at the 1946 AAMC meeting also spoke positively of LCME effectiveness. "This committee fills a need and makes it possible for the two groups represented to take like action.… Furthermore, it has brought the two groups together and established harmony and unity."[87] The Executive Council recommended that the AAMC undertake a study of the curriculum and of medical education in general.

The most notable accreditation-related event of 1947 was a proposal from the CMEH for the AMA and the AAMC to jointly conduct a complete survey of all U.S. medical schools, in part because such a comprehensive survey had not been conducted since the mid-1930s and in part because medical education had undergone dramatic changes in the intervening period. Concerns about the financing of medical education also began to surface, as federal support for medical education during the war was now being phased out. At the AMA, Weiskotten succeeded Wilbur as chair of the CMEH, and Donald Anderson was appointed to succeed Weiskotten as secretary of the council. On the AAMC side, MacEwen, who had served as chair of the AAMC Executive Council and a founding AAMC representative to the LCME, passed away, and Joseph Hinsey, PhD, who served as dean at the Cornell University Medical College, was appointed to replace him. At the October 1947 meeting of the LCME, the need for stricter evaluation of approved medical schools was discussed. At the time, the general practice of both organizations was to conduct detailed inspections only for new medical schools, for established schools that requested evaluations, or for schools with documented difficulties. The committee agreed that stricter evaluations should be made as a part of the inspection program of both organizations.

The only LCME minutes available for 1948 are from the June meeting. The topics for discussion at that meeting were the financial problems of medical schools and the potential impact of pending war manpower legislation. On the latter point, the LCME drafted a communication to the AMA Board of Trustees outlining several recommendations for such legislation, including preservation of a continuous and adequate flow of medical students from premedical study through internship, insistence that medical education be conducted by civilian organizations, maintenance of enough faculty members to preserve the high quality of medical education, and emphatic opposition to the imposition of accelerated curricula at any medical schools.

The proceedings from the AMA's June 1948 annual meeting outlined CMEH activities related to the planned survey of medical education, manpower issues, the adequacy of facilities for medical education, and financial support for medical schools. In discussing the first of these issues, the CMEH report to the House of Delegates noted that while the general structure of the medical curriculum had not changed appreciably over the past 50 years, there had been substantial change in content and methods of instruction. Regarding manpower, the council argued for caution in reacting to projections by the U.S. Public Health Service of a major physician shortage by 1960. On the topic of medical school finances, the council's report acknowledged that although medical school operating budgets were at an all-time peak, additional funding was needed to sustain the quality of medical education. The report recommended resistance to federal funding unless private sources proved to be demonstrably insufficient. One other item of note was recorded in a supplementary CMEH report to the House of Delegates that year—a concern about occasional House of Delegate resolutions recommending that the council condition

its approval of some medical schools and hospitals on the basis of the financial arrangements between such organizations and their professional [physician] staffs. The report noted that "conditioning approval … on any other basis than educational standards might be interpreted as illegal by the federal courts."[88] This statement provides the first evidence of awareness as to the limitations of accreditation authority by either of the sponsors.

Meanwhile, at the 1948 AAMC annual meeting, the retirement of Secretary Zapffe, after 45 years of service to the organization in that capacity, was announced. Zapffe was replaced by Dean F. Smiley, who by virtue of his new position also replaced Zapffe as a member of the LCME. In his final report to the AAMC, Zapffe responded to the proliferation of questionnaires inundating medical schools. He wrote, "So many persons seem to have developed a 'yen' to get up a questionnaire, all feeling that the matter dealt with was of the utmost importance. Manifestly, medical college administrators cannot give the time needed to supply the information sought nor do they have the clerical help to do the job."[89]

Like the CMEH, the AAMC Executive Council expressed concerns about medical school financing, similar to those of the AMA. To address the issue, it established a subcommittee that included two LCME members, Hinsey and Bachmeyer. The Executive Council also announced that the planned national survey on medical education would commence in January 1949 under the direction of John Deitrick from Cornell University.

Because of growing concerns about medical school financing, the usual February LCME meeting in 1949 was supplanted by a joint meeting of the CMEH and the AAMC Executive Council. It was attended by 10 members of the CMEH and eight representatives of the AAMC; Deitrick also attended the meeting on behalf of the national survey on medical education. The express purpose of the meeting was to discuss progress in establishing a private foundation for the voluntary support of medical education. The issue of private versus federal funding of medical schools was a contentious one, with strong advocates on both sides speaking to the issue at each organization's annual meetings. The outcome of the discussions at this meeting was an agreement to proceed with plans for the creation of a National Foundation for Medical Education.

After agreeing on a strategy for private funding of medical schools, the group turned its attention to the other major issue of the period, namely, medical school preparedness should there be another war emergency. To that end, the participants endorsed a report—produced jointly by representatives of the two organizations—that confirmed the need for sufficient numbers of faculty to preserve educational quality, opposed the adoption of accelerated curricula, and retained the authority of medical school admissions committees to select students (as opposed to assignment of students to medical schools by the armed forces).

The LCME resumed its regular meetings in June 1949, when it met jointly with the newly created Committee for the Survey of Medical Education. At that meeting, the members were informed that the sponsoring organizations had agreed to explore the development of a list of approved foreign medical

schools. The remainder of the meeting was taken up with a discussion of the planned survey of medical education. Deitrick, director of the survey, informed the group about potential funding from the Kellogg Foundation for a special project on postgraduate medical education and the relationship of the medical school to the community. Most of the ensuing discussion concerned potential members of the survey staff, as well as some of the topics to be included (notably medical school finances and premedical education).

The November 1949 meeting of the LCME included reviews of several medical schools and discussion of potential new schools. As the committee considered upcoming schools scheduled for visits, the conversation shifted to a consideration of the advisability of continuing the program of regular inspections of medical schools "because of the burden placed upon the schools in assembling the necessary detailed preliminary data and in filling out the questionnaire forms."[90] After brief discussion, the LCME chose to maintain the schedule of inspections. Also at the 1949 meeting, the LCME was informed of the status of a bill being considered in the U.S. Senate regarding federal aid to medical education, a progress report on the development of a list of approved foreign medical schools, and a progress report on the National Fund for Medical Education. Bachmeyer and Anderson gave a brief report on their attendance at the meeting of the fledgling Association of Canadian Medical Colleges (ACMC).

1950: Fault Lines Appear

All of the public statements about the LCME dating from its inception in 1942 suggest that it was functioning well and that it was providing a cohesive framework for cooperation on medical education matters between its two sponsoring organizations. The public appearance of harmony masked underlying tensions, however, and those tensions emerged starkly when the LCME met in February 1950.

The February meeting was attended by all of the appointed members from each sponsoring organization. Weiskotten opened the meeting by expressing his personal disturbance regarding "certain developments during the last two or three years" and requested an expression from the AAMC of its desire to continue cooperative relations.[91] In elaborating on the AMA concerns, Weiskotten began by pointing out that in 1934 he had been requested by the AMA (after a meeting with the AAMC) to undertake a survey of medical schools; although Weiskotten had worked jointly with representatives of the CMEH, AAMC, and FSMB in the conduct of the survey, he asserted that "Dr. Zapffe was very resentful of it," an attitude he said he chose to ignore.

Weiskotten went on to note that when he took on the role of secretary of the CMEH in 1942, he reached out to members of the AAMC and arranged the February 1942 meeting that ultimately led to the creation of the LCME. At this point, Hinsey inquired if there had been any opposition. Weiskotten replied that after the February 1942 meeting ended, Willard Rappleye of the AAMC stated that the AAMC had "sold out to the Council." Bachmeyer of the AAMC then confirmed that Rappleye was opposed at the time and that Rappleye had voiced that opposition at meetings of the AAMC Executive Council. Bachmeyer also pointed out that there was no other opposition expressed within the Executive Council.

Weiskotten again alluded to "recent developments" and stated that there were "open and implied accusations made against me at Sun Valley." In response, Hinsey of the AAMC asserted that he had no personal problems with Weiskotten and that any perceived slights if they existed were unintentional. He did, however, acknowledge that there "had been a reaction" at the AAMC to the AMA's stand of public opposition to federal aid for medical education. Weiskotten replied that the problems antedated that particular issue, at which point Hinsey stated, "There are many cases which we could cite where through the years the College Association has had the position of the stepson," a sentiment which was not appreciated at the AAMC.

Johnson of the AMA then stepped into the discussion, asserting that the CMEH had on many occasions "carried the College Association on the back of the Council." He specifically noted that several medical school inspections were carried out without AAMC participation, even though the reports of those inspections bore the names of both organizations. He also mentioned that two medical schools were closed by the CMEH without any help from the AAMC. He attributed this lack of cooperation to "Dr. Zapffe's condition," presumably a reference to the AAMC secretary's declining health or energies in his final years with the organization. Weiskotten stated quite frankly that "Dr. Zapffe was not functioning."

Bachmeyer reported that he was unaware of any specific controversy between the AAMC and the CMEH, noting that the CMEH was blamed for the AMA Board of Trustees' action supporting the AMA's stand on federal financial support for medical education. He then returned the discussion to the 1934 survey, asserting, "Because of the politics in the [American Medical] Association several colleges were not put on probation at the time of the 1934 survey." Weiskotten replied that there were no politics involved and that the report of that survey was intended to be constructive rather than destructive, saying, "Mass disapproval would have wrecked medical education."

Discussion then turned to the influence of the AMA House of Delegates in relation to actions of the CMEH, with a clear sense on the part of some that the House of Delegates held sway on the matters of medical education that were the presumed purview of the CMEH. This again focused the discussion on federal financial aid, with Anderson of the AMA stating that the AMA's position, endorsed by the CMEH, had been made explicit both in congressional hearings and in discussions with the AAMC. Anderson also pointed out that some of the AMA's recommendations were accepted by the AAMC while others were not. He noted that the resulting legislation included some provisions that did not sit well with the CMEH but that the overall legislation was an improvement over the initial bill. He observed that the AAMC had been invited to confer with the AMA but chose not to and instead opted to take no position on the bill. AAMC representatives were invited to attend the December meeting of the CMEH but did not. This seeming lack of AAMC interest was perceived as "a culmination of the evidence that the College Association was pursuing a course of studied indifference." AAMC Secretary Smiley, who had succeeded Zapffe, asserted that his failure to attend was simply a "happenstance."

Anderson then shifted the subject to the AAMC's dissatisfaction with the AMA's role and position regarding oversight of residency education, noting that AMA representatives who attended the 1949 AAMC meeting in Colorado Springs were stunned by the AAMC's attitude about the cooperative

internship placement plan promulgated by the AMA. He also took note of "the generally hostile attitude toward the Council's approving hospitals for residencies." By this point in the discussion, representatives from both organizations had started rehashing earlier arguments about perceived slights regarding medical education funding, the actions of the two organizations on the two medical schools closed by the CMEH without AAMC input, and the absence of the AAMC at CMEH meetings. Discussing medical school inspections, Anderson claimed, "We carried Dr. Zapffe and never let on to a single medical school that he was slipping, because we wanted a strong College Association and nothing would be gained by trying to embarrass you."

Weiskotten mentioned that he had suggested at one point to Zapffe that the CMEH could relieve him of some of his workload, "a suggestion made with good intentions." Weiskotten then stated, "[Zapffe] reported to the College Association that the Council was trying to move in." Discussion continued along these lines, with the rancor and frustration evident in several of the statements made by the participants, for example, "[W]e want nothing but a strong College Association but we have put our best foot forward for ten years and each time it has been stepped on."

By this point in the conversations, both sides began to admit some culpability in the events that had culminated in the current state of affairs. Smiley confessed to some ineptness on his part. Bachmeyer admitted that Zapffe had indeed been slipping in his later years with the AAMC and had developed definite negative attitudes toward the CMEH.

Weiskotten then returned to the main issue, that is, preservation of the Liaison Committee, and asked if the AAMC Executive Council wanted to pull out of the cooperative arrangement and act independently. Both Hinsey and Bachmeyer responded that the issue would need to be presented to the Executive Council, the former noting that "there may be sentiment that I do not know about." To that statement, Johnson responded, "Many of these are intangibles. The important thing is that we saved the College Association. We had no motive except that we liked the College Association." The members then returned to discussion of the differences between the two organizations in their approach to the proposed legislation on federal financial aid to medical schools. At this point, Weiskotten declared that the discussion could go on endlessly and continuation of it would be fruitless. The final comment, from Hinsey, was that the issue of cooperation between the two organizations would be presented to the AAMC Executive Council and he would get in touch with Weiskotten later.

The meeting then proceeded to other items on the agenda, which included updates on the National Fund for Medical Education, the status of federal legislation on financial aid for medical education, and the survey on medical education. Regarding the survey, Johnson of the AMA said he understood there was a feeling that the AMA was dominating the survey, to which Hinsey replied that there was such a feeling among some of the foundations, and he had endeavored to clear up the matter.

The next item on the agenda was the development of a list, prepared by the AMA, of foreign medical schools whose graduates might be considered to be of comparable quality to graduates of approved U.S. schools. The list had been shared with Smiley. Hinsey inquired if the list was intended to be a joint

venture. Weiskotten asked if the AAMC would be interested in the list, and Hinsey agreed to present it to the Executive Council. Much of the remaining discussion focused on specific medical schools and upcoming inspections.

The details of this meeting have been described here for several reasons. Foremost among those reasons, they dramatically illustrate the tensions between the organizations over disagreements on major issues of the time. The discussion also provides some illuminating insights into the attitudes of the AMA and the AAMC and the events leading to the creation of the LCME, particularly the seminal role of Weiskotten. It should also be clear from this description that the true focus of the LCME discussions during the early years was, as described shortly after its creation, on issues of mutual interest between the two participating organizations. While inspections of medical schools were a significant part of those discussions, it seems clear from this meeting and from the agendas of preceding meetings that inspections were but one of several matters that both organizations had a common interest in and that shared action on those inspections (i.e., accreditation) was not the primary catalyst for the LCME's creation.

1950–1952: The LCME Begins to Develop a Distinct Identity

Apparently the airing of differences that took place during the February 1950 meeting was sufficient to get the issues out into the open and remind both organizations of the benefits of collaboration. The proceedings of the parent organizations later that year acknowledged continuing differences on many of the issues that surfaced at the LCME meeting but also demonstrated a continued interest to work with each other. For its part, the CMEH (whose chair, Weiskotten, had initiated the airing of frustrations in February) reported to the AMA late in 1950 that "the close relations that the Council enjoys through regularly constituted liaison committees with the Association of American Medical Colleges and the Advisory Board for Medical Specialties have been particularly beneficial."[92] The emotions that surfaced at the February LCME meeting were notably absent at the June 1950 and subsequent meetings of the LCME. The June meeting was occupied for the most part by discussions of preparedness for the Korean War, and the members agreed that the committee should function as the conduit for its two sponsoring organizations in the development of policy and interactions with other concerned groups. Another item of note at the June meeting was a recognition of discrepancies between the lists of approved schools at each organization; the secretaries of the two organizations were asked to compare their respective lists as soon as possible and plan to make adjustments for any discrepancies.

The October 1950 meeting began with discussion of a request from the National Security Resources Board, a federal agency, inquiring about the conditions under which the AMA and the AAMC would consider federal aid to medical education acceptable during a national emergency. This inquiry precipitated an extensive discourse on the concerns of each organization, and an agreement was reached that the AAMC Executive Council should negotiate a common position with the AMA Board of Trustees; a parenthetical insertion in the minutes indicated that the AAMC Executive Council agreed to do so, but by way of the CMEH rather than through direct discussions with the AMA Board.

In other matters, the secretaries of each organization reported the findings from comparing their lists of approved schools and identified several schools for which the organizations had taken different actions. As a result of this finding, they were instructed to inspect the schools involved as soon as possible to resolve the differences. LCME members were informed by an AMA representative that the AMA-published list of acceptable foreign medical schools had not created any problems. Among other items discussed at the meeting were a proposed study of the financing of higher education that would include medical education, AMA concerns about the manner in which the fledgling Student American Medical Association was being formed, and a plan to allow direct payments to California medical schools for the care of indigent patients being treated at university hospitals under their authority. The meeting concluded with a brief update on the status of a few new and existing medical schools.

The year 1951 saw the beginning of formal engagement of the LCME with other organizations involved in accreditation. Most important of these organizations was the National Commission on Accrediting (NCA), described briefly in the introductory chapter of this work. Smiley reported at the February meeting that he had been invited to meet with the NCA, and informed the LCME members that he intended to "tell them what is involved in accreditation."[93] In addition, several LCME members reported at that meeting that they had participated in a January conference of several health professions accrediting agencies, including dentistry and veterinary medicine, to discuss common problems and challenges. Other topics at the February meeting included federal financial aid (still unresolved), recognition of additional foreign medical schools, and the accreditation status of several U.S. schools. Attendance at the February meeting increased to eight (four from each organization); there is no evidence that the LCME formally agreed to expand its membership, but later meetings consistently included more than the original number of six. (Note: Although not indicated in LCME minutes, the 1951 AAMC Proceedings list Dean Smiley as an ex officio member of the LCME.[94] Thus, the increased number of participants at this time likely does not represent an increase in voting members.)

The LCME did not meet during the summer of 1951. The October meeting had an extensive agenda (27 items in total). As usual, several medical schools were reviewed. Members were informed about a communication received from the NCA, asking the LCME for a moratorium on the accreditation of programs for the remainder of academic year 1951–1952, or "until such time as the Commission is able to meet with the accrediting groups."[95] In response, the LCME communicated to the NCA leadership that visits had already been scheduled and would proceed as planned. The October meeting was also noteworthy for the first detailed discussion of accreditation procedures, as the membership considered the advisability of on-site inspectors sharing with the school the outcome of their recommendations when their inspection report was reviewed by the LCME. The LCME decided that inspectors should be free to use their judgment and discretion but to be circumspect if they felt that the likely outcome of a recommendation was highly uncertain. Another important discussion at this meeting concerned revisions to *Essentials*; what is interesting about this discussion is that the AAMC Executive Council had been invited to review the proposed revisions when it met earlier that day. Furthermore, whenever any revisions were ultimately adopted by the AMA, *Essentials* would then be forwarded to the AAMC so that its bylaws could be amended to conform to *Essentials* requirements, if needed.

The agendas for LCME meetings in 1952 evinced a greater focus on medical school accreditation and less on discussion of issues of concern to the sponsoring organizations, although the latter still figured prominently. The February meeting began with grateful acknowledgment of Arthur Bachmeyer, the last of the founding AAMC representatives still serving on the LCME, who had submitted a gracious letter of appreciation to the group informing them of his retirement from it. Joseph Hinsey, who chaired this meeting, informed the membership that the AAMC had agreed to modify its bylaws to bring them into alignment with the requirements established in the revised version of *Essentials*, specifically regarding extension of the premedical requirement from two years of college education to three. This change posed a problem for some Canadian schools in provinces where senior matriculation was equivalent to the first year of college in the United States. The LCME agreed that Canadian schools need not be held to this requirement under those circumstances.

This opened a broader discussion of the accreditation of Canadian schools. Anderson of the AMA noted that Canadian schools did not undergo a regular schedule of inspections. He also pointed out that there had been numerous discussions between the CMEH and the Canadian Medical Association during the 1930s, with the latter expressing great appreciation for the work of the U.S. accreditors but a reluctance to develop its own accreditation system. The outcome of those discussions was that, effective in 1945, Canadian medical schools would be included on the CMEH-approved list only if they requested it (which they did annually once the policy was put in place). Although approved Canadian schools continued to be listed by the AMA, some of them had not been inspected for as many as 15 years. Smiley mentioned that three of the Canadian schools on the list had not applied for membership in the AAMC. The LCME therefore agreed that the issue needed more extensive discussion and directed that the Canadian Medical Association and the ACMC be invited to meet with the LCME to discuss their future participation in U.S. accreditation activities. Most of the remainder of the February meeting was taken up by discussion of the accreditation status of several U.S. medical schools.

While inspections of medical schools were a significant part of those discussions, it seems clear from this meeting and from the agendas of preceding meetings that inspections were but one of several matters that both organizations had a common interest in and that shared action on those inspections (i.e., accreditation) was not the primary catalyst for the LCME's creation.

The minutes included a brief item on the NCA, simply reporting that both the CMEH and AAMC Executive Council felt that an attempt should be made to maintain reasonably friendly relations with that organization.

The June 1952 meeting paid more attention to accreditation processes. After reviewing the accreditation status of several medical schools, the members discussed the possibility of conducting shorter, more informal visits to medical schools; the context for such visits was not stated in the minutes, but the likely intention was for such visits to be consultative, rather than providing the basis for accreditation decisions. Smiley mentioned that the AAMC was finding it increasingly difficult to identify medical school deans to participate in site visits and raised the possibility of permitting some associate deans to participate in lieu of deans; the LCME concurred with the suggestion, subject to the approval of the dean of the school being visited. The LCME also considered, but rejected, a recommendation that

reports of visits be simplified (i.e., shortened); it was thought that schools would not be satisfied with a summary and instead wanted a complete report of an on-site inspection. Smiley then noted that the AAMC had modified its bylaws to allow for the long-standing CMEH practice of placing some schools on "confidential probation," in addition to its previous practice of placing schools with difficulties on "open probation" or denying membership in the organization. The difference between confidential and open probation was that schools holding the former status were not identified as being on probation in the annual list of CMEH-approved medical schools, while schools on open probation were identified as such on that list and on the AAMC list of approved member medical schools. The general effectiveness of confidential probation was discussed, with the LCME concluding that any school with this status should be revisited within two years and that more stringent action should be taken if sufficient improvement had not been shown by the time of the revisit.

Other issues that came up for discussion at the June meeting included a report on a study by the AAMC about the cost of medical education, a draft report from the AAMC Executive Council regarding the objectives of undergraduate medical education, an update on correspondence with the NCA, and updates on several ongoing activities and programs such as the National Fund for Medical Education and medical education during times of war. Anderson of the AMA informed the members about the AMA president's annual address, which raised the possibility of "elevating the standards of osteopathic schools" if any of them were willing to abandon the basic tenets of osteopathy. Anderson noted that the CMEH would be willing to advise any such osteopathic schools if they made the initial approach.

The November 1952 meeting further fueled the role of the LCME as the agency responsible for the accreditation of medical schools, even though the decisions about accreditation continued to be made by the sponsoring organizations. The agenda for this meeting combined three items under the heading "Accreditation": the NCA, a communication from the Middle States Association of Colleges and Secondary Schools, and the response of a university president to a recent LCME inspection visit. Members were informed about a recent meeting of the NCA, which articulated its core purposes as preserving the identity of higher education institutions as a whole, defending those institutions from outside pressure groups that do not acknowledge the integrity of the institution as a whole, reducing the time required to complete accreditation documents, and reducing the cost of accreditation. The NCA focus on the institution as a whole was interpreted as a concern that a specialized accrediting agency (like the LCME) might mandate a disproportionate share of institutional resources for use by the program being accredited. The NCA meeting also called for strengthening the regional accrediting organizations and cooperation of specialized accreditors with the regionals. The AAMC representative attending the NCA meeting came away with the sense that an organization such as the AAMC would be considered a quality improvement agency and not an accreditor by the NCA, while the CMEH more closely conformed to the NCA notion of an accrediting body.

This report was followed up by one from the Middle States Association, whose secretary reiterated the recommendations outlined by the NCA and articulated several principles favoring joint evaluations by professional accrediting organizations with the activities of the regional accreditors. The LCME then reviewed a letter from the chancellor of a university whose medical school had been placed on

probation by LCME sponsors after a joint inspection; although the letter and its contents were not detailed in the minutes, references to that letter in the minutes made clear that the university considered the accreditation decision a violation of the basic premises outlined by the NCA.

The LCME took strong issue with the NCA's recommendations. Speaking for the AAMC, Hinsey stated that the Executive Council had concluded that several NCA procedures were considered to be detrimental and that the CMEH and Executive Council should "join forces in whatever action is necessary." For the CMEH, Weiskotten stated that he "did not believe that American medicine would be willing to surrender its position with regard to the accreditation of medical schools, neither would the [AMA] Council be willing to surrender its cooperative relationships with the Association for American Medical Colleges and neither did he think that medical educators, in general, would be willing to accept such a program as that proposed by the National Commission on Accrediting."

Summarizing the discussion of the accreditation issue that had been placed on the agenda, the minutes of the meeting state, "[I]t was the thinking of the Liaison Committee that the program of both the Council of the A.M.A. and the College Association is more than one of accreditation of medical schools; that certain responsibilities have been placed on both organizations by medical schools and medical educators which cannot be delegated to any other agency. Further, both groups have responsibilities to the public and to the people generally as expressed in the medical acts of the various states."[96] Considering the fault lines that had emerged in the LCME at its February 1950 meeting, the subsequent events of the following two years had clearly fostered a sense of cohesion and purpose that had never been apparent during the formative years of the LCME. A communication sent to medical school deans by Weiskotten and Smiley shortly after the LCME meeting that discussed the activities of the NCA made it abundantly clear that the LCME served on behalf of its parent organizations as the agency responsible for conducting the accreditation process for medical schools and that the parent organizations operated jointly in making accreditation decisions.[97] It is probably no coincidence that the LCME name was adopted for the letterhead on correspondence at this time.

A few other items from the November 1952 meeting are also included here to round out the scope of that meeting. Members heard a report of the joint meeting with the Canadians, which concluded with no more than a statement of continued Canadian approval of the LCME's role as the agency for accreditation of Canadian medical schools. Anderson reported that the National Fund for Medical Education was encountering challenges in determining the financial needs of medical schools and recommended that the CMEH and the AAMC undertake a thorough analysis of medical school funding. Brief mention was made of a provision in the recently approved GI Bill for "accrediting of accrediting agencies by the United States Office of Education;" this possibility was not considered to be problematic for the LCME. Finally, Smiley pointed out that the forms provided to medical schools by the AMA in preparation for an inspection did not include any mention of the AAMC; the LCME decided that one copy of the duplicate forms sent to schools should bear the AMA name and the other should bear the AAMC stamp.

Chapter 4

Refinement of the Accreditation Process, 1953–1971

The challenges posed by the National Commission on Accrediting (NCA) clearly mobilized the LCME and its sponsoring organizations to assert more staunchly the organization's essential role as medical school accreditor. Over the course of a decade, the LCME had shifted from a joint committee that discussed issues of interest to its sponsoring organizations and conducted inspections of medical schools, to an accrediting organization that acted on behalf of its sponsoring organizations and discussed issues of interest to its sponsors. Over the next two decades, cooperation between the two sponsors would shape the distinctive identity of the LCME, and both accreditation standards and processes would undergo substantial refinement as LCME autonomy grew.

Major historical events of the period included the following:

- Establishment of Evaluation Service for Foreign Medical Graduates, subsequently renamed the Educational Commission for Foreign Medical Graduates (1956)
- U.S. Congress approved Health Research Facilities Act to support medical school research (1956)
- LCME adopted *Functions and Structure of a Modern Medical School* as its compendium of accreditation standards (1957)
- Health Professions Educational Assistance Act signed into law, providing funding for medical school construction (1963)
- Federal legislation passed to authorize creation of Medicare and Medicaid (1965)
- Congressional approval of the Higher Education Act restricted federal student financial aid programs to institutions and programs accredited by federally recognized accrediting organizations (1965)
- U.S. Office of Education established the National Advisory Committee on Accreditation and Institutional Eligibility to oversee the federal recognition process for accreditors (1965)
- Role of LCME secretary established to provide continuing administrative support (1966)
- AAMC offices relocated to Washington, D.C. (1967–1970)

1953–1955: Increasing Collaboration

The year 1953 ushered in a period of greater interaction between the LCME and other organizations. At the February meeting, LCME members were informed that the CMEH had approached the U.S. Office of Education, "expressing the hope that … the Association of American Medical Colleges be designated by the Office of Education as a nationally recognized accrediting agency."[98] The request was almost certainly a reaction to the NCA's proposal that the AMA serve as the accrediting organization for medical schools and the AAMC role be relegated to a quality improvement organization without authority for accreditation. In another effort presumably intended to blunt the effect of the NCA, LCME leadership began exploratory discussions with regional accrediting organizations (most notably the Middle States Association of Colleges and Secondary Schools but also the Northwest Association of Secondary and Higher Schools) about possible collaboration when circumstances permitted. The LCME also learned about a CMEH discussion of ways to enhance "guidance and leadership" in physician

licensure, culminating in a recommendation (supported by the LCME) to explore the establishment of another liaison committee consisting of representatives from the CMEH, the AAMC, and the Federation of State Medical Boards (FSMB); the precise functions of this committee were not described.

On the day preceding the May 1953 meeting of the LCME, its members met with representatives of the Middle States Association to discuss the establishment of a cooperative relationship between the organizations. The minutes of this meeting are of interest not only because of the subject, but also because they provide a more detailed picture of LCME operating procedures at the time (described in more detail in Chapter 10). The meeting concluded with the LCME and Middle States Association agreeing to undertake a pilot study of collaborative evaluations over a twelve-month period, beginning with a simultaneous review of an East Coast medical school and its parent university.

Although the LCME was becoming a more cohesive organization, the independence of its sponsors in the evaluation of medical schools was still evident.

At the May 1953 meeting proper, the LCME received an update on the development of a questionnaire about financial needs of medical schools, which had been formulated jointly by representatives of the sponsoring organizations. There was also an update on visits by LCME members to foreign medical schools in Switzerland and Ireland, as well as discussion of several U.S. medical schools. The issue of foreign medical schools surfaced again at the October 1953 LCME meeting, when Joseph Hinsey of the AAMC described concerns within the AAMC Executive Council about the advisability of maintaining a list of acceptable foreign medical schools. The detailed LCME inspections of medical schools in Ireland led the Executive Council to question whether this established a precedent and to express concern about the advisability "to look after medical education in all parts of the world."[99] LCME members agreed that the issue merited further discussion. The October meeting was otherwise unexceptional, as the committee discussed the status of various schools and received updates on activities taking place within the sponsoring organizations.

Cooperation with regional accreditors and concerns about foreign medical schools continued to be major themes in 1954. Collaboration with regional accrediting agencies continued, as the LCME considered a request for joint activities from the Southern Association of Colleges and Secondary Schools and continued its program of joint inspections with the Middle States Association. In addition, the North Central Association requested, and the LCME approved, a proposal to include a North Central Association representative on LCME visits to schools within that association's geographic territory.

The February 1954 meeting was notable for extensive follow-up discussion of foreign medical schools. Members learned about a recommendation of the AAMC Executive Council that the philosophy should focus on the product of foreign medical education rather than the school responsible for that product; the LCME then voted to recommend to its respective councils that no new foreign schools be added to existing lists and that the program of evaluating such schools be reconsidered with appropriate input

from the FSMB, National Board of Medical Examiners, and any other interested organizations. At the June meeting, the LCME heard a proposal from the FSMB to create a joint commission for evaluating the credentials of foreign medical school graduates; AAMC representatives to the LCME noted that their organization felt it should not be an active sponsor of such an effort, notwithstanding its willingness to provide assistance if needed.

Although the LCME was becoming a more cohesive organization, the independence of its sponsors in the evaluation of medical schools was still evident. This was apparent at the October 1954 meeting, when the process for evaluating new medical schools underwent reconsideration. At that meeting, Hinsey reported that the AAMC Executive Council had approved a procedure to evaluate a new school after two years, which would serve as the basis for a decision regarding provisional approval. Such approval would remain confidential and would not be shared with the public. CMEH members of the LCME concurred and stated their intention to bring the issue to the upcoming CMEH meeting. Clearly, LCME sponsors maintained separate decision-making autonomy regarding how to accredit medical schools.

One other item of note during 1954 was the discussion, at the June meeting, of possible federal financial support for basic science investigators. The minutes noted "the dangers and implications of medical schools accepting Federal aid and particularly … the inference that a school participating in such a program would be accepting a long term responsibility toward the investigator that it might not be able to fulfill in the event that the Federal aid is withdrawn in the future."[100] Modern medical schools affected by the National Institutes of Health (NIH) budget cuts can certainly appreciate the prescience of the LCME on this topic.

Few major changes in medical school accreditation emerged during LCME discussions in 1955. Members learned that both sponsoring organizations had approved the process of granting provisional approval to new medical schools at the conclusion of the second curriculum year if they met specified requirements. The committee also discussed three medical schools that had a discrepant accreditation status between the AMA and AAMC. Two schools were approved by the CMEH but did not hold membership in the AAMC, and the third was an AAMC member located outside the United States but not approved by the CMEH. The problems with the former would likely be addressed by impending visits. The AAMC was considering withdrawal of membership in the latter case, but the decision was put on hold pending further developments regarding the evolution of the Cooperating Committee on Graduates of Foreign Medical Schools (which would eventually become the Educational Commission for Foreign Medical Graduates).

The February 1955 meeting produced action on one policy issue, an agreement that all approved medical schools should be revisited within a 10-year interval, not including follow-up visits. At the June meeting, the secretaries of the two sponsoring organizations informed the membership that after a review of upcoming visits, eradicating the inspection backlog and establishing a schedule of regular resurveys using a 7–10-year cycle seemed possible.

The June meeting included discussion of issues about joint visits with regional accreditors (the Middle States Association in this case) and the potential for misinterpretation of LCME findings by the regional

accreditors when the LCME had concerns about a school. These topics were carried back to the sponsoring organizations, resulting in the approval of a policy change at the October LCME meeting. In the new policy, joint visits would be conducted when calendar logistics coincided, and in such circumstances a report would be prepared for review by both the LCME and the regional accreditor (maintaining then-current practice); however, when a joint visit was requested but not possible, the LCME would, if requested by the university involved, prepare a special report of the last survey for the regional accreditor and send a representative, preferably from the last LCME survey team, to the meeting of the regional accreditor to provide any information needed.

1956–1959: Unified Standards

Increasing cooperation between the CMEH and the AAMC regarding the LCME was clearly taking place, as reflected in LCME meetings during the first half of the decade. The most convincing evidence of this trend surfaced at the February 1956 meeting, when the staff of both organizations informed LCME members that the sponsors had agreed to work together on a revision of *Essentials of an Acceptable Medical School* (*Essentials*). The understanding of the CMEH was that this would continue to be a council document. That point of view was reiterated at the June LCME meeting, where it was noted that one reason for the collaboration was to bring the CMEH standards and AAMC membership requirements into alignment. The intention to maintain *Essentials* as an AMA document dissipated by the time the LCME met in October 1956, and the document had a new name: *Functions and Structure of a Modern Medical School* (*Functions and Structure*); the term "modern" in the title was dropped in succeeding revisions. This new standards document was now characterized as a statement by the LCME. By the end of 1957 both sponsors had signed off on the new document, and *Essentials of an Acceptable Medical School* ceased to exist. Chapter 9 summarizes the differences in content between the first *Functions and Structure* and the last *Essentials*.

The development of a shared standards document contributed to the growing identity of the LCME as an accrediting organization, but the decision-making authority behind the LCME continued to be held closely by its sponsoring organizations. This authority became evident at the February 1956 meeting, when concerns surfaced that medical schools were receiving copies of site visit reports and their accompanying recommendations about accreditation status before the sponsoring organizations had an opportunity to act on the reports; this led to a procedural change in which reports were not sent to the schools until after the sponsoring organizations took action.

The June 1956 meeting of the LCME produced two items of note. First, the members agreed that the publication of a list of approved foreign medical schools would no longer be necessary given the impending establishment of the Evaluation Service for Foreign Medical Graduates, and they recommended to the sponsors that the list be withdrawn as soon as the new organization began operations. However, the challenges of foreign medical schools had not disappeared from the radar screen of the LCME or either sponsor. The AAMC had received a request for full membership from a school in the Middle East, which was chartered by the state of New York. The Executive Council had disapproved the request because approval would open the door for AAMC membership to military hospitals and other U.S. organizations operating abroad. The matter was brought to the attention

of the LCME because the institution was not an AMA-approved school, and if the AAMC approved it, the two sponsoring organizations would be maintaining different lists. CMEH members of the LCME felt that this was ultimately an AAMC decision but noted that problems could arise if the lists of the two organizations differed.

The second item related to external recognition of the LCME as an accrediting organization. On that front, members learned that the Office of Education was preparing a volume detailing its approved accrediting agencies, and that the NCA had proposed criteria for its own recognition of accrediting agencies. The LCME instructed CMEH and AAMC staff to review the Office of Education document to ensure its accuracy regarding the LCME. Discussion of NCA criteria was deferred pending review by the AAMC Executive Council.

One other example of sponsor cooperation took place at the November 1956 meeting of the LCME, when members heard that the AAMC Executive Council had voted to create a small committee, representing both the AAMC and the CMEH, to develop guiding principles for medical school evaluators to use when preparing their reports.

Other than approval of the new standards document, no notable accreditation issues arose during LCME meetings in 1957, although some of the topics discussed reflected the changing landscape for medical education and practice. One of the issues discussed at the February meeting was a concern about preparation for general medical practice, and it resulted in the formation of a committee to study the problem. Concern about the increasing loss of focus on patient-centered care in the light of growing scientific knowledge had been apparent for several years. In their history of the AAMC, Bowles and Dawson quote from the 1952 presidential address of George Packer Berry, dean of Harvard Medical School, to the AAMC: "[I]t is essential that we regard with a critical eye the mounting tendency to impose specialization on the teaching of the medical student.… Our preoccupation with scientific medicine has tended to let the patient fade into a faceless, nebulous creature, often no more than a number on a test tube or an entry on a chart."[101]

For reasons not indicated in its minutes, the LCME did not hold its customary June meeting that year. The October 1957 meeting included discussion of the anticipated need for more physicians in the near future because of the swelling population that resulted from the postwar baby boom, and the role of two-year basic science medical schools in addressing that need. The membership was informed that Dean Smiley, previously the secretary of the AAMC and an LCME member, had been appointed as director of the new Educational Council for Foreign Medical Graduates. The AAMC's new executive director, Ward Darley, reported that a medical school in the Middle East had been accorded full membership in the AAMC after an evaluation of the school, notwithstanding the CMEH practice of not approving medical schools outside the United States and Canada. Finally, to address the ongoing problem of excessive questionnaires being sent to medical schools, the LCME discussed the desirability of developing a joint questionnaire to address the information needs of both sponsoring organizations.

In the final two years of the decade, the LCME took additional steps toward the establishment of regularized accreditation procedures and slowly increased its engagement with other organizations.

The February 1958 meeting allowed another glimmer into LCME operating procedures in a discussion of the visit schedule for the upcoming year; one of the members questioned the desirability of conducting annual visits to developing medical schools, including those that had not yet admitted any students, and he also wondered if it was necessary for teams evaluating new schools to have four members. The LCME decided that the need for annual visits to new schools was an administrative issue, presumably to be handled by the secretaries of the sponsoring organizations; the minutes made no mention of a response to the question about the size of survey teams. Another February agenda item concerned the participation on survey teams by individuals "not related to the activities" of the survey team; the genesis for this agenda item was not apparent, and the LCME agreed that such participation was inappropriate.[102] The LCME apparently had achieved some level of rapprochement with the NCA, as it agreed to participate in a national study of accreditation to be undertaken by that organization. In another area of potential collaboration, members learned that the AAMC had been approached by some osteopathic medical schools to engage in mutual discussions regarding medical education and the philosophy of medical care. Members were also informed that the CMEH and the AAMC were developing a new guidebook titled *Functions and Structure of a School of the Basic Medical Sciences.*

Notable items from the June 1958 LCME meeting included endorsement of a document prepared by Darley and others called "A Program to be Considered for Surveys of Potential Medical School Sites," which provided criteria for the development of new schools. The LCME also approved *Functions and Structure of a Modern School of Basic Medical Sciences* for two-year basic science schools. Members were informed that the AAMC was changing its language to identify schools as approved or unapproved (conforming to CMEH language) rather than "accepted for full membership." In a follow-up to the previous meeting's mention of possible participation in the NCA's national study of accrediting, the members learned that the councils of its two sponsors approved the study in principle, but "the initial plans were not well received" by either organization.[103] Members were also informed that the annual questionnaire sent to medical schools by the AMA to collect information for *JAMA*'s annual educational issue was prepared jointly by the sponsoring organizations for the first time and was being sent out under the authorship of the LCME.

At the June meeting, Darley introduced the notion, developed by him and his CMEH counterpart Walter Wiggins, of "giving some thought to the possibility of a paid part-time secretary to assume the responsibility for the meetings and other activities of the Liaison Committee."

The logistical administrative challenges inherent in dual sponsorship of the LCME surfaced at the October 1958 meeting and resulted in an agreement that the agenda for October meetings would be set by AAMC staff, with the agenda for June meetings determined by AMA staff, since each organization's annual meeting occurred in those respective months. The agendas for other meetings would continue to be determined jointly, and the organization preparing the agenda for an October or June meeting would continue to consult the other organization in the development of that agenda. This decision

represented the first step toward the creation of the dual LCME Secretariat that distinguishes the LCME from every other U.S. accrediting organization.

The other administrative issue discussed at length during the October 1958 meeting was the proliferation of questionnaires being sent to medical schools. To address this issue, the AAMC had established a policy requiring Executive Council approval for the administration of questionnaires; in addition, staff from both sponsors had reviewed several questionnaires in use and decided to combine many of the items within the framework of the LCME annual questionnaire. Finally, Darley reported on the development of two new questionnaires to capture information on medical school faculty, to be administered under the auspices of the LCME; the project was approved by the LCME membership.

LCME activities in 1959 reflect further development of internal operations and engagement with other organizations. Several topics related to site visits were discussed at the February meeting, when the LCME reviewed the schedule of visits for the coming year. Resulting changes included a revision of the presurvey questionnaires, creation of a surveyor pool from the staffs of the two sponsors, and establishment of the length for a regular site visit at three and one-half days (two days for limited visits). At the June meeting, Darley introduced the notion, developed by him and his CMEH counterpart Walter Wiggins, of "giving some thought to the possibility of a paid part-time secretary to assume the responsibility for the meetings and other activities of the Liaison Committee."[104] Finally, the LCME at its November meeting approved the appointment of four "assistant secretaries" from various medical schools; these individuals functioned as survey team secretaries and were responsible for the preparation of site visit reports, although they were not members of the LCME. One of the assistant secretaries was James R. Schofield of Baylor University, who would later become the AAMC secretary to the LCME during the 1970s and early 1980s.

As for external relationships, LCME members learned in February 1959 that several members had attended the first meeting of the Joint Top-Level Committee, a group that included representatives from the councils of the LCME sponsors, university presidents, and the AMA Board of Trustees. This top-level committee was created to address general issues of higher education, including federal aid to medical education. At the June 1959 meeting, LCME members discussed pending federal legislation to authorize a 10-year, $250 million program for construction of facilities for medical, dental, and public health education and research. The bill included a provision for a two-thirds to one-third matching program for construction of new schools or expansion of existing schools. Representatives from both sponsoring organizations indicated their support for the legislation. In a discussion of NIH funding at the June meeting, the LCME approved a motion recommending that its parent organizations request the NIH change its current policies to allow for full reimbursement of the costs for research in medical school grants.

Thus, while the decade of the 1950s began with major tensions surfacing about the commitment of the LCME's sponsoring organizations, those tensions had dissipated completely within two years as a national organization of university leaders attempted to rein in the authority of accreditors. That galvanizing action helped to create a sense of identity for the LCME as an accrediting agency,

and the next several years saw that function take on a more concrete form through the development of common standards, standardized procedures, and recognition from—as well as engagement with—outside organizations. Apart from these accreditation-related activities, the LCME meetings continued to serve as a forum for discussion of numerous issues associated with medical education and practice but not directly accreditation related; examples included ongoing discussions about federal financial aid for medical schools, the various issues associated with the graduates of foreign medical schools, payments for physician and resident services, impact of the baby boom on physician supply and demand, and challenges with the internship period and graduate medical education in general.

1960–1961: The Foundations of the Modern LCME Accreditation Process

The attention given to accreditation standards during the 1950s, including major revisions in 1951 and 1957, waned in the next decade as the LCME concentrated more on accreditation processes. While the minutes of LCME meetings during the late 1950s document the beginning of a shifting focus on procedures, the transition became much more evident in 1960 and later years.

The first LCME meeting in the decade did not break any new ground, notwithstanding an interesting discussion about the accreditation of osteopathic medical schools. The precipitating issue was a request from a freestanding osteopathic college to be evaluated for accreditation by the Middle States Association. Because the LCME did not accredit osteopathic schools, the Middle States Association and the osteopathic college had agreed to a plan in which the Middle States Association would accredit the college only if, in the judgment of competent observers, the work of the college compared favorably with that of LCME-accredited schools. When apprised of this situation, the LCME came to an agreement with the Middle States Association that if the college wanted to be evaluated as an MD-granting medical school, the LCME would provide consultation to help the college move in that direction and at the appropriate time would conduct an evaluation jointly with representatives of the Middle States Association. If the college chose to seek Middle States Association accreditation as a freestanding osteopathic college, the LCME would identify potential "competent observers" who could assist the Middle States Association in making the determination about the comparability of the college's activities with LCME-accredited schools.

The renewed interest in policy and procedure was more apparent at the June 1960 meeting. The first item on the agenda after review of the schedule of upcoming site visits was a request from the staff of the sponsoring organizations to develop a joint accounting system for the LCME that would cover LCME expenses, especially those arising from medical school site visits. The LCME authorized the staff to pursue further exploration of such an accounting system. The influx of federal funds for medical school construction served as the impetus for another item on the agenda, a report by the AAMC's Darley on plans for a workshop to be held for presidents of universities or other institutions interested in establishing a new medical school. Darley pointed out that many of the inquiries about new medical schools were originating from "agencies and areas not equipped to establish new medical schools" and few were being received from strong academic institutions.[105] One of the tools that would facilitate the offering of such a workshop was a manual on the subject prepared by Schofield, now a member

of the AAMC staff. The LCME agreed that several strategies were desirable to accommodate the interest in new medical schools, including creation of two-year basic science schools in strong liberal arts colleges, creation of new four-year schools, and expanded freshman enrollments in existing medical schools.

The AAMC Executive Council asked that the CMEH work with the AAMC on development of a document titled *Essentials of a Medical School–Hospital Affiliation Agreement*, to which the AMA had agreed. The last item on the June agenda, brief in scope but significant in terms of later influence, was a recommendation that the assistant secretaries (medical school representatives who served as team secretaries on site visits) be convened for a meeting, separate from the LCME, to discuss the development of a new type of survey report that would meet the purpose of a living survey of medical education. This was the first time that individuals who were agents, rather than members, of the LCME would have significant input into LCME operations.

Since the creation of the LCME in 1942, its meetings consisted of a mix of discussions of specific medical schools, other issues related to the approval (i.e., accreditation) of schools, and broader issues of interest to the LCME sponsors. In most years the committee met three times, each meeting taking place over dinner on a single day. By October 1960 the nature and workload of the discussions apparently began to wear on at least some of the members. The October meeting began with CMEH representative Wiggins inquiring if the time might be ripe for the LCME to reconsider its fundamental purpose. He noted that the accreditation function (review of schools) had been proceeding smoothly in recent years, so much so that "if this were to continue as its [the LCME's] only responsibility, the meetings could almost be discontinued."[106] He then pointed out that agendas continued to grow over the years with extended discussions of matters not related to accreditation. His comments led to extensive discourse about the role and purpose of the LCME and the possibility that it might take on additional responsibilities in areas outside medical school accreditation. The outcome of that conversation was the appointment of a committee consisting of each sponsoring council's chair Darley from the AAMC and Wiggins from CMEH, to review the issue and make recommendations about the future objectives of the LCME and how it should function.

Another topic on the agenda of the October meeting concerned the forms used for school visit reports. The issue came out of the summertime meeting of assistant secretaries, when the presurvey questionnaire had been reviewed and suggestions were made for reducing the length of the questionnaire and incorporating much of the data directly in visit reports. The assistant secretaries also indicated that their work would be facilitated if they received copies of the survey reports, as well as the comments on the reports made by the members of the sponsoring councils. Finally, the assistant secretaries suggested that animal quarters and animal usage should be included as part of school visits and documented in survey reports. These recommendations were approved by the LCME.

Nothing of great consequence occurred at the February 1961 meeting of the LCME. The members decided that the "top-level committee" mentioned earlier in this chapter should reconvene to discuss the effect of research and training grants on medical education. A committee to reconsider the purpose of the LCME had been constituted by the sponsors, with its first meeting scheduled to occur the morning

after the LCME meeting. The February agenda mentioned three studies being undertaken by the LCME: clinical externships, the *Essentials of a Medical School–Hospital Affiliation Agreement*, and the effect of full-time practice by clinical faculty members on medical education. Darley reported that he had been approached about consulting with another freestanding osteopathic school located in California, to determine how it might obtain approval from its regional accreditor; the AAMC agreed to provide assistance, but the CMEH was prohibited from doing so as a matter of AMA policy.

The LCME did not meet in June 1961, but the final meeting in November (held in Montréal, Québec, Canada) was an extremely active one, arguably the most eventful single meeting in its history to that point. After reviewing medical school survey reports, the LCME began a discussion of the draft report prepared by the ad hoc committee that had previously been constituted to reexamine the purpose and activities of the LCME. In its review of the report, LCME members suggested that the report begin with a preamble clearly stating that no LCME policy would be effective until approved by the sponsoring organizations and that all actions and recommendations of the LCME were subject to approval by the parent organizations. The LCME then considered two options for managing the LCME workload. The first possibility was to appoint a single individual, employed by the LCME, to direct the activities of the group; the responsibilities of such an individual would include arranging the details of all school surveys, updating the presurvey questionnaire on a regular basis, and reviewing and editing survey reports from the assistant secretaries. The alternative, which was favored by the majority of members, was to designate one person from the staff of each parent organization with the responsibility of managing accreditation activities. While no decision was made at this time, the need for dedicated LCME staff had become clear. Oddly, the LCME also expressed concerns about the challenges resulting from the geographical distance separating the two Illinois-headquartered organizations—the Chicago-based AMA and the Evanston-based AAMC; no details were recorded about why this was seen as a problem. The discussions concluded with recommendations for further revisions and reconsideration of the report by the LCME, noting a particular need for further study of the entire survey procedure, joint financing of LCME operations, and continued two-way communication with the parent councils about issues outside the realm of accreditation.

The next item on the November agenda was a draft of "Suggested Guide for Medical School Visitations" (later simplified to "Guide for Medical School Visitation") that had been developed by staff of the two parent organizations. Several points of agreement about the conduct of surveys emerged from the related discussion, including roles of team members, content of the survey report, communication with the school being surveyed, and the responsibilities of the sponsoring organizations for review of the survey report (see Chapter 11 for details). The draft was then returned to the staff with instructions to incorporate these changes and resubmit the revised version to the LCME for additional review. Thus, the basic procedure for the conduct of LCME accreditation surveys was formalized, providing a framework for on-site visits that has persisted largely intact to the present day.

The November meeting continued, with several other notable activities and issues brought to the fore. Members considered a memorandum prepared by Glen Leymaster, associate secretary of the CMEH,

recommending a "living survey of medical education."[107] The underlying premise of this proposal was that survey reports contained a wealth of information, and culling those reports for relevant data would provide for the most thorough and comprehensive analysis of the state of medical education. Leymaster suggested that the survey might be undertaken by the LCME, with assistance provided by the AAMC as needed. Among the topics that could be addressed by such a survey were the nature of the medical school-university relationship, types and usage of medical school teaching facilities and libraries, noneducational activities of medical school faculty, socioeconomic characteristics of medical students, comparative effectiveness of teaching methods, the effect of research on medical education, and the role of medical schools in postgraduate medical education. After reviewing the memorandum, the LCME agreed to designate an ad hoc committee to further explore Leymaster's proposal.

The LCME then proceeded to a discussion of two-year basic science medical schools and concluded by recommending that the two sponsors undertake a review of the most recent draft of the document *Functions and Structure of a Modern School of Basic Medical Sciences*. Members considered accreditation challenges associated with Canadian medical schools, in light of the recent creation of a full-time executive secretary position at the Association of Canadian Medical Colleges (ACMC). The LCME directed Wiggins and Darley to confer with the ACMC executive secretary about the relationship of ACMC with the AMA and the AAMC and report back at the next LCME meeting.

There remained much more to consider. The LCME discussed the procedure for reviewing new medical schools, particularly during the early stages of development. It concluded that staff and members of the parent councils should engage schools at the onset of their development to offer expertise as individuals, not as formal representatives of the councils or the LCME; that such consultations be reported to the LCME; and that a statement be made indicating how the councils could be of help and when the councils would become formally involved in the new school's evaluation.

After discussion of Canadian issues, a concern was voiced that the same medical schools always seemed to appear "in the gray area between full accreditation and probation."[108] It was noted that such schools commonly faced serious financial difficulties. This led to a suggestion that a program of assistance be developed for such institutions, either through grants from private foundations or with federal support. Other options were to undertake a detailed analysis of underfinanced medical schools to determine their major needs or to identify well-qualified individuals (not necessarily from the LCME or its sponsors) who could provide consultation over several years and assist with grant solicitation. The LCME agreed to forward these suggestions to the CMEH and AAMC Executive Council for further consideration.

Clearly, accreditation-related procedures and processes dominated the November 1961 meeting more so than in all the previous LCME meetings combined. This, however, was only the beginning of the focus on process, which would continue for the remainder of the decade.

1962–1971: Committees, Guides, and Reports

In a letter to Wiggins after the November 1961 meeting, Darley listed a series of actions that required follow-up from the meeting, including revisions of the reports on the role of the LCME and the site visit process, updating of *Functions and Structure of a Modern School of Basic Medical Sciences*, creation of a committee to revise concepts expressed in the memorandum on conducting a living survey of medical education, clarification of policies and procedures regarding new schools and the accreditation of Canadian schools, development of a program to assist financially troubled schools, and exploration of a shared accounting system to cover the cost of site visits. This ambitious framework resulted in quick action on several items, beginning at the April 1962 LCME meeting.

One of the first actions stemming from the April meeting was the establishment of the LCME's first standing committee, the Committee on Accreditation Procedures. Members were Vernon Wilson, who was chair, and W. Clark Wescoe from the CMEH, along with John A.D. Cooper and John Deitrick from the AAMC. Leymaster of the AMA provided staff support. The charge to the committee was to "… study and make recommendations to the Liaison Committee regarding accreditation procedures in the light of existing policies as stated in the 'Functions and Structure of a Modern Medical School' and 'Functions and Structure of a Modern School of Basic Medical Sciences.'"[109] As part of that charge, the committee was to determine the best way of using information collected in the accreditation process for the benefit of individual schools, as well as for medical education in general.

The LCME then turned its attention to the draft of the "Guide for Medical School Visitation," which now included revisions made after the November 1961 meeting. Members recommended several relatively modest changes to the language of the new draft, but most of the concerns and discussion centered on how the survey team made its recommendations. The LCME found statements on the topic to be confusing and suggested that team recommendations differentiate (1) those related to curriculum, administration, etc., that represented the opinion of the survey team and (2) those regarding accreditation status, which continued to require official action by the parent councils. The draft also proposed boilerplate language to be used in all reports that would serve as a disclaimer of sorts, indicating, "Until this report has been duly acted upon by the sponsoring organizations, the statements should be considered as those of the consultant team and not as official recommendations of the Liaison Committee and the two Councils."[110] The LCME then approved the amended draft and forwarded it to the sponsors for final approval, which was obtained and announced at the June 1962 LCME meeting. At that June meeting, the LCME also endorsed a program to assist weak medical schools.

The next major process issue undertaken by the LCME occurred at the November 1962 meeting, when it discussed the report of its recently established Committee on Accreditation Procedures. The report focused on several basic matters regarding accreditation procedure that needed resolution and offered four general recommendations:

- Accreditation should be *primarily* oriented to evaluation of the MD educational program, with secondary consideration to other activities related to medical education.

- Schools should be surveyed at intervals of 10–12 years, with visits occurring sooner when needed.
- The survey process needed to be flexible to accommodate the extreme variability among medical schools.
- Schools on confidential probation should be accorded a period of no more than five years to either be restored to full approval status or be placed on public probation; such schools should also receive frequent consultation visits to obtain expert assistance, in lieu of resurveys.

Other specific recommendations from the committee included the appointment of a full-time LCME secretary, supported by a half-time staff person from each sponsoring council; substantial overhaul and simplification of the presurvey questionnaire and more detailed presurvey preparations by survey teams to anticipate potential concerns; creation of a surveyor pool drawn from the medical schools, with each participant engaged in two surveys per year over a three-year term; development of a shorter and more concise report, with supporting data attached as an appendix to the report; and a fee levied for consultation visits. Finally, the report offered some preliminary suggestions regarding the approach to be used in the proposed living survey of medical education.

After reviewing the report, the LCME endorsed the four general recommendations and indicated that the committee should provide a more detailed proposal for the staff and funding needed to implement the centralized management of the LCME implicit in those recommendations. The LCME also approved the recommendations for revision of the presurvey questionnaire, incorporation of data from its annual medical education questionnaire, and development of a survey team questionnaire. Finally, the LCME accepted the concept of a surveyor pool and asked for further elaboration, noting that education of team members would need to be addressed. Those revisions were made subsequent to the LCME meeting, and the revised final report of the committee was accepted by the LCME at its May 1963 meeting.

The March meeting was dominated by an extensive discussion of the core purpose and possible future functions of the LCME, especially on matters beyond the immediate scope of medical school accreditation.

At the November 1963 meeting, the LCME reaffirmed the role of its sponsoring organizations in making final determinations regarding a school's accreditation status. During the meeting, representatives from the CMEH proposed that the responsibility for accrediting Canadian medical schools be transferred to the fledgling ACMC, but no action was taken. The LCME also reviewed a letter from the Office of Education asking that the LCME provide letters of reasonable assurance to new medical schools that showed promise of meeting LCME standards, as a safeguard for the prudent use of federal funds supporting medical school expansion.

The main accreditation issues considered by the LCME in 1964 involved new medical schools and the Canadian relationship. At the February meeting, the LCME agreed to a three-tiered system for categorizing new schools to determine their eligibility for a letter of reasonable assurance: (1) schools whose documentation indicated that they were ready for on-site evaluations, (2) schools whose documentation was insufficient to make a determination that they were ready for on-site evaluations, and (3) schools

whose documentation was considered unsatisfactory. Letters of reasonable assurance would only be provided to the Office of Education for schools in the first group.

In June the LCME approved a recommendation from the Council on Medical Education (CME, so named once again after being changed from Council on Medical Education and Hospitals in 1964) that the executive secretary of the ACMC be allowed to attend LCME meetings periodically as an observer. At the October 1964 meeting, the ACMC executive secretary informed the LCME that Canadian medical school deans emphatically reaffirmed their desire to continue to be accredited by the LCME and expressed a willingness to provide additional manpower and financial support to facilitate LCME surveys of Canadian schools.

The February 1965 LCME meeting was the first to carry over to a second day. One of the issues to emerge at that meeting was the desirability and appropriateness of confidential probation and other accreditation actions that fell short of full approval; the matter was referred to staff for further analysis. At the next LCME meeting, the original Committee on Accreditation Procedures was discharged and succeeded by another committee of the same name, continuing under the chairmanship of Vernon Wilson. The new committee was asked to examine presurvey materials, the composition of survey teams, the potential participation of other organizations on survey visits, and other matters associated with the LCME process. The committee was also asked to review the merits of confidential probation and the possibility of allowing an appeal hearing that would allow a school to contest confidential probation status.

When the procedures committee presented its first report to the LCME at the February 1966 LCME meeting, the membership decided not to accept recommendations to expand the size of site visit teams to six members and rejected a recommendation to include a meeting with the medical school or university board of trustees as part of each visit. The LCME reaffirmed its timetable for approving new medical schools, including a visit before matriculation of the charter class and another visit before graduation of that class. A discussion of the role of the LCME in assisting low-budget schools (i.e., schools with limited financial resources) prompted a statement in the minutes of the meeting that "… there was a general agreement that the accreditation procedure should strive to become a consultatively oriented activity."[111]

Several new issues surfaced in 1967 meetings. The March meeting was dominated by an extensive discussion of the core purpose and possible future functions of the LCME, especially on matters beyond the immediate scope of medical school accreditation. Such future activities included accreditation of programs in other health professions and of graduate medical education, as well as the role of the LCME in relation to expanding federal funding programs to support medical education. No decisions were made at this time, but the topics would be revisited in future meetings. The LCME again discussed its relationship with Canadian medical schools (again, no decisions made) and began to consider the need for a substantial revision of the then titled *Functions and Structure of a Modern Medical School*. A subcommittee was established for the standards revision and was instructed to work with staff from the sponsoring organizations on a new version. The major topic for consideration at the June meeting was the perceived value of confidential probation as an accreditation action. The general sense of the committee was that the concept had outlived its usefulness and should be phased out in

favor of public probation; this sentiment reflected a perception that the LCME's accountability to the public was not being met when medical schools with problems sufficiently serious to justify probation were listed as approved, with no qualifiers, in annual listings. The topic was referred to staff for the development of specific proposals to address the issue.

At the February 1968 meeting, the LCME endorsed a recommendation to adopt a four-level system of accreditation actions: approval for an unlimited term, approval for a limited term, probation for a limited term, or disapproval. The recommendation was then forwarded to the sponsoring organizations for their consideration. The committee also considered but tabled a recommendation to establish a fixed seven-year cycle for reaccreditation. The LCME formally discontinued the practice of assigning confidential probation the following year, and schools that had been in that category were reviewed, with their status changed to "approved for a limited term." The LCME was also informed during the year that the Canadian Medical Association was considering a partnership with the ACMC to accredit Canadian medical schools.

Several other procedural changes were adopted in 1969. A system was established for annual rotation of the chairmanship of the LCME and for the primary staffing from the sponsoring organizations; in this system, the chair would rotate annually between the two sponsoring organizations on January 1, and the principal secretary would rotate between the sponsors on July 1. The LCME reviewed a new presurvey questionnaire (predecessor of the medical education database, later the data collection instrument) for use by medical schools preparing for reaccreditation visits. The role of the LCME secretary was discussed at the September 1969 meeting, resulting in authorization for the principal secretary to draft and sign correspondence on behalf of the LCME. Curiously, the records of neither the LCME nor its sponsors clearly indicate when the title of "LCME secretary" was formally adopted, although the signature authority established in late 1969 provided the vehicle for using that title. The proceedings from the 1967 AAMC annual meeting mention that Cheves McC. Smythe of the AAMC served as LCME secretary from September through December 1966, with C.H. William Ruhe of the AMA succeeding Smythe during the next year.[112] The first use of the title "LCME secretary" in LCME meeting minutes appeared in February 1968.

Among other activities in 1969, the LCME discontinued the practice of publishing the term of accreditation for approved medical schools, replacing it with the designation of the previous and next years for full accreditation surveys. The first draft of a revised *Functions and Structure* was presented to the LCME for discussion when it met in December 1969; the draft was accompanied by a recommendation to develop a companion guide to *Functions and Structure* that would provide greater detail on the meaning and application of the statements in *Functions and Structure*.

As the next decade began, the LCME continued its focus on sharpening policies and procedures, while also confronting significant issues in the medical education environment. It proposed that members of survey teams receive stipends for their contributions (rejected by the sponsoring organizations). In July 1970, Marjorie Wilson of the AAMC succeeded Smythe, becoming the first female secretary of the LCME; that meeting was also the first one attended by a new member category, the "federal participant." At the October 1970 meeting, the LCME Committee on Accreditation Procedures was replaced by a new Task Force on Accreditation Policy, responsible for the further development of *Functions and Structure*, as well

as review and recommendations regarding policies and operating practices. The task force presented a report of its deliberations in July 1971, summarizing continuing work on the *Functions and Structure* revision and including a recommendation for a similar document applicable to two-year basic science schools.

At the April 1971 meeting, the LCME crafted a response to a policy statement adopted by the AAMC that was intended to increase access to medical education for minority populations in the United States. The LCME concluded that, while it was desirable to increase public pressure on medical schools to enroll more minority students, the LCME itself "… should not make such explicit requirements for accreditation."[113] Regarding the international arena, in 1971 the LCME debated the merits of a recommendation from the AMA Council on Medical Education to consider the development of a joint accreditation process for Mexican medical schools similar to its activities with Canadian schools; it chose instead to offer advice and assistance if requested by the Mexican schools.

Discussions about expansion of the LCME's scope of activities, which had begun in 1967, were further advanced in a 1969 proposal to create a commission on medical education—separate from but based on the organization of the LCME—that would undertake accreditation of graduate medical education, continuing medical education, and allied health programs. Discussion of the proposed commission continued in the following year and took a different turn early in 1971, when the LCME reviewed and approved a proposal to include accreditation of allied health, graduate medical education, and continuing medical education programs as a logical extension of its historical role in the accreditation of medical schools. The proposal was sent to affected organizations, and positive responses from the AAMC Executive Committee and the American Hospital Association led to the creation of an LCME Task Force on Graduate Medical Education at the July 1971 meeting.

The growing influence of the federal government on medical schools during the 1960s and 1970s was also shaping LCME activities. This was most obvious in federal funding programs that fueled medical school expansion early in the 1960s, heightening the workload for the LCME and facilitating the development of two-year basic science schools that had their own unique issues. LCME functioning was affected much more directly by federal approval of the Higher Education Act of 1965, which ushered in a new era of accountability for disbursement of federal funds for student financial aid. The government looked to accrediting organizations as gatekeepers for verifying the quality of education at institutions whose students received federal funding assistance, leading to the creation of the Office of Accreditation and Institutional Eligibility within the Office of Education in 1968. That office would have a profound effect on the LCME four years later, when the LCME and its sponsors were faced with charges of sex discrimination in medical education, brought forward by the Women's Equity Action League and supported by the Federal Trade Commission during the LCME's 1972 recognition review from the Office of Education.

Chapter 5

Making of the Contemporary LCME, 1972–2015

Most of the organizational structure and operating procedures of the LCME became firmly entrenched during the 1970s and 1980s, with relatively modest refinements in the period that followed. The first major step in the development of the modern LCME was the achievement of full autonomy in making accreditation decisions. Later organizational changes included the adoption of a fixed accreditation term, development of *Rules of Procedure* and various supporting documents for the conduct of accreditation surveys, expansion and functional differentiation of LCME staff, a new framework for accreditation standards, and a revised governance structure for the organization. As the LCME moved into its "modern era," the major challenges it would face centered on medical school expansion, international engagement, and a resulting greatly increased workload.

Major historical events of the period included the following:

- Founding of the World Federation for Medical Education (1972)
- Creation of the Liaison Committee for Graduate Medical Education (1972), later to become the Accreditation Council for Graduate Medical Education (1981)
- National Commission on Accrediting merged with Federation of Regional Accrediting Commissions of Higher Education, creating the Council on Postsecondary Education (1975)
- Creation of the Committee on Accreditation of Canadian Medical Schools (1979)
- AAMC published *Physicians for the Twenty-First Century. The GPEP Report: Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine* (1984)
- Adoption of the United States Medical Licensing Examination as the single pathway for physician licensure in the United States (1990)
- U.S. Department of Education established National Committee on Foreign Medical Education and Accreditation (1995)
- World Federation for Medical Education initiated plan for development of international standards for medical education (1998)
- National Board of Medical Examiners incorporated clinical skills examination as a required component of United States Medical Licensing Examination (2004)
- LCME and its sponsors agreed to a new governance structure, the LCME Council (2012)

1972–1976: Women in Medicine and Federal Recognition of the LCME

The LCME, along with other accrediting organizations, had been recognized as an accrediting body by the federal government since the early 1950s, when passage of the Veterans' Readjustment Assistance Act of 1952 authorized financial aid to military veterans only when those veterans attended an accredited institution or program. The early recognition process was quite simple, based mainly on a list of accrediting organizations that had been compiled by the National Commission on Accrediting and adopted without change by the U.S. Office of Education. Oversight of accreditors by the government became more stringent with the passage of the Higher Education Act of 1965 and the establishment of

the Office of Accreditation and Institutional Eligibility within the Office of Education three years later. The Office of Accreditation and Institutional Eligibility established strict criteria for the recognition of accrediting organizations, including a system for public comment whenever an accreditor was due for renewal of its recognition.

The LCME was scheduled for renewal of its federal recognition in 1972. At the October 1971 meeting of the LCME, the organization was informed that the Office of Accreditation and Institutional Eligibility had received public comment from the Women's Equity Action League. The league was protesting renewal of LCME recognition based on alleged sexual discrimination in medical school admissions that had gone unchallenged by the LCME. At the time, women represented approximately 10% of all students enrolled in U.S. medical schools, although the percentage had been slowly rising, from 9% of the entering class of 1969 to 11% by the fall of 1971.[114] The minutes of the January 1972 LCME meeting included a letter responding to the Office of Education on this issue. In October of that year the LCME was informed by the Office of Education that its recognition would be continued for a period of four years, albeit with follow-up reporting on several issues including enrollment of women and minorities in medical schools. The LCME was formally exonerated of the allegations made against it by the Women's Equity Action League. The federal challenge to LCME authority was thus allayed for a time, although it would return in force four years later.

Although not formally recorded in the minutes or proceedings of the LCME and its sponsoring organizations, the circumstances surrounding the renewal of recognition likely led the sponsoring organizations to cede some of their authority for the accreditation of medical schools. A digest of AAMC actions included in LCME documents indicated that at a February 5, 1972, meeting, the AAMC Executive Council approved a five-point proposal regarding creation of a new organization to accredit graduate medical education programs that resulted from discussions with the AMA, the American Board of Medical Specialties, the American Hospital Association, and the Council of Medical Specialty Societies. One point of that proposal was recorded as follows:

> The existing Liaison Committee on Medical Education and the new Liaison Committee on Graduate Medical Education will have the authority to make decisions on accreditation in their respective areas within the limits of policies established by the parent organizations.…[115]

The proposal also reserved the right of the sponsors to approve policy decisions by the accrediting bodies, along with the right to approve accreditation decisions involving probation or other adverse actions. Summaries of AAMC Executive Council recommendations on medical school accreditation decisions began using the term "ratify" rather than "approve" by 1972.

Other findings from the 1972 recognition process that needed to be addressed in subsequent reporting by the LCME were the lack of a requirement that institutions conduct a self-analysis as part of the program evaluation process, the need to adopt formal procedures for preaccreditation, and the relationship of

the LCME to the proposed Coordinating Committee on Graduate Medical Education and the Liaison Coordinating Committee on Medical Education. The latter two organizations had been discussed by the LCME's sponsors as possible vehicles for providing a more coherent approach to quality assurance and quality improvement across the medical education continuum. The LCME formally incorporated institutional self-study into its accreditation process, for selected medical schools, at the October 1973 meeting. That change, revision of LCME preaccreditation procedures, and an explanation of different functions of the LCME and other proposed oversight organizations for later stages of medical education, proved to be sufficient to address Office of Education concerns.

While the LCME was dealing with the issues raised in the federal recognition process, it had also undergone review for recognition by the National Commission on Accrediting (NCA) and was awarded a five-year term of NCA recognition in 1972. Several other 1972 LCME decisions related to its policies and procedures were influenced to varying degrees by these recognition processes. The major revision of the then titled *Functions and Structure of a Modern Medical School* (*Functions and Structure*) that had been in the works since late 1969 was approved and forwarded to the sponsoring organizations for their endorsement in 1972, with the word "modern" removed from the title of the document. In April 1972 the LCME approved a motion requesting that the sponsors authorize the appointment of additional public members to the LCME, especially women and minorities; the request was granted, and the addition of a second public member was approved by the LCME at its July 1972 meeting. At the April meeting, the LCME also approved a new policy that required schools to demonstrate sufficient resources to support the total number of enrolled medical students. In October 1972 Ed Peterson succeeded Hayden Nicholson as AMA secretary of the LCME.

In the aftermath of recognition by both the Office of Education and NCA, the LCME continued to refine its accreditation procedures over the next few years. In 1973 the LCME implemented its first formal fee for accreditation activities, charging new medical schools $1,000 plus expenses for conducting the preaccreditation survey. It also addressed the issue of class size regulation, determining initially that its decisions regarding class size would not be subject to appeal and then referring the entire issue of accreditation for a specific class size to its Task Force on Accreditation Policy. The latter recommended, and the LCME approved, a procedural change eliminating references to class size from the transmittal letters conveying LCME accreditation decisions.

Other notable events during the year included adoption of a new appeal procedure for adverse decisions and a decision not to accredit combined baccalaureate-MD and postbaccalaureate programs. In the realm of accreditation standards, the LCME's sponsors approved the new version of *Functions and Structure*, and the LCME approved the use of a checklist based on the new standards to be included in the *Guide for Medical School Surveys* it provided to schools. The LCME voted not to include a statement in its standards requiring that family medicine be included in the curriculum. Also in 1973, James R. Schofield was appointed the director of the AAMC's new Division of Accreditation and succeeded Marjorie Wilson as AAMC secretary to the LCME.

Procedural matters, and to a lesser extent accreditation standards, provided a recurring focus of the LCME over the next few years. In March 1974 the LCME's Task Force on Accreditation Policy met the day before the LCME meeting and recommended that the LCME hold a "non-agenda" meeting (i.e., a retreat) later that year. This was the first time that two days were planned in advance to conduct LCME business, and the June 1974 LCME meeting was the first scheduled to take place over a two-day period (on occasion, some previous LCME meetings spilled over into a second day but were not planned as two-day events); the era of one-day meetings was now over. The non-agenda meeting took place in October 1974 and focused on both standards and processes. The standards discussion began with LCME review of a memorandum from Wilson describing a review of standards that had been undertaken by the AAMC Council of Deans. The AAMC activity was prompted by concerns about the recently adopted regulations of the Office of Education in its oversight of accrediting organizations, particularly in relation to the periodic evaluation of standards. The AAMC exercise had focused on three questions:

- Are the standards adequate?
- Are the standards being consistently applied to the evaluation of each institution?
- Are the standards well understood and agreed to, or should the LCME develop a more detailed statement to elaborate each standard for the institutions, the survey teams, and the public?

The LCME and its parent organizations were becoming more sensitive to the role of the sponsors in accreditation decisions.

Addressing the initial question, the LCME approved a new paragraph in *Functions and Structure* regarding various student issues (see Chapter 9 for details). No actions were taken in response to the second question. To address the third question, the LCME initiated work on what would ultimately become a companion document to *Functions and Structure*, called *Guidelines to Functions and Structure of a Medical School*; the guidelines were not adopted in final form, however, until October 1976.

In dealing with process issues, the LCME instructed future team secretaries to schedule a meeting with students as part of the normal routine of a site visit and determined that on-site visits to branch campuses had become necessary to validate their proliferation among U.S. medical schools. The variable quality of survey teams and survey reports surfaced as a topic for discussion, with no definitive action taken; however, the LCME did decide that its reviews of survey reports would henceforth be assigned to both a primary and secondary reviewer, a procedure that continues to the present day. The organization also discussed Canadian issues and concluded that it would be open to appointing a voting member from the Association of Canadian Medical Colleges (ACMC) if so requested by the ACMC; a representative from ACMC had been attending LCME meetings as an observer in the preceding two years. The LCME also endorsed the principle that there should be a U.S. member on survey teams for Canadian medical schools and that surveyors from Canadian schools should have the opportunity to serve on teams for U.S. medical school site visits. Finally, after extensive discussion of standards and procedures in relation to Office of Education recognition criteria, the LCME opted to establish two new subcommittees, one focused on the educational program of medical schools and the other on medical school faculty.

Early in 1975 the LCME recommended to its sponsors that the ACMC be authorized to appoint a voting member to serve on the LCME, and in June it proceeded to appoint an ACMC member pending sponsor approval of voting privileges for the individual. The voting issue met with resistance from the Council on Medical Education, however, and the LCME opted to include the ACMC representative as a participant in its meetings, without voting privileges.

The January 1975 meeting also included reports from the two new LCME subcommittees. The group on educational program matters recommended that provisionally accredited medical schools, as well as established medical schools "whose educational program has concerns," be required to have their students take Part I of the National Board of Medical Examiners (NBME) licensure examination and then report the results to the LCME.[116] The group also recommended that the LCME give further consideration to development of standards to ensure that students were learning appropriate clinical skills. The group working on faculty matters recommended that a task force be established to explore the issues in greater depth. At the March 1975 meeting, the LCME approved the recommendation of its educational program subcommittee on a Part I requirement and established a task force to develop guidelines for faculty issues in a subsequent revision of *Functions and Structure*; the subcommittee on faculty issues was disbanded.

The LCME and its parent organizations were becoming more sensitive to the role of the sponsors in accreditation decisions. This was manifested at the June 1975 meeting when the LCME eliminated the "approve" (for CME actions) and "accept" (for AAMC membership) options that had been included on the comment sheets completed by members of the sponsoring councils who reviewed LCME survey reports. Sponsor review of LCME reports would continue, however, until 1984. The LCME also learned at its June meeting that the AAMC had agreed to accept provisional LCME accreditation as the gateway for membership in the organization. In October the LCME approved *Guidelines for Clinical Components*, a new document to provide guidance to schools regarding LCME expectations for clinical campuses.

The year 1976 began with the LCME continuing to refine its procedures. Several decisions were made at the March 1976 meeting. The maximum period of service for public members of the LCME was established as two three-year terms. When survey reports included a team recommendation for follow-up progress reports, each team was instructed to itemize exactly what was required in the progress reports to address the team's concerns. (Review of progress reports began appearing as a routine agenda item for LCME meetings in 1972.) The LCME also requested authorization from its sponsors to hire additional staff to meet the demands of a rapidly increasing workload. Notwithstanding such business as usual, when the LCME reconvened in June for its next regular meeting, it was informed that the U.S. Federal Trade Commission (FTC) had launched an investigation into possible restraint of trade actions on the part of the AMA and was challenging the LCME petition for renewal of recognition from the Office of Education.

1976–1977: The Federal Trade Commission Challenge to LCME Authority

According to the 1976 proceedings of the AMA House of Delegates annual meeting, the FTC issued a complaint in December 1975 alleging "that the portion of the AMA's Principles of Medical Ethics that prohibits 'solicitation of patients' is a ban on advertising and restricts competition among physicians."[117] The proceedings noted that in addition to the complaint regarding physician advertising, the FTC announced that it would investigate the organization to determine if it may have illegally restrained the supply of physicians and health care services through its accreditation activities related to medical schools and graduate programs.

In 1976 the LCME was slated for the next renewal of its recognition by the Office of Education as a reliable national accrediting authority for U.S. medical schools. In November of that year, the acting director of the FTC's Bureau of Competition wrote to the U.S. commissioner of education requesting that the LCME's petition for renewal of recognition be denied because the AMA's sponsorship of the LCME and the alleged role of the AMA in limiting physician supply created a perceived conflict of interest. In the FTC's eyes, such a conflict would preclude the LCME from meeting Office of Education recognition criteria relating to organizational autonomy, conflicts of interest, and due process. In essence, the FTC argument asserted that the AMA was able to influence LCME decisions (and therefore the supply of physicians who graduate from LCME-accredited schools) by selecting some of the members who served as the decision makers for the LCME, employing AMA staff to provide administrative support to the LCME, and controlling the finances available to support the LCME's operations.

The challenge received considerable notice in the higher education world, and several organizations provided statements supporting the LCME and refuting the FTC assertions. Organizations providing testimony on behalf of the LCME during the recognition process included the following:

American Council on Education
American Association of Community and Junior Colleges
American Association of State Colleges and Universities
National Association of State Universities and Land-grant Colleges
Association of American Universities
Association of American Law Schools
Council on Postsecondary Accreditation

Newton Minow, who would later head the U.S. Federal Communications Commission, was enlisted by the AMA to defend its position. The Office of Education staff analysis ultimately rejected the FTC challenge, although it expressed concern about the LCME's relationship with its sponsors. The staff analysis by education officials noted that "the LCME is part of a system, albeit an important part, which ultimately encompasses the overarching policy bodies of the American Medical Association and the Association of American Medical Colleges. The DEAE [Division of Eligibility and Agency Evaluation] staff believes that the present method of 'layering' the decision- and policy-making responsibilities has

serious implications relative to the impartiality and objectivity of the accreditation process."[118] DEAE staff also noted, "The complexity of the accreditation program for undergraduate medical education frequently has made it difficult for the staff to offer a consolidated judgment regarding compliance or noncompliance with several of the Criteria for Recognition. Sometimes a policy or practice at one level of the process would seem to be well within the range of acceptability, but it would be offset by factors in another part of the accreditation hierarchy."[119]

The influence of the sponsoring organizations manifested itself in several of the weaknesses in the LCME petition noted by the Office of Education staff, specifically:

- Methods of selecting LCME members by the AMA Council on Medical Education and the AAMC Executive Council, both of which were involved in the accreditation decision-making process, were problematic; DEAE staff expressed concern about "whether or not there are enough safeguards to insure the selection of individuals who are competent and knowledgeable about the accreditation process." The staff analysis noted that the same concern could be raised regarding the AMA House of Delegates and the AAMC Assembly, both of which had final authority for approval of LCME accreditation standards.
- The staff analysis questioned whether the policy to remove accreditation only after a two-thirds vote of the AAMC Assembly, which has representatives of each accredited school among its membership, met the Office of Education criterion for due process; it also noted that "the fact that the two Councils must 'ratify' the LCME's decision in connection with the formal appeals procedures, which involves an 'outside' appeals panel, would appear to be a breach of due process."
- The involvement of the AMA Council on Medical Education, the AAMC Executive Council, and the AAMC Assembly in certain facets of the decision-making process, and the DEAE staff belief that these three bodies were not accountable for the process in the same fashion as the LCME, indicated noncompliance with the criterion regarding impartial and objective judgment.
- The LCME failed to meet criteria for decision-making autonomy, notably the role of sponsors in approving probation decisions and withdrawal of accreditation, as well as the establishment of accreditation standards. On the latter point, the staff analysis singled out the AMA as an organization "that can be regarded to have purposes and objectives which overreach, and could potentially conflict with, the purposes and objectives of accreditation."[120]

Notwithstanding the concerns that emerged from the Office of Education review of the LCME petition, renewal of recognition was granted in June 1977 for a two-year period, with a written follow-up report requested in one year to address numerous areas of concern. The concerns encompassed the budgetary authority of the LCME, selection of competent and knowledgeable individuals as LCME members, LCME authority to make final determinations regarding its operating policies and procedures, identification of specific areas of noncompliance related to standards in LCME survey reports, clarity of LCME reasons for taking any adverse action, lack of due process in the LCME appeal procedure, lack of a structured program for evaluating the reliability and validity of standards, absence of student input in the decision-making process, and the relationship of the LCME to the nascent Coordinating Council on Medical Education, established by the LCME's sponsors to monitor the activities of the LCME and the Liaison Committee on Graduate Medical Education. Thus, although the LCME survived the FTC challenge, the issues that sprang from the incident led to substantial changes in LCME operation in the aftermath of that event.

Subsequent to the Office of Education decision, the LCME secretaries sent a written request to the AMA Council on Medical Education and the AAMC Executive Council seeking final authority for all accreditation decisions (including probation and withdrawal of accreditation), final authority for adoption of operating procedures and policies, authorization to establish formal criteria for the selection of LCME members, presentation of a formal LCME budget for approval by the sponsors, and clarification of the relationship between the LCME and the Coordinating Council on Medical Education. The LCME proposal would continue to allow the sponsors to review and comment on survey reports and the recommendations of survey teams, to provide input on new or revised accreditation policies and procedures, to continue providing the financial resources needed for LCME operations, and to appoint LCME members. The request was granted.

1977–1985: Refinements in Structure and Process

As the LCME was working through its recognition process with the federal government, it continued to refine its operating procedures at an accelerating pace. 1977 was a particularly productive year in that regard, with the following activities taking place:

- Expansion of the maximum term of accreditation to 10 years, with an interim self-study report at the midpoint of that term (only available to schools that had conducted a self-study in conjunction with their full survey)
- Development of the first *Guide for Writing a Survey Report*
- Approval of voting privileges for the president of the ACMC on decisions regarding Canadian medical schools and denial of voting privileges for such schools to the federal member of the LCME
- Agreement to eschew involvement in accreditation of medical schools outside the United States and Canada
- Establishment of workshops for team secretaries, with an opportunity for those secretaries to observe an LCME meeting after completion of workshops
- Designation as "assistant LCME secretaries" applied to survey team secretaries who were not members of either the AAMC or AMA staff, reviving an earlier practice
- Inclusion of the student member of the Council on Medical Education as a reviewer of survey reports and team recommendations
- Adoption of a draft code of ethics
- Appointment of student members (one from each sponsor, for a one-year term, without voting privileges)
- Adoption of a policy to consider accreditation requests from for-profit medical schools on the individual merits of their applications
- Solicitation of site visit evaluations from the dean of the visited school and from the team chair

The decision to expand the maximum term of accreditation allowed the LCME to renew a school's accreditation for a period ranging from 1 to 10 years, although there were no specific guidelines to determine the length of the term granted. The distaste for foreign involvement was also manifested in the LCME denial of a request from the New York State Board of Regents to include an LCME member on the board's planned survey of a medical school in the Middle East. Domestically, the LCME also denied a request for accreditation consideration from a newly established two-year basic science school, citing its policy of no longer accrediting two-year basic science schools as justification for the denial.

The rationale for designating team secretaries as assistant LCME secretaries was presumably to justify individuals otherwise not associated with the LCME as official agents of the LCME in the decision-making process, recognizing that team secretaries from medical schools functioned as the formal authors of survey reports that included recommendations regarding a school's accreditation status. The LCME had previously used such a designation as early as 1959 but abandoned it at some unspecified time afterward. At the staff level, the AMA also conferred the title of associate LCME secretary on Ira Singer; later documents from the LCME indicated that this title was accorded to staff from the sponsoring organizations who provided significant and ongoing support to the LCME. With the addition of students, the LCME membership now consisted of 18 individuals: six members appointed by each sponsoring organization, two public members, two (nonvoting) student participants, a federal member, and a (mostly nonvoting) Canadian participant.

The whirlwind of activity during 1977 abated somewhat in the following two years. To address issues identified in the requested progress report to the Office of Education, the LCME established a standing subcommittee on educational measurement. It also modified its feedback system for the review of survey reports, creating a comment sheet to be used by LCME members for evaluating the surveyed school's strengths and weaknesses and a separate sheet for reviewers from the sponsoring organizations to identify the issues the LCME should address in its accreditation decision regarding the school. The two-year basic science school that was previously denied resubmitted its request to be considered for accreditation by the LCME and was again denied. The AMA designated a second associate LCME secretary, Susan Carver.

The discussion of standards was particularly timely since both sponsors had created groups to reexamine medical education as a whole: the AMA Task Force on Future Directions for Medical Education and the AAMC Task Force on General Professional Education of the Physician.

The most significant event taking place during 1978 was the LCME's review of the first draft of a new policy document, *Rules of Procedure*.[121] The LCME formally adopted *Rules of Procedure* at its February 1979 meeting. Most of the policy discussion at that meeting focused on Canada. The LCME endorsed a recommendation from the ACMC that the maximum term for accreditation of Canadian medical schools be set at 7 years, rather than the maximum of 10 years available for U.S. schools. The ACMC agreed to pay a $500 stipend for U.S. team secretaries who served that function on survey visits to Canadian schools. Most importantly, the LCME was informed that Canada had created its own accrediting body, the Committee on Accreditation of Canadian Medical Schools (CACMS). The LCME would officially recognize CACMS at its June 1979 meeting, and henceforth Canadian schools would be jointly accredited by the two organizations.

On the federal front, two noteworthy events took place in 1979. To address concerns related to federal financial aid for U.S. citizens attending foreign medical schools, the Office of the Surgeon General invited the LCME to become involved in a process that would compare the educational quality of foreign medical schools with that of LCME-accredited schools; the LCME declined the invitation. In 1995 the Department of Education would create such a committee to determine comparability. The U.S. Senate Subcommittee on Nutrition requested that the LCME include nutrition as a required topic in its accreditation standards; the LCME again declined, noting that its standards were intentionally designed not to be overly specific regarding curriculum content.

Standards issues resurfaced as the 1980s began, most likely in anticipation of the next submission of materials for renewal of recognition by the now U.S. Department of Education (which had previously cited the LCME, as it had many other accreditors, for lack of a system to validate accreditation standards). At the February 1980 meeting, the LCME requested that the introduction, definition, and mission sections of *Functions and Structure* be further developed for discussion at the following meeting. The LCME approved some changes in the language of those sections at the June 1980 meeting and began discussion of standards related to the educational program at its meeting in October. The discussion of standards was particularly timely since both sponsors had created groups to reexamine medical education as a whole: the AMA Task Force on Future Directions for Medical Education and the AAMC Task Force on General Professional Education of the Physician. No further action would take place on standards, however, until 1983.

Policy matters that arose in 1980 spanned several areas. The LCME approved specific procedures for accrediting Canadian medical schools, going so far as to allow francophone schools to submit their accreditation documents in French rather than English. The CACMS representative to the LCME was afforded full voting privileges. Student members of the LCME were asked to review the draft of a new document, *The Role of Students on LCME Accreditation Surveys*. The student members requested that the LCME assign a student to each survey team; the request was denied, but the LCME did authorize student members to participate as observers on one survey visit during their term of service. The possibility of evaluating foreign medical schools came up again for discussion. Problems associated with foreign medical schools became an ongoing topic of discussion during the year. Of particular note was the growing concern about students from unaccredited schools mingling with students from LCME-accredited schools during required clerkships offered by U.S. schools. The NBME plan to develop a residency entrance examination for graduates of both U.S. and foreign medical schools figured prominently in the LCME discussion of this issue. Increasingly sensitive to budgetary issues, the LCME decided to hold all future meetings in either Chicago, Illinois or Washington, D.C. At the October 1980 meeting, the LCME learned that its petition for renewal of federal recognition was likely to be granted for a four-year period. It also considered a recommendation to appoint an Arizona appeals court judge, the Honorable Sandra Day O'Connor, to fill the vacancy for a public member. Judge O'Connor was appointed as a public member in 1981, the year she was appointed a justice of the U.S. Supreme Court.

Over the next few years, the difficulties of the variable accreditation term became clearer. Most notably, the option of granting accreditation within the range of 1 to 10 years was creating serious challenges in the scheduling of site visits, with excessive numbers of visits in some years and few in others. Heavy site visit volumes posed a significant budgetary challenge, so in 1981 the LCME opted to simplify its decisions for an accreditation term: schools would receive 3 years, 6 or 7 years, or 10 between full accreditation surveys. Later that year the LCME adopted formal guidelines for accreditation terms to foster greater consistency in decision making (see Chapter 13).

Besides grappling with the issue of accreditation length, the LCME in 1981 also reviewed a prototype of a benchmarking report on medical schools, prepared by the AAMC (this would eventually become the

Longitudinal Statistical Summary Report, or LSSR). After further discussion and revision, the report was approved by the LCME a year later. Other notable activities in 1981 included the approval of a new appeals process for accreditation decisions and revision of the survey report comment sheets to allow space for general comments and evaluation of report quality. The New York State Board of Regents requested that the LCME identify surveyors who could participate in evaluations of foreign medical schools; the request was denied. The LCME also directed its secretaries to remind medical school deans about expectations for an appropriate balance between institutional resources and educational program requirements in an effort to stem the problem of students from foreign medical schools taking clerkships in LCME-accredited schools.

The major event taking place in 1982 was the onset of discussions for a major revision of *Functions and Structure*. On the procedural front, the LCME developed a formal plan for addressing the closure of a medical school, established a requirement that a school must notify enrolled or entering students if it was on probation or had its accreditation withdrawn, and adopted a procedure designating an LCME representative to serve on CACMS.

Standards revision continued as a topic in 1983, and the LCME began that effort by discussing a set of guiding principles for developing new standards. Draft language for a new *Functions and Structure* continued to be debated throughout the year. The consequences of medical school expansion during the previous two decades were now coming to the fore, as the LCME considered a possible role it might have in reducing medical student enrollment in light of an anticipated physician surplus; however, no action was taken. The LCME reviewed a request from a medical school dean to return to the ABC system of classifying medical schools that had prevailed at the AMA during the early part of the 20th century. The LCME did not see the merits, although its system of variable accreditation length functioned very much like an ABC system.

A completed new draft of *Functions and Structure* was approved in 1984 and conveyed to the sponsors for their approval. This version differed from its predecessor in two major ways. First, the statements of accreditation requirements were frequently more concrete, as they had been in the pre-1972 versions of LCME standards. Second, this revision adopted a substantially expanded section of standards on the educational program, incorporating contemporary thinking about medical education as described in the *GPEP Report* and the AMA study on the future directions for medical education.

Along with the major standards revision, the 1984 LCME meetings also yielded procedural changes. The application fee for new medical schools seeking accreditation increased from $1,000 to $5,000. An updated version of *Rules of Procedures* was reviewed and approved. Notably, with another Department of Education review forthcoming, the LCME discontinued its policy of sharing survey reports with its sponsoring organizations to solicit their feedback; henceforth, accreditation decisions would be made by the LCME entirely on the basis of its own internal evaluation of medical schools.

After approving the new version of *Functions and Structure* in 1985, the LCME directed the Secretariat to modify the medical school survey forms, self-study instructions, and questionnaires to conform to the requirements of the new standards document. In addition, formal training of survey team chairs and

secretaries would be provided during the AAMC meeting that year. To improve the quality of survey visits and reports, the LCME increased the honorarium for team secretaries to $1,000, doubling what had been provided since 1958. The LCME also decided that full-time chief academic officers of medical schools should be actively recruited to serve as team secretaries to improve the quality of the accreditation process. At the behest of LCME Secretary Schofield, the LCME also initiated the development of a set of quantitative benchmarking guidelines, the "Profile of the Typical Medical Education Program Leading to the M.D. Degree," to assist medical schools in preparing for an LCME review.

Finally, the LCME undertook a major revision of its "LCME Guidelines for Terms of Accreditation." In contrast to the 1981 version, this revision offered more flexibility among the various options. The first option (short-term, two or three years) was reserved for schools with "serious problems that could affect the quality of the educational program in specifically demonstrated areas. The future stability of the school may be in jeopardy unless matters improve quickly." Intermediate terms of four to six years were reserved for schools with "some significant, but apparently solvable problems that seem to be affecting the quality of the educational program." Long-term accreditation of 7 to 10 years would be awarded to schools with "only minor, or a few solvable problems touching the quality of the educational program."[122]

The guidelines also clarified the options for schools whose accreditation was in jeopardy. A one-year term was recommended if a school "has major, serious problems that clearly have begun to adversely affect the quality of the educational program and could worsen rapidly." Probation would be based on a judgment that a school "has critical problems that have not been resolved or addressed successfully. The educational program is expected to fall below the minimum standards of the LCME in the near future. Evidence is lacking that solutions will be forthcoming." A school placed on probation would have the option of requesting a "show cause" hearing to contest the probation decision. In the worst case scenario—removal of accreditation—the guidelines stipulated that "the school has not satisfactorily resolved the critical problems causing the program to be placed on probation, and the educational program no longer meets the minimum standards of the LCME. There is insufficient evidence that progress will be made to resolve the problems and deficiencies in the proximate future."[123]

1986–1990: Rethinking the Purposes of Accreditation

Having undergone a substantial upheaval in its standards and procedures, the LCME determined at its February 1986 meeting that the time was ripe for an extended retreat, to be held in October, to consider the changing medical education environment. Particular issues identified for discussion included the increasing costs of health care, the physician surplus, qualifications of medical school applicants, the state of clinical teaching, the growing use of NBME licensure examination results for program evaluation by medical schools, and the effect of offshore medical schools on U.S. medical education. Concerns about foreign medical schools were also growing in light of the introduction of a U.S. House bill that would authorize the secretary of the Department of Health and Human Services to establish a system for accrediting foreign medical schools as it related to federal aid to students. The retreat originally planned for October was postponed until the February 1987 meeting of the LCME. Other than the ongoing review of medical schools for continued accreditation, no especially noteworthy events took place during the remainder of 1986.

The 1987 retreat covered a broad swath of topics related to LCME mission, policies, and standards. The discussion reaffirmed that, as noted in the minutes of the retreat, the LCME's "primary responsibility is to attest to the educational quality of accredited programs, directly serving the interests of the general public and of the students enrolled." Subsidiary objectives included advising of state medical boards and assistance to programs accredited by the LCME. The LCME acknowledged an inherent tension between its accountability function in ensuring educational quality and its "good shepherd" function in assisting medical schools to address their problems. External influences on the LCME, most notably the periodic intrusions of the FTC, suggested to the members that greater autonomy from LCME sponsors was highly desirable. The members also clearly stated that "health manpower issues [the focus of many of the FTC's concerns] must not be taken into consideration by the LCME" when making accreditation decisions.[124]

In its consideration of accreditation standards, the LCME noted that the conduct of residency training programs was not an essential requirement for accreditation, but supervision of medical student clerks engaged in patient care, whether by faculty members or residents, was an absolute. It also conceded that family medicine residents could provide such supervision in any of the five core clinical disciplines, but only in the absence of specialists in those areas. The importance of outcome measures was reaffirmed, as the LCME acknowledged that information related to performance in residency and on licensure examinations was of considerable value in making accreditation determinations.

The main policy issue at the retreat concerned the relative merits of a fixed term versus the existing LCME practice of accrediting for a variable term. The latter was thought to provide greater flexibility, although it carried implications that the length of accreditation represented a de facto grade of the program evaluated. There was concern about the likelihood that a fixed term of accreditation would result in more frequent limited surveys of schools and increased use of probation. No changes in policy resulted from this debate, but the topic was moved to the April meeting for additional discussion.

The major challenge for the LCME arose from the difficulty in providing quality assurance for medical education programs in a "gray area" where there were questions, but no comfort or certainty, that such programs were indeed graduating competent physicians.

As a coda to the retreat, the chair of the LCME invited Joseph Keyes, who had attended LCME meetings for over a decade as general counsel to the AAMC, to offer his perceptions of the proceedings. In a thoughtful set of reflections on the retreat, Keyes proposed some basic premises about the accreditation of medical education, the operation of the LCME in relation to those premises, and the conclusions and recommendations resulting from those considerations. He presented two axioms of accreditation as a starting point: the need to ensure that medical school graduates were competent in the practice of medicine and the value in assisting medical schools to improve program quality. He observed that most medical schools do quite well on the former, with the effect of accreditation therefore felt, in most cases, through the latter. The major challenge for the LCME arose from the difficulty in providing quality assurance for medical education programs in a "gray area" where there were questions, but no comfort or certainty, that such programs were indeed graduating competent physicians. The issue for the LCME

to consider was whether schools in a gray zone should be identified publicly. During the retreat, the LCME was split, with some members noting the potential negative impact of singling out such schools, while others felt that schools which had been cited publicly in the past for their inadequacies typically benefited from being given additional resources to correct their problems.

In making recommendations based on his reflections about the retreat, Keyes articulated an issue that continues to confound all accreditors today in an era of emphasis on outcomes-based decision making. In his words, "It is clear that the chief and most difficult tasks for the LCME are in the domain of judgment—professional judgment tempered by the views of those with perspectives from the public and from affected students. No amount of data will relieve the LCME from this task. On the other hand, quantification is not antithetical to the exercise of judgment and, indeed, in some respects is essential to it."[125] To enhance LCME decision making, Keyes recommended that the organization take greater advantage of the data and analytical resources of its sponsors to provide further insights into educational trends, processes, and outcomes. He also recommended continued internal reflection on some contentious operational issues, such as the relative merits of having a member of the LCME participate in a survey visit, the ensuing discussion of that visit during an LCME meeting, and the pros and cons of having survey teams recommend the term of accreditation.

The April meeting of the LCME in 1987 did return to the issue of the term of accreditation, and at the June LCME meeting that year the organization decided to adopt a fixed, seven-year term of accreditation to take effect for all schools beginning with the 1987–1988 cycle. Institutional self-study would be required of all schools as part of the process.

LCME staff had a landmark year in 1987, as the LCME secretaries from both sponsoring organizations concluded their terms of service. Both Schofield, who served at the AAMC since 1971and as LCME secretary since 1973, and Peterson, who held comparable roles and titles at the AMA since 1972, stepped down that year. Peterson was replaced by former University of Missouri–Kansas City medical school dean Harry S. Jonas, who began his tenure as AMA secretary to the LCME at the October 1987 meeting. On the AAMC side, Keyes functioned as acting LCME secretary until October of 1988, when former University of Oklahoma dean Donald G. Kassebaum began service as the AAMC secretary to the LCME. 1988 also marked the first appearance of Barbara Barzansky as a member of the AMA staff supporting the work of the LCME.

During 1988 the LCME focused on relatively modest process improvements and consideration of changes and additions to accreditation standards (without major revision of *Functions and Structure* as a whole). At the April 1988 meeting the LCME took up discussion of "accreditation outliers"—medical schools demonstrating quantifiable problems in areas such as student performance on licensure examinations, high attrition rates, low per student expenditures for financial aid, and dissatisfaction with graduates on the part of residency program directors. The concept fleshed out earlier concerns about schools in the "gray area" and was referred to staff for further analysis. A task force was established to reexamine the medical education database that provided most of the documentation needed for conducting a survey

visit. The LCME expanded the size of its survey teams from four members to five, by selecting an initial cadre of "faculty fellows," new surveyors nominated by their institutions to gain experience that would augment the accreditation expertise within those institutions.

At the June 1988 meeting of the LCME, two new documents were approved that addressed two extremes of medical school operation: *Guidelines for New and Developing Medical Schools* and *LCME Considerations for Action Relating to Medical School Closure or Removal of Accreditation*. Later that year, the LCME approved revisions to its *Guide for Writing a Survey Report* and to its annual financial questionnaire. 1988 was also the year the LCME was up for renewal of its recognition by the Council on Postsecondary Accreditation (COPA). One of the obstacles to renewal was the absence of external participants in the appeal process for schools being considered for adverse action, so the process was referred to an ad hoc committee for analysis and recommendations.

During the June meeting, a member of the LCME staff shared data indicating that numerous medical schools did not include any formal instruction in health promotion and disease prevention. Concerns also arose about perceived ambiguity in the language of the standard dealing with nondiscrimination. At the prompting of one of its new members, the LCME also discussed several suggested changes to its accreditation standards and decided that all standards-related issues emerging at the June meeting should serve as the focus for a retreat to be held during the next meeting in October. As a result of that retreat, the LCME recommended changes to its standards including (1) new content requirements for the curriculum on the subjects of statistics, epidemiology, and health promotion, as well as immunology, genetics, nutrition, aging, and rehabilitation; (2) adoption of new language regarding student diversity; and (3) changes to the requirements for overseeing the activities of visiting medical students from non-LCME-accredited medical schools. The LCME also considered, but did not approve, a standard addressing the availability of computer systems to assist in teaching and learning about computer technology in medical education and patient care and for support of information sciences.

External events shaped much of the work of the LCME in the next two years. To address COPA recognition concerns, the LCME created an external review mechanism in February 1989 as part of the process for schools appealing an adverse decision. At that February meeting, the LCME was informed about yet another inquiry from the FTC that targeted LCME standards (and the corresponding rationale) for students from non-LCME-accredited medical schools taking core clinical rotations at LCME-accredited schools. COPA issued a request in the summer of 1989 asking all its member organizations, including the LCME, to revise their standards and policies as needed to encourage quality improvement among accredited institutions and programs and to emphasize the accreditation process as being helpful for the organizations subject to it. Early in 1990 *U.S. News and World Report* published its first ranking of medical schools, leading the LCME to consider (but not adopt) a proposal to develop an LCME pamphlet for applicants about choosing a medical school. Instead, the LCME recommended that the AAMC consider developing such a document to supplement its existing annual publication, *Medical School Admission Requirements*. Publication of the AAMC's *Educating Medical Students: Assessing Change in Medical Education—The Road to Implementation* (ACME-TRI report) and reports from the Kellogg and Robert

Wood Johnson Foundations calling for major changes in medical education prodded the LCME to consider further changes in its accreditation standards.

LCME sponsors and staff brought other issues to the attention of the LCME in 1989 and 1990, providing more fodder for discussion. At the February 1989 meeting, Barzansky provided data that indicated nearly two-thirds of medical schools did not have outcome objectives for their educational programs. At the June 1989 meeting, the LCME secretaries voiced concerns about inadequacies in medical schools' documentation of the completion of patient logs and clinical learning objectives. In 1990 the AMA House of Delegates approved resolutions requesting that the LCME address discrimination based on sexual orientation as part of its standards and that the LCME consider a standard regarding protocols for student exposure to bodily fluids during clinical educational activities. In October 1990 Barzansky gave LCME members a summary of accreditation concerns noted from 1986 to 1990, prompting the LCME to request that its standing Task Force on Accreditation Policy, Validation, and Reliability consider additional standards changes.

In addition to modifying its appeal process, the LCME also adopted several other changes in procedure during 1989 and 1990. The LCME authorized workshops for survey team members to be conducted during the annual AMA meeting, to complement workshops already being offered at AAMC annual meetings. To improve meeting organization, the LCME established a policy to assign responsibility for conducting the meeting of the LCME Task Force on Accreditation Policy, Validation, and Reliability to the cochair who was not responsible for managing the meeting as a whole. The informal checklist that had been used by survey teams to verify compliance with standards was formally adopted as part of the survey process, to be completed at each survey and submitted to the LCME along with the survey report. The LCME Secretariat was instructed to align the separate questionnaires completed by U.S. and Canadian medical schools, to ensure consistent data collection. The LCME also approved the distribution of the medical education database on diskette and increased the honorarium for team secretaries to $1,250 for full surveys and $750 for limited surveys.

Several standards changes resulted from the LCME meetings in 1989 and 1990. The standard calling for medical schools to provide data on student achievement of national norms was modified to simply require that schools use a variety of outcome measures to demonstrate educational program effectiveness. Other changes provided new language regarding faculty authority for curriculum oversight, use of varied methods to assess student achievement of objectives, equivalency of student assessment across multiple sites, clinical skills assessment, and policies regarding student exposure to infectious and environmental hazards.

As 1990 was winding down, the LCME was preparing for another of its periodic petitions for renewal of recognition from the Department of Education. This would prove to be another contentious event in the LCME's relationship with the federal government, largely because of previous LCME actions.

1991–1996: Internal Problems, External Pressures

The precipitating event that colored the impending LCME review by the Department of Education was a seemingly innocuous decision made earlier in 1990, placing a medical school on probation because of an extensive list of documented deficiencies in compliance with standards. What made this decision different from others, however, was that the LCME staff also provided information beyond the survey report (newspaper accounts describing some of the school's difficulties and other materials) as part of the background for discussion of the report. The LCME recommended probation on the basis of this information, and the school appealed the decision. As part of the appeal process, the school was provided with copies of all of the documents considered by the LCME when it made the decision to place the school on probation, including the information that did not directly reflect the survey team's evaluation of the institution. During the appeal hearing, the school objected that the LCME decision was influenced by extraneous documentation that the school considered to be hearsay evidence. The LCME nevertheless sustained its original decision to place the school on probation, based on the deficiencies noted in the survey report.

After the appeal hearing, the president of the medical school's parent university wrote a letter to the LCME Secretariat requesting that the LCME set aside the accreditation process involving the school, including the original survey, the decision to place the school on probation, and the appeal hearing, and resurvey the school afresh. The request was based on the alleged introduction of postsurvey anecdotal information and hearsay into the LCME deliberations, which contributed to the adverse accreditation decision. The LCME denied the university request and reaffirmed its original decision.

The university then took the issue to the next level, informing the LCME of its intention to (1) file a complaint with the Department of Education's Advisory Committee on Accreditation and Institutional Eligibility and (2) pursue injunctive relief from the LCME decision in its state circuit court. This led the cochairs and secretaries of the LCME to call a special meeting in December 1990, with special counsel from a Chicago law firm in attendance. The day before the meeting, the two LCME secretaries met with senior officials from the university and its medical school. The institution informed the secretaries that it was willing to drop all pending legal action, withdraw its complaint to the Department of Education, and endorse the petition for renewal of LCME recognition, should the LCME decide to set aside the original process and reevaluate the medical school. On advice of the outside counsel, that was indeed the decision of the LCME, and the matter was thus resolved. The school was asked to conduct a new self-study as part of a full accreditation survey to take place by the summer of 1992. The Department of Education considered the LCME petition for renewal of recognition in May 1991 and approved the LCME's continued recognition for a five-year period. As an aside, the medical school performed much better in the subsequent accreditation survey, which was hardly surprising given its awareness of LCME concerns and the additional time it had to address them.

The LCME continued to adjust its procedures and revise standards during the early 1990s. The position of federal participant on the LCME was eliminated in February 1991. The LCME decided that the role was unnecessary with public members and student participants providing external perspectives on LCME decision making. In the follow-up to the Department of Education review, the LCME also modified

its procedures at the February meeting to clarify the kinds of information considered when making accreditation decisions, for the most part restricting that information to the survey report, the medical education database, and the institutional self-study report. Any other sources of information received after the survey would be considered only if the information was considered to "bear significantly on the accreditation status of the educational program" and would also be disclosed to the school so that it would have an opportunity to respond.[126] Finally, the LCME opted to discontinue its practice of having survey teams include a recommendation regarding a school's accreditation status as part of the survey report.

The LCME's focus for the remainder of 1991 shifted to its accreditation standards. The consistency and quality of medical education at geographically separated campuses had become a concern, and the Secretariat was asked to develop a discussion paper outlining all the issues involved. The LCME also instructed the Secretariat to craft discussion papers on diversity and minority access to medical education and due process related to adverse decisions about a student's academic standing. The CACMS secretary, acting on behalf of that organization's sponsors, asked the LCME to consider a standard requiring that schools establish a department of continuing medical education; the LCME denied the request, acknowledging the importance of lifelong learning but expressing concern that the proposed standard was overly prescriptive. The LCME also received a request from a constituent seeking strengthening of its standards related to health promotion, disease prevention, and the social and behavioral context of health care.

The 50th anniversary of the establishment of the LCME was noted in 1992, and to commemorate the occasion, the LCME suggested that its sponsors convene a special conference on medical education that highlighted the LCME's contributions (Figure 3). That conference was held at the Drake Hotel in Chicago, Illinois, a day in advance of the regular LCME meeting in June. In addition to LCME members and staff, invitations were also sent to all former LCME secretaries, medical school deans, and former LCME members and surveyors. The theme was "Innovation and Quality in Medical Education: The LCME as Facilitator?" Speakers included the deans of several medical schools, including Harvard, Jefferson Medical College, Vanderbilt, Creighton, and the University of Missouri–Kansas City. Outcomes measurement, setting goals and objectives for learning, the economics of medical education, and the factors facilitating or impeding educational change were some of the topics covered. Speakers from three medical schools described major curricular innovations at their institutions. A luncheon address was given by Kenneth Shine, president-designate of the Institute of Medicine, and dinner remarks were given by the president of the AAMC and the executive vice president of the AMA.

1991 — 1992
Liaison Committee on Medical Education

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LCME Co-Secretaries
Harry S. Jonas, MD (AMA)
Donald G. Kassebaum, MD (AAMC)

50th Anniversary Conference
of the
Liaison
Committee
on
Medical
Education

June 2, 1992
Drake Hotel
Chicago, Illinois

Sponsoring Organizations

American Medical Association

Association of American Medical Colleges

Innovation and Quality in Medical Education: The LCME as Facilitator?

9:00 – 9:10 am
Welcome –
LCME Co-Secretaries
Harry S. Jonas, MD (AMA)
Donald G. Kassebaum, MD (AAMC)

9:10 – 9:30 am
Keynote Speech –
The LCME: 50 Years of Reacting to Change
J. Robert Buchanan, MD
General Director
Massachusetts General Hospital
Boston, Massachusetts

9:30 – 9:50 am
Challenges to Quality
Richard L. O'Brien, MD
Co-Chair, LCME
Vice President and Dean
Creighton University
School of Medicine
Omaha, Nebraska

9:50 – 10:10 am
What Drives the Need for Innovation?
Daniel D. Federman, MD
Dean for Medical Education
Harvard Medical School
Boston, Massachusetts

10:10 – 10:30 am
The Challenges in Measuring Educational Outcomes
Joseph S. Gonnella, MD
Senior Vice President for
Academic Affairs and Dean
Jefferson Medical College of
Thomas Jefferson University
Philadelphia, Pennsylvania

10:30 – 11:00 am Break

11:00 – 11:20 am
Setting Goals & Objectives
John E. Chapman, MD
Dean, Vanderbilt University
School of Medicine
Nashville, Tennessee

11:20 – 12:00 Noon
Panel Discussion
(Program Presenters)
Moderator, Harry N. Beaty, MD
Dean, Northwestern University
Medical School
Chicago, Illinois

12:00 – 1:30 pm Luncheon
Luncheon Speaker – Kenneth I. Shine, MD
Dean and Provost of Medical Sciences at UCLA School of Medicine
President-Designate, Institute of Medicine, Washington, DC

1:30 – 1:50 pm
ACME-TRI Data
The Impediments to Change
M. Brownell Anderson
Director
Section for Educational Programs
Association of American Medical Colleges
Washington, DC

1:50 – 2:10 pm
The Social Agents of Change
Steven Schroeder, MD
President
The Robert Wood Johnson Foundation
Princeton, New Jersey

2:10 – 2:30 pm
The Economics of Medical Education – Driver and Inhibitor
Lee F. Fetter
Associate Vice Chancellor and Associate Dean
Washington University School of Medicine
St. Louis, Missouri

2:30 – 3:00 pm Break

3:00 – 4:15 pm
Curricular Changes & Evaluation of those Changes

The Sherbrooke Experience
Jacques E. Des Marchais, MD
Vice Dean, Education
Universite de Sherbrooke
Faculty of Medicine
Sherbrooke, Quebec, Canada

The New Mexico Experience
S. Scott Obenshain, MD
Assistant Dean for Undergraduate
Medical Education
University of New Mexico
School of Medicine
Albuquerque, New Mexico

The Kansas City Experience
James J. Mongan, MD
Dean, University of Missouri-
Kansas City
School of Medicine
Kansas City, Missouri

4:15 – 4:30 pm
Wrap-up and Closing Comments
Sam A. Nixon, MD
Co-Chair, LCME
Assistant Dean for
Continuing Eduction
University of Texas
Health Sciences Center
Houston, Texas

7:00 pm Conference Dinner ***The Drake Hotel***

Remarks:

James S. Todd, MD, Executive Vice President, American Medical Association
and
Robert G. Petersdorf, MD, President, Association of American Medical Colleges

Figure 3. Program from the LCME 50th anniversary celebration.
The brochure was circulated to inform the medical education community about the 50th anniversary celebration.
Source: the AAMC.

As it had in the preceding year, the LCME continued to wrestle with accreditation standards issues in 1992. It acted on draft revisions addressing family medicine as a required clerkship; the process for accepting transfer students; the effect of institutional self-financing on the achievement of the medical school mission; the role of graduate basic science and graduate medical education in medical student education; notification about visiting students from non-LCME-accredited schools taking required clerkships in LCME-accredited schools; and revised requirements for clinical education. On the policy side, the LCME considered and denied a request from a medical school dean to extend the maximum term of accreditation to 10 years. It also initiated a pilot program allowing medical school deans to evaluate the performance of survey teams, and it formalized its procedure for evaluating the performance of faculty fellows on surveys. In terms of external relationships, the LCME was informed about potential changes in Department of Education criteria resulting from the 1992 congressional reauthorization of the Higher Education Act, including a new distinction between institutional and specialized (programmatic) accrediting organizations. LCME staff members were also preparing for renewal of recognition from the Council on Postsecondary Accreditation.

The major standards issue in 1993 related to affirmative action, prompted in large part by the launch of the AAMC Project 3000 by 2000 to increase medical school enrollment of applicants from minority populations.

The next few years of LCME activity produced further changes in standards and procedures. The major standards issue in 1993 related to affirmative action, prompted in large part by the launch of the AAMC Project 3000 by 2000 to increase medical school enrollment of applicants from minority populations. Discussion of affirmative action ultimately led to a new standard on student diversity. In other diversity-related matters, a new member of the LCME inquired about medical students' skills in communicating with patients from diverse backgrounds; the matter was referred to staff for further analysis and would culminate several years later in a new standard on cultural competency. Other standards revisions approved during 1993 addressed student immunizations and library resources. Discussions also began regarding the lack of an LCME standard on the numbers and types of patients that students needed to encounter during their clinical education.

Other topics for discussion in 1993 included a Macy Foundation recommendation that the LCME reduce medical student enrollment by 15% by the year 2000 to address an anticipated physician surplus. The LCME demurred, citing its long-standing practice of eschewing workforce issues in its deliberations. The Department of Education confirmed that under the revisions to the Higher Education Act, the recognition process for accreditors would indeed distinguish institutional and programmatic accreditors, with more stringent criteria for demonstrating that institutional accreditors were "separate and independent" from any related or sponsoring organizations; the criteria also included a provision that would grant waivers from the separate and independent requirements under certain conditions. The LCME also learned that year about the impending dissolution of the Council on Postsecondary Accreditation.

The following year was relatively quiet for the LCME, apart from its customary function of reviewing the accreditation status of medical schools. The only new standard, which originated from discussions that began at CACMS, was one addressing the teaching and evaluation of medical students'

communication skills. The LCME was asked by the AMA to consider standards on computer use in patient care and on nondiscrimination toward members of the lesbian, gay, and bisexual communities, but it declined action on both requests.

The LCME adopted some minor procedural changes in 1994. It agreed to share the final survey report with the survey team members who crafted the original report draft, with the proviso that such sharing was for informational purposes only. The LCME also purged language related to letters of reasonable assurance from its policy document *Rules of Procedure,* since there was no longer any need for such letters in the absence of federal funding for new medical school construction. The LCME initiated exploratory relations with two successors to COPA, paying preliminary dues to the Commission on Recognition of Postsecondary Accreditation (CORPA) and to the Association of Specialized and Programmatic Accreditors (ASPA).

Changes to LCME standards were more prominent in 1995. The new standard on student communication skills was approved that year. Concerned about the potential for new medical schools to emerge "under the aegis of little more than a health care organization and medical staff," the LCME modified its standard on institutional accreditation, making institutional accreditation a "must" rather than a "should" for schools that were not already part of an institutionally accredited university.[127] The LCME began consideration of new standards on faculty development and on the medical consequences of domestic violence, but it rejected a proposed standard on strategic planning. The only other activity of note in 1995 was a report on the activities of the newly formed National Committee on Foreign Medical Education and Accreditation (NCFMEA), a group established by the Department of Education to make determinations about the comparability of accreditation systems in foreign countries with the requirements of the LCME. NCFMEA recognition was required as a condition for federal financial aid to U.S. citizens attending medical schools in foreign countries.

Little of note took place during 1996. A new standard on faculty diversity was approved and forwarded to sponsoring organizations for action. The LCME gave some consideration to new standards addressing academic honesty and professional conduct and on a curriculum requirement to ensure student learning about "cross-cultural issues." The former was rejected, and the latter was referred to staff for additional data collection. At the September 1996 meeting, LCME Secretary Kassebaum announced the launch of the Medical Education Standards and Assessment (MESA) project, a comprehensive review and analysis of the impact and effectiveness of LCME accreditation standards on medical student education.

1996–2002: Evidence-Based Accreditation

The MESA project represented Kassebaum's effort and desire to cement his legacy as a scholar of accreditation; during his tenure as LCME secretary, he published several papers on both medical education and accreditation topics. Two precipitating events contributed to the form and outcome of the project. In 1995 he recruited an assistant vice president to share some of the LCME workload (Jonas, his AMA counterpart, had Barzansky serving in that capacity for nearly a decade), thus freeing up more time for his scholarly work. Second, the LCME was coming up for another round of recognition renewal with the Department of Education, and Kassebaum perceived that event as

an opportunity to address one of the department's recognition criteria that had always vexed the accreditation community: establishing the reliability and validity of accreditation standards. As he was approaching retirement age, Kassebaum saw the project as a capstone for his service to the LCME.

The project was designed to address five issues:

1. The extent to which medical schools had articulated, and were using, program objectives to guide curriculum design and evaluation
2. Identification of accreditation standards that were associated with identifiable operational correlates
3. Demonstration of the validity of standards to predict and improve educational quality
4. The consistency of interpretation and application of standards by schools, survey teams, and the LCME itself
5. The role of accreditation in facilitating constructive educational change

The project spanned nearly two years and resulted in four published papers that addressed most of the original goals (see Appendix E). The study of educational objectives coincided with the AAMC's Medical School Objectives Project, although the two projects proceeded independently of each other. Kassebaum and his staff documented the paucity of development and use of educational objectives by reviewing the findings of the most recent LCME survey report for every U.S. medical school, and the AAMC produced a series of documents recommending educational objectives for various educational subject areas.

In discussions with Department of Education staff during preparation for the renewal of LCME recognition, Kassebaum bluntly asked how they expected accreditors to demonstrate the reliability and validity of standards. Department staff suggested that a survey of stakeholders should suffice, and so he and his staff undertook the administration of a series of questionnaires to various stakeholder groups (medical school deans, associate deans, department chairs, faculty members, students, resident physicians, and practicing physicians), asking them to rate LCME standards for clarity and importance as indicators of educational quality. The resulting data were summarized in two published papers and would later serve as a principal source of information for the next major revision of LCME standards in 2002. The final paper from the MESA project attempted to ferret out the differential effects of the LCME, private foundations, and other organizations on the improvement of educational quality but found little that could be unquestionably attributed to any specific organization.

The stakeholder survey was perhaps the most important outcome of the MESA project. The LCME received preliminary results of that survey at its September 1997 meeting and decided to reserve the April 1998 meeting as a retreat to discuss the MESA project and its implications. During the period preceding that retreat, the LCME remained active in addressing both processes and standards. Student representatives to the LCME were given voting privileges in February 1997; the LCME also decided at that meeting to reintroduce training workshops for survey team secretaries and for new members of survey teams. In June of that year, the LCME discontinued its use of in-house AMA and AAMC legal counsel and contracted for legal services with the Chicago-based law firm Sidley & Austin (which

also provided legal services for the AMA). At the September 1997 meeting, the LCME increased the honorarium for team secretaries to $1,500 for full surveys and $1,000 for limited surveys; it also reinstated the title of assistant LCME secretary, which was accorded to the two primary professional staff members (Barzansky and Robert Eaglen) supporting the LCME secretaries, rather than the former practice of conferring the title on the secretaries of LCME survey teams. A proposal to offer a seat on the LCME to a resident physician was turned down. Finally, as part of the LCME's petition for renewal of federal recognition, the organization voluntarily changed its status from an institutional and programmatic accrediting agency to an exclusively programmatic accreditor; the change was made to ensure that the LCME would not run afoul of Department of Education requirements that accreditors be separate and independent from sponsoring or supporting organizations.

The LCME was also active with standards during 1997. It approved initial language for the standard regarding the numbers and types of patients students were expected to see during their clinical experiences. It revived an earlier standard on the availability and content of medical school catalogs and informational materials, largely in response to new Department of Education recognition requirements. The LCME also approved language for a standard on periodic review of graduate programs in basic medical sciences; it had been prompted by one of its members to consider adding the accreditation of such programs to its scope, but in the face of significant opposition from several professional organizations representing the basic sciences, it opted for the standard instead. At the February 1998 meeting, the LCME also took initial steps toward the creation of a new standard on student abuse and mistreatment.

The April meeting included the retreat on the findings of the MESA project. The most notable outcome of the retreat was a decision to establish an ad hoc subcommittee to review accreditation standards. That subcommittee was established at the June 1998 LCME meeting, and its initial focus was to be a reexamination of 13 standards that had been either identified as problematic in the survey of stakeholders or treated inconsistently in survey reports. Also at the June meeting, the LCME considered a new standard on palliative and end-of-life care, prompted by a formal request to address the issue by a faculty member at a Canadian medical school. Canadian issues resurfaced at the October 1998 meeting: finding French-speaking survey team members from U.S. medical schools who could participate on surveys of francophone schools, and the relevance of LCME confidentiality and conflict of interest policies in the comparatively small (17 medical school) and politically distinct Canadian environment. The new Subcommittee on Standards made its first report to the LCME at the October meeting and indicated its intent to reexamine other problematic standards from the MESA project after it completed work on the initial set of 13 difficult standards.

LCME Secretary Kassebaum attended his final LCME meeting in June 1999. The first rumblings about possible new medical schools in Florida were brought to the attention of the LCME at the June meeting, amid statewide concerns about an impending physician shortage to meet the needs of Florida's rapidly expanding population. At the October 1999 meeting, David Stevens took up the mantle of AAMC secretary to the LCME. The Subcommittee on Standards informed the LCME that it would undertake a review of 31 standards related to teaching, learning, and the assessment of student performance. Earlier that year, the LCME approved draft language for standards on palliative and end-of-life care,

student mental health services, and cultural competency. The LCME also considered a new standard on the adequacy of medical school finances at the October meeting.

In February 2000 the Task Force on Accreditation Policy and Reliability and Validity of Standards was rechristened the Executive Committee, charged with the oversight and management of LCME activities, One of the Executive Committee's first acts was to recommend that the Subcommittee on Standards be designated as a standing subcommittee called the Subcommittee on Review of Accreditation Standards, and the LCME concurred. The role and functions of the subcommittee were defined at the April 2000 meeting and entailed (1) review and/or revision of existing standards and development of language for any needed annotations to current standards, (2) initial consideration of ideas for new standards and crafting of draft language for such standards, and (3) comprehensive review and revision of *Functions and Structure*.
A major topic of policy discussion at the April 2000 meeting of the LCME was its approach to dealing with schools exhibiting serious problems that fell short of requiring probationary status. The LCME considered creation of a "warning" status for such schools, as well as the possibility of reverting to a variable term of accreditation, but declined both options; it chose instead to maintain its existing policy of conveying the extent of concern about program deficiencies in its letter of accreditation informing schools of the LCME's decision regarding accreditation status.

The June 2000 meeting saw another transition in the LCME Secretariat, with Jonas retiring as AMA secretary to the LCME after the meeting and Frank Simon appointed as his successor. At the June 2000 meeting, the Subcommittee on Review of Accreditation Standards proposed to the LCME that a complete overhaul of *Functions and Structure* take place, with a goal of producing a new standards document by October 2001; the LCME authorized the subcommittee to proceed with that plan and placed a moratorium on any further revisions of existing standards until the *Functions and Structure* review was completed (although new standards could still be considered). The subcommittee began its work by reviewing all the standards listed under the heading "Educational Program for the M.D. Degree." The June meeting also included a discussion of Executive Committee functions, and the LCME agreed that the main purpose of that group was to conduct a preliminary examination of accreditation issues and make appropriate recommendations to the full LCME membership. Responsibilities of the Executive Committee included the development of proposals for change in policies and procedures, oversight of the standards creation and review process, recommendations regarding appointment of public members, and the monitoring of relationships with external organizations.

With two recently appointed LCME secretaries having taken on those responsibilities within a one-year period, the new Secretariat staff met during the summer of 2000 to undertake a critical examination of LCME operations to identify potential improvements in efficiency and effectiveness. A retreat for that purpose occurred in September. The outcomes of the retreat were shared with the LCME membership at the October 2000 meeting of the LCME, and in response to those outcomes the LCME appointed ad hoc groups to examine the quality and effectiveness of LCME meetings, the organization of survey visits, and the role and functions of public members. The LCME also decided at that meeting to shift the cycle for professional member appointment to academic years so to coincide with the appointment cycle for student members and with the alternating academic year cycle of Secretariat meeting support by

the AAMC and AMA staff. Members were informed about preliminary discussion among the leadership of several physician credentialing organizations regarding topics of common concern; this broadband group, as it was informally known, included the two LCME secretaries and leaders of the Accreditation Council for Graduate Medical Education (ACGME), Accreditation Council for Continuing Medical Education (ACCME), Educational Commission for Foreign Medical Graduates (ECFMG), NBME, and Federation of State Medical Boards (FSMB), a veritable potpourri of acronyms. Finally, Florida State University initiated the process for accreditation of a new medical school, ending two decades of dormancy in the establishment of new medical schools.

Expansion in the number of medical schools was a major topic of discussion within the LCME during 2001, with announcements of possible new medical schools in Ohio, Virginia, and Ontario, Canada. A further complication was presented to the LCME when a U.S. medical school decided to establish a four-year MD-granting program in a foreign country, for which it would seek LCME accreditation. Secretariat consultations took place during that year with the potential new schools in Ohio and Ontario. The LCME was also informed that a medical school located in the Caribbean had been in communication with the Secretariat (although the communications did not imply any imminent request for LCME accreditation). The possibility of a U.S.-based medical school operating in a foreign country reopened the question of LCME accreditation of foreign medical schools, with the unique twist that the U.S. medical school sponsoring a new MD educational program in a foreign country was already accredited by the LCME. This spurred the LCME to reconsider its operational definition of what constitutes an accreditation-eligible medical school. At the October 2001 meeting, the LCME discussed the issue thoroughly and adopted the following operational definition of an accreditable entity: "… complete and independent medical education programs whose students are geographically located in the United States or Canada for their education and which are operated by universities or medical schools that are chartered and operated in the United States or Canada."[128]

While the LCME wrangled with medical school expansion issues and involvement in medical education programs outside the United States and Canada, its Subcommittee on Accreditation Standards continued its work. As the subcommittee was working through its review of the various sections of *Functions and Structure*, the need for a major reorganization to clarify standards and eliminate accumulated redundancies in the language of several standards statements became apparent. One of the biggest challenges was that the prose format of standards made it difficult to incorporate explanatory annotations, which were needed in many cases to provide sufficient clarity for understanding the scope or interpretation of standards; thus, the LCME agreed to revert to the list format that had been employed in the earliest iterations of the *Functions and Structure* predecessor, *Essentials of an Acceptable Medical School*. The subcommittee emphasized that it did not intend to alter the meaning or intent of existing standards but felt that a new organizational framework was needed to ensure appropriate precision in the language of standards and annotations. The LCME agreed to the new, list-based framework for standards at its October 2001 meeting, with the understanding that the reorganized *Functions and Structure* would be presented to the LCME's sponsoring organizations for their review and endorsement, even though there was no intention to make substantive changes to the standards.

Modest changes in LCME operating procedures were also made in 2001. Regular updates on Secretariat activities became a standing item on LCME meeting agendas, known as the "Secretariat Report." Internal

guidelines for addressing discrepancies in accreditation decisions between the LCME and CACMS were approved. The LCME approved a shortened schedule for full accreditation survey visits, allowing team members to complete their work by late in the day on Wednesday, instead of wrapping up on Thursday morning. The LCME also abandoned review of student write-ups of patients during the course of survey visits in compliance with the federal government's newly adopted Health Insurance Portability and Accountability Act (HIPAA) requirements.

In February 2002 LCME staff proposed, and the LCME approved, a series of changes in its processes and procedures. Most notably, the medical education database prepared by medical schools as supporting documentation for accreditation surveys was redesigned to link the database questions to specific LCME standards; this change made it easier for schools and survey teams to identify and evaluate the evidence supporting compliance with standards. The LCME also abandoned the use of the term "concern" as the identifier for accreditation shortcomings, replacing it in survey reports and letters of accreditation with the phrase "partial or substantial non-compliance." Later in the year, the LCME agreed to eliminate its April meeting, partly as a cost-saving measure and partly because the April meeting typically carried a much lighter workload than the other meetings during the year.

Another long-standing logistical challenge for LCME staff was the varying annual workload of accreditation surveys, which over the seven-year cycle for all medical schools ranged from a low of 8 full surveys of U.S. schools in some years to more than 30 full surveys in others. Logistics were particularly difficult for Canadian school surveys since some years had no full surveys at all. The problem had arisen because the LCME did not make any adjustments in the annual number of visits when it originally switched from a variable term of accreditation to the fixed seven-year term in the late 1980s. A staff analysis of the distribution of full surveys across the seven-year cycle indicated that the workload could be relatively evenly distributed by shifting to an eight-year cycle and by adding one additional year to roughly one-third of the schools currently in the seven-year cycle. The LCME approved this process improvement recommendation as well.

The new version of *Functions and Structure*, now in a list format that included annotations when needed, was approved by the LCME sponsors in 2002. Also during the year the LCME approved several new standards that addressed strategic planning, the identification of physician competencies to guide the development of educational program objectives, and the importance of graduate and continuing medical education as part of the educational environment in which medical students learn their craft. The LCME also developed clearer definitions for the geographical scope of LCME accreditation, the delineation of geographically separate campuses of a single medical school, and the defining features of an alternate curriculum track within a school's overall educational program. These definitions were incorporated in the preamble and body of the new *Functions and Structure* as appropriate.

Medical school expansion provided the other major focus for the LCME in 2002. The Florida State University College of Medicine received initial, provisional accreditation that year, the first newly accredited MD-granting medical school since the opening of the Mercer University School of Medicine in 1982. Planning continued for a new medical school in Ontario, and the Secretariat was engaged in consultations about other proposed new medical schools in Florida and Texas. The growing interest in

new medical schools led to the creation of a new document, *Guidelines for New and Developing Medical Schools*, which was reviewed in draft form by the LCME at its October 2002 meeting.

2003–2005: The LCME in an Era of Expansion

After the whirlwind of events that took place in 2002, the last decade or so of the LCME's history should have led to a period of consolidation and relative calm. That was the case for a while, but fundamental changes in LCME structure and standards were still to come before this history would be complete. The next period began with another staff change. The LCME learned at the June 2003 meeting that Stevens, the AAMC secretary to the LCME, would be taking a one-year leave of absence to complete a fellowship at the Institute for Healthcare Improvement, after which he would assume a new role at the AAMC and forgo his LCME responsibilities. Also in 2003 the LCME authorized the creation of the Subcommittee on Policy and Procedure, a new standing subcommittee responsible for ongoing analysis and recommendations regarding the organization's operations; its first major task was a comprehensive revision of the policy document *Rules of Procedure*. The AMA and the AAMC began discussions about possible consolidation of the LCME Secretariat into a single office. Finally, the Council for Higher Education Accreditation (CHEA) instituted a recognition process for accrediting agencies, requiring recognition as a condition of membership in the organization; the LCME, which had been a member of CHEA since the latter's inception, opted to discontinue its membership, noting that it was already recognized by the Department of Education and would gain little from the CHEA process.

Carol Aschenbrener succeeded Stevens as the AAMC secretary to the LCME at the start of the February 2004 meeting. During her first year as LCME secretary, issues associated with medical school expansion dominated the discussion. In June 2004 the LCME granted initial, provisional accreditation to a Canadian medical school for the first time since the early 1980s. The LCME was also approached during the year about possible new medical schools in Arizona and New Jersey. As the workload or evaluating new medical schools began to accelerate, the LCME instituted an application fee for those schools, assessing them $25,000 for an initial application and a $10,000 fee should a reapplication be required.

While new schools were beginning to dot the medical education landscape, existing medical schools were expanding enrollments in response to an AAMC call for increased output to address anticipated physician shortages; as a result, virtually every LCME meeting included several reports of class size increases. Concerned about unrestrained class size growth, the LCME approved guidelines for reporting class size increases when it met in June 2004. At the following meeting in October, the LCME also began wrestling with procedures to address new medical school organizational structures, such as a single medical school offering two complete and nonoverlapping MD educational programs or a single MD program operated by two independently operating universities. During the October meeting, the LCME learned about the increasing requests for involvement of the Secretariat staff in international accreditation issues. Before concluding the meeting, the LCME reviewed a staff summary of its previous decisions to place medical schools on probation, attempting to identify specific events that were likely to trigger a probation decision.

International engagement continued to be a major LCME activity in 2005. Secretariat staff worked collaboratively with officials of the World Federation of Medical Education to promote the development of international accreditation standards; they were also invited to conduct a workshop on accreditation at the annual meeting of the Association of Medical Educators of Europe and hosted a delegation from Egypt interested in establishing a system of accreditation in that country. Simon, the AMA secretary to the LCME, informed the LCME about the first meeting of a new Special Committee on the Evaluation of Undergraduate Medical Education, formed by the FSMB to address the lack of a suitable quality assessment process for foreign medical schools whose graduates sought licensure in the United States. Finally, the increasing U.S. medical school involvement with, and support of, medical schools in other countries raised LCME concerns about the possibility of students in U.S. schools taking required courses or clerkships in partner or subsidiary medical schools operating in foreign countries.

Reconsideration of the LCME's scope of accreditation occurred in 2005, as overtures from the osteopathic community led the LCME to explore how it might respond if asked to develop a process that would allow it to accredit osteopathic medical schools. In addition, the LCME received its first inquiry from a for-profit university interested in establishing an MD-granting medical school.

With the new format of accreditation standards now firmly in place, the LCME continued consideration of new standards during 2005. A mini-retreat at the June 2005 meeting led to the creation of an ad hoc working group to reexamine the LCME's diversity standards. Another working group created earlier by the LCME to examine the medical student learning environment presented draft language for an accreditation standard to ensure that such an environment was conducive to the student's appropriate professional development; this effort was buttressed by a resolution passed by the AMA House of Delegates requesting the LCME to adopt a standard requiring the assessment of medical students' professional behavior.

In 2005 the LCME formalized the process for accreditation of new medical schools that entailed a three-stage approach in which a new school could obtain preliminary accreditation before admitting a charter class, provisional accreditation before the beginning of clerkship education, and full accreditation when the charter class graduated. The LCME reaffirmed its policy to conduct oral exit conferences at the conclusion of survey visits, concerned that the sharing of any written findings from the team during the exit conference could undermine a school's understanding that accreditation decisions and findings were the province of the LCME itself, not of the survey teams. Finally, the LCME agreed that the increased workload resulting from medical school expansion and the reduction from four meetings a year to three made it exceedingly difficult to find time for reflection; it therefore decided to set aside at least some time during its meetings for in-depth discussions about accreditation-related issues.

2006–2015: New Staff, New Structure

The most notable activity for the LCME during 2006 was the major turnover in its professional staff. At the February meeting, LCME member Darrell G. Kirch informed the group that he would be

stepping down after the June meeting to take on responsibilities as the next president of the AAMC. As the incumbent head of the AAMC, Kirch had appointed Aschenbrener, the AAMC secretary to the LCME, as the AAMC's senior vice president for medical education. Thus, her last appearance as LCME secretary took place at the June meeting; that was also the final LCME meeting for CACMS Secretary David Hawkins, who was retiring as executive director of the Association of Faculties of Medicine of Canada. The October 2006 LCME meeting convened with news that Simon, the AMA secretary to the LCME, had resigned on September 1, thus completing the wholesale turnover of the Secretariat leaders within a three-month period. Nick Busing replaced Hawkins as the CACMS secretary, and the AMA and AAMC designated their respective assistant LCME secretaries as interim secretaries while searches were conducted for permanent successors.

The LCME continued to grapple with the consequences of accelerating medical school expansion during 2006. Potential new medical schools continued to seek LCME guidance or evaluation for accreditation, and established medical schools sought LCME approval for increasing enrollments. Concomitant growth in osteopathic and foreign medical schools was increasing the demand for U.S. schools (or their affiliated hospital partners) to accept students from such schools for clerkship education, placing additional pressures on the clinical educational capacity of LCME-accredited schools. To address the capacity issue, the LCME modified its policies to encourage U.S. schools to restrict clinical education of students from non-LCME-accredited schools to elective courses, retaining core clinical clerkships for exclusive use by enrolled students. With so many schools increasing their entering class sizes, the LCME also established reporting thresholds for class size increases as a mechanism to maintain educational quality; henceforth, obtaining prior LCME approval was required for any school that increased its entering class size by either 15 students per year or by 10% of its established entering class size and for any school that anticipated an increase of 20% or more for its entering class size over a three-year period.

The other prominent activity of the LCME during 2006 involved standards changes. At the February meeting, the LCME gave its initial approval to a new standard on the learning environment, which had been developed by its working group charged with exploration of that subject. At the June 2006 LCME meeting, the organization approved new standards on service learning and on student understanding of core principles of clinical and translational research. The LCME declined a request from the National Transportation Safety Board to adopt a standard requiring medical student education about the effects of medical conditions and medications on safe driving. It reviewed a request from the American Academy of Neurology (supported by other professional neurology organizations) to include neurology as one of the core clinical disciplines to be included in medical student clerkship education, referring the request to its Subcommittee on Standards for further analysis.

The neurology request spurred the Subcommittee on Standards to rethink the broader issue of how LCME standards dealt with content issues generally, and at the February 2007 meeting the LCME instructed the subcommittee to perform an in-depth examination of the topic and suggest alternatives. The LCME also held an educational session, or mini-retreat, on diversity at this meeting. Later that year

Secretariat staff attended a conference on diversity in the accreditation of health professions, sponsored by the Sullivan Alliance. Partly as a result of these activities, the LCME approved draft language for new diversity standards at its June 2007 meeting, addressing both diversity among faculty, staff, and students at medical schools and efforts to enhance diversity in the medical school applicant pool.

At the October 2007 meeting, a new slate of AAMC professional staff began working with the LCME, with Dan Hunt serving as the new LCME secretary and Robert Sabalis as the assistant LCME secretary. Also at the meeting, the LCME changed the terminology for accrediting new schools, designating those that had simply applied (and paid the corresponding fee) for accreditation as "applicant" medical schools and those that had successfully passed a preliminary review of their planning documents (and were therefore authorized to undergo an on-site survey) as "candidate" institutions.[129] Both types of schools would also be listed on the LCME website, with appropriate language emphasizing that such schools were not yet accredited by the LCME.

The LCME's Subcommittee on Policy (previously called the Subcommittee on Policy and Procedure) undertook an ambitious agenda at the October meeting, beginning with a comprehensive review of the circumstances surrounding schools that had been cited for noncompliance with the same standard over two or more consecutive accreditation cycles. The subcommittee also decided that it should explore several other topics, including the desirability of establishing a new accreditation action (intent to place on probation, the equivalent of the confidential probation status that had been in use by the LCME and its sponsors several decades earlier); development of a better procedure to reconcile divergent decisions between the LCME and CACMS regarding the accreditation status of Canadian medical schools; identification of benchmarks that could trigger a decision to impose probation; development of a statement on professional behavior for survey teams, including a formal policy on acceptance of gifts; and an in-depth analysis of the educational value of medical schools' fourth-year curricula.

Under its new staff leadership, the LCME would steadily confront increasing demands on its time over the next decade, stemming from medical school expansion, growing involvement in international matters, and greater demand for consultations and assistance from established medical schools.

The turnover in the Secretariat leadership was completed when Barzansky was appointed as the AMA secretary to the LCME before the February 2008 meeting, the first non-MD to hold that title on a permanent basis. Under its new staff leadership, the LCME would steadily confront increasing demands on its time over the next decade, stemming from medical school expansion, growing involvement in international matters, and greater demand for consultations and assistance from established medical schools. 2008 was a year for exploration of new procedures. The LCME adopted a "warning of probation" status for schools with serious problems short of probation, hearkening back to the era of confidential probation in its early history. New medical school organizational structures prompted reexamination of LCME definitions of and approaches to complete educational programs, geographically separate campuses, and educational tracks. As a result of that effort, a formal policy was adopted for the initial

accreditation of four-year educational programs currently offered as educational tracks at geographically separate campuses by established medical schools. The site visit also underwent reconsideration, particularly with regard to the identification of a medical school's strengths and the desirability of citing strengths. The LCME approved a stricter conflict of interest policy for survey team members that prohibited receipt of any gift, no matter how inconsequential the monetary value might be. The LCME also negotiated an agreement with its CACMS counterpart on the development of a single letter of accreditation for Canadian medical schools that reflected the shared judgment of the two accrediting organizations, and it reaffirmed its policy of not accrediting medical education programs offered outside the political jurisdiction of the United States and Canada.

The LCME continued to fine tune its standards and annotations during the year and also decided that it should seek sponsor approval before eliminating any standards (for example, when a survey of stakeholders indicated clearly that a standard was considered unimportant for educational quality). The decision was prompted by a finding from a stakeholder survey, indicating that the LCME standard related to faculty collaboration in teaching, research, and patient care was held in very low regard (it was ultimately eliminated). The LCME began work on language for a standard addressing medical student and patient safety during the course of a student's clinical education. The LCME turned down a request from a clinical specialty society to adopt a standard on administrative support for required clerkships.

The most visible challenge in 2009 was the growing workload of the LCME and its administrative staff as new medical schools and campuses continued to proliferate, more schools were reporting class size increases and requesting Secretariat consultations, and more foreign organizations sought LCME assistance or advice. In light of the increased workload, the Secretariat was instructed by the LCME to seek additional support from the LCME sponsors to handle the growing demand. Draft language for the new standard on student and patient safety was approved at the June 2009 meeting. On the policy and procedure front, the LCME undertook a review of its policy for exit conferences of on-site surveys, a procedure to handle findings regarding institutional strengths, and strategies for conveying best practices identified as a part of accreditation surveys. Secretariat staff engaged in ongoing discussions with officials from the ECFMG and its Foundation for the Advancement of International Medical Education and Research (FAIMER). The ECFMG had approved a policy that would require foreign medical schools to be accredited before their graduates could obtain a license to practice in the United States, and it sought LCME assistance and expertise in determining how such accreditation might be accomplished.

The discussions of 2009 produced several actions in 2010. At the February 2010 meeting, a new policy on exit conferences was approved in which a written copy of the survey team's findings would be given to the medical school, albeit without any indication as to whether the individual findings constituted strengths, noncompliance, or areas in transition. To lighten the Secretariat staff's workload, the LCME's sponsors authorized the Secretariat to appoint field secretaries to serve as team secretaries for multiple accreditation surveys and to assist staff as needed in other administrative responsibilities. A retreat on international accreditation issues in February 2010 led to further consultations with the ECFMG and FAIMER later in the year. By October 2010 the LCME had agreed to a tentative plan for disseminating best practices.

New business for the LCME in 2010 involved extended discussions about the accreditation challenges posed by new medical school organizational models and governance structures, as well as the business models and organizational values associated with the changing medical school landscape. To accommodate recent changes in the criteria for recognition established by the Department of Education, the LCME approved the addition of a third public member (although no third public member was appointed). It also reexamined the purpose and function of annotations to accreditation standards in an effort to determine the extent to which the annotations were being treated like standards among schools and survey teams. The only notable standards change to take place involved the differentiation of two standards related to information technology resources, which had previously been included in standards on library support and services.

The seeds of a major change in LCME governance were sown at the beginning of 2011, as the chair and chair-elect of the LCME informed the membership about a letter from the leaders of the AMA and the AAMC indicating that the sponsoring organizations had initiated a discussion of LCME governance. After the February meeting, the Task Force on LCME Structure was formed and included representation from the LCME membership and from each of the two sponsoring organizations. The task force held a two-day meeting in April 2011 to discuss the sponsors' role in approval of standards, the appointment of members, the LCME's authority to enter into contracts, and the budgetary autonomy of the LCME. Three subcommittees emerged that would focus on LCME structure and governance, membership, and operations.

The LCME's relationship with Canadian medical schools surged to the forefront again in 2011. At the June LCME meeting, CACMS Secretary Busing informed the LCME that the role of CACMS secretary was being separated from the directorship of the Association of Faculties of Medicine of Canada (AFMC) and that CACMS would be appointing a new secretary (Busing would continue as executive director of AFMC). The LCME met jointly with CACMS in June 2011 and discussed how to approach student mistreatment issues, the role of accreditation with respect to interprofessional education, and the details of a recently instituted interim review process developed by CACMS to encourage ongoing quality improvement by Canadian medical schools between accreditation surveys. The LCME also learned at the meeting that AFMC had initiated an independent review of its relationship with the LCME as part of its periodic process for organizational evaluation.

Separate from these topics of discussion, the LCME also engaged in continuing discussions about the role of its members and the Secretariat staff in activities associated with quality assurance of international medical education. At the October 2011 meeting, the LCME endorsed a white paper prepared by the Secretariat staff outlining the role of the LCME in international accreditation issues. The LCME also heard a report on preliminary discussions among Secretariat staff and their counterparts in nursing and pharmacy to explore possible approaches to standards on interprofessional education, and the announcement of an AAMC initiative to prepopulate some of the content that schools provided for accreditation surveys in the LCME's medical education database. The other item of note to arise from the October meeting was a recommendation by the Subcommittee on Policy that the LCME consider clustering its standards to reduce their overall number.

As 2012 began, the LCME was informed that the AMA and the AAMC had begun work on a memorandum of understanding to redefine their relationship to the LCME. The draft memorandum was reviewed by the LCME in June 2012, and when the terms of the memorandum were accepted by the sponsors during the summer, the LCME officially came under the authority of a new advisory council whose members represented the AMA, the AAMC, and the LCME. The LCME designated its chair and chair-elect as members of the new council, with the immediate past chair of the LCME serving as an ex officio member of the council. A new Subcommittee on Planning was established by the LCME in October to identify activities for reporting to the advisory council. The first set of such activities included international engagements, alignment of LCME efforts with the ACGME Milestones Project, development of an interim quality review process for U.S. medical schools, research on the value of accreditation, and strategies for communication with the council.

The Canadian relationship underwent further review during 2012, with discussion of the draft recommendations that had come out of the independent review of CACMS commissioned by the AFMC. At the October 2012 meeting, the LCME also heard details of an ongoing process to review the relationship of the LCME and CACMS that had arisen at the request of the AFMC Council of Deans. While the Secretariat continued to collaborate with other organizations on international accreditation issues, both the LCME and CACMS agreed to seek formal recognition from the now well-established World Federation for Medical Education (WFME).

At the June 2013 meeting, the LCME approved the reorganization and clustering of standards and began to grapple with the consequences of that structure for making accreditation decisions.

At the February 2012 meeting, the LCME approved a new accreditation standard on the oversight of elective courses taken at other medical schools. At the October 2012 meeting, it approved a new standard on interprofessional education. Work on the clustering of standards continued during the year, and in October a draft schema was approved that reorganized the standards into a grouping of 12 overarching standards and a subset of elements within each of those standards. While there were no major policy changes during the year, there was one significant change in LCME operations: the alternate-year Secretariat staffing model was eliminated and replaced by a division of labor and support functions among the members of the professional staff.

The following year saw action on many of the events that were initiated in 2011 and 2012. The new advisory council held its first meetings during 2013. One of its first decisions was concession of authority for member appointment to the LCME rather than the sponsoring organizations. To implement the decision, the LCME at its February meeting created a nominating committee for the selection of its members and for recommending candidates as chair and chair-elect; the committee's composition included the current chair-elect, the chairs of the Subcommittees on Standards and Policies, a public member, and a student member. The Subcommittee on Planning adopted an agenda for the year that included the development of a pricing structure for international consultations, continued work on an interim review process, development of an internet-based system

for submission of each medical school's medical education database, and exploration of possible linkages with the ACGME Milestones Project.

Discussions about the LCME relationship with CACMS culminated in a memorandum of understanding between the two organizations, approved by the LCME at its June 2013 meeting, to take effect June 2014. The terms of the agreement called for a written agreement about the process for LCME review of Canadian medical schools, joint representation on survey teams and committees, creation of a joint committee to reconcile divergent accreditation decisions between the two accrediting bodies, clarification of standards and elements that applied uniquely or not at all to Canadian medical schools, and the establishment of an affiliation oversight committee that would provide oversight and review of the organizations' accreditation processes at least once every three years.

At the June 2013 meeting, the LCME approved the reorganization and clustering of standards and began to grapple with the consequences of that structure for making accreditation decisions. At its October meeting, it approved a new nomenclature that reserved the term "compliance" (with or without monitoring) to indicate fulfillment of the expectations for its 12 standards and the designation "satisfactory" (again, with or without monitoring) to describe fulfillment of expectations regarding the elements within each standard. The LCME also approved deletion of its standard on the nonprofit status of a medical school or its parent university and initiated discussion of a new element that would require schools to engage in continuous quality improvement. In addition, it debated the issues arising from variability in survey team interpretations of how schools were achieving accreditation expectations regarding diversity and active learning.

Regarding policy, the LCME created a task force to examine the challenges posed by U.S. medical schools with international branch campuses where U.S. students could take required course work. It approved a new fee structure and expense reimbursement policy for selected accreditation activities. It also introduced a series of modifications to its policies for accrediting new medical schools, setting time limits for submitting documents in support of a request for preliminary accreditation, placing a limit of three tries on a new school's efforts to obtain candidate status, and imposing a one-year waiting period for resubmission after denial of preliminary accreditation.

The remaining years of LCME history consisted largely of consolidating the spate of activities that took place in the immediately preceding years. In February 2014 the LCME officially approved the new version of *Functions and Structure*, including a nested hierarchy of standards and elements, with all annotations removed. In June it approved modified versions of *Functions and Structure* and *Rules of Procedure* for Canada that had been developed by CACMS to address the distinctive circumstances of Canadian medical school accreditation. To address one of its ongoing international issues, it approved a draft policy that would have permitted the inclusion of international campuses for U.S. medical schools as part of the LCME's accreditation; however, the LCME's advisory council, after review of the policy by the AMA's and the AAMC's legal counsel, concluded that international campuses should remain off limits for LCME evaluation.

In this final period, the LCME also adopted some relatively modest changes in policy and procedure and continued its collaborative activities with external organizations. It revised its procedures for accreditation of developing medical schools, approving a 12-month waiting period for any developing school that was denied candidate status (i.e., authorized to undergo a site visit for preliminary accreditation). It authorized the creation of an internal operations manual to accompany its policy document, *Rules of Procedure.* In June 2015 the LCME ended its long-standing practice of citing institutional strengths as part of its accreditation findings, opting instead to incorporate positive team observations in the exit conference with medical school officials. It also approved white papers that had been developed by its subcommittees and staff on the topics of clinical teaching sites that hosted students from multiple medical schools and distance learning in medical education. It endorsed for LCME use a uniform clinical training affiliation agreement that had been developed by the AAMC.

Late LCME history was marked by increased collaboration with other organizations. Secretariat staff continued to work closely with their counterparts at FAIMER to foster the development of a system for quality assessment of foreign medical schools. The staff also embarked on a joint effort with several other health professions accreditors to enhance their approaches to interprofessional education by way of a nascent Health Professions Accreditors Collaborative; the proposed organization included accrediting agencies for osteopathic medical education, dentistry, nursing, pharmacy, and public health. The LCME also agreed to explore options for closer collaboration with the Commission on Osteopathic College Accreditation, focusing on strategies for dealing with shared clinical sites used by students from both MD- and DO-granting medical schools.

This concludes the overview of the events that took place in the shaping and evolution of the LCME. The remaining chapters provide greater depth in the descriptions of the evolution of LCME standards, policies and procedures, and relationships.

PART II

Origins and Evolution of LCME Accreditation Standards

Chapter 6

AMA Standards, AAMC Membership Requirements

It is highly unlikely that accreditation can be well understood without a substantial appreciation for the origin and development of the standards that institutions and programs have accepted as the criteria by which they should be evaluated. Within the realm of medical education accreditation, such standards originally developed independently within the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC). The two organizations did not mutually agree on a common set of standards until the Liaison Committee on Medical Education (LCME) adopted the first edition of *Functions and Structure of a Modern Medical School* in 1957. The story of how medical school standards arose begins here.

The Beginning of the American Medical Association and Its Early Standards

As noted in Chapter 1, the AMA was created in large part to foster adherence to a quality of medical education higher than what prevailed in the mid-19th century. To achieve that goal, the charter members of the AMA set out formal recommendations at the 1847 convention to address the desired qualifications of medical students and the minimum expectations for a medical education program. These earliest standards were articulated in two resolutions adopted by the assembly. The resolution on premedical requirements first set out the background needed for the pursuit of medical studies.

> *Resolved*, That this Convention earnestly recommends to the members of the medical profession throughout the United States, to satisfy themselves, either by personal inquiry or written certification of competent persons, before receiving young men into their offices as students, that they [the students] are of good moral character, and that they have acquired a good English education, a Knowledge of Natural Philosophy and the Elementary Mathematical Sciences, including Geometry and Algebra; and such an acquaintance, at least, with the Latin and Greek languages, as will enable them to appreciate the technical language of medicine, and read and write prescriptions.[130]

The resolution then continued with a requirement that students who demonstrated these qualifications obtain a written certificate, which would serve as a warrant for acceptance into a medical college where the individual intended to pursue medical studies. The final part of the resolution recommended that all U.S. medical colleges require such a certificate as a condition of matriculation.

The resolution concerning the uniform standards of requirements for the MD degree contained 10 parts:

> *Resolved,* 1st. That it be recommended to all the colleges to extend the period employed in lecturing, from four, to six months.
> 2d. That no student shall become a candidate for the degree of M.D., unless he shall

have devoted three entire years to the study of medicine, including the time allotted to attendance upon the lectures.

3d. That the candidate shall have attended two full courses of lectures, that he shall be twenty-one years of age, and in all cases shall produce the certificate of his preceptor, to prove when he commenced his studies.

4th. That the certificate of no preceptor shall be received who is avowedly and notoriously an irregular practitioner, whether he shall possess the degree of M.D. or not.

5th. That the several branches of medical education already named in the body of this report [theory and practice of medicine, principles and practice of surgery, general and special anatomy, physiology and pathology, materia medica, therapeutics and pharmacy, midwifery and diseases of women and children, chemistry, medical jurisprudence], be taught in all the colleges; and that the number of Professors be increased to seven.

6th. That it be required of candidates that they shall have *steadily* devoted three months to dissections.

7th. That it is incumbent upon Preceptors to avail themselves of every opportunity to impart clinical instruction to their pupils; and upon Medical Colleges to require candidates for graduation to show that they have attended upon Hospital practice for one Session, whenever it can be accomplished, for the advancement of the same end.

8th. That it be suggested to the Faculties of the various Medical Institutions of the country to adopt some efficient means for ascertaining that their students are actually in attendance upon their lectures.

9th. That it is incumbent upon all schools and colleges granting Diplomas, fully to carry out the above requisitions.

10th. That it be considered the duty of Preceptors, to advise their students to attend only such institutions as shall rigidly adhere to the recommendations herein contained.[131]

Both resolutions were adopted at the convention, albeit with some vocal opposition. The major concern regarding premedical education was that it would deny acceptance to students with academic potential but limited means who lacked a suitable early education. The main objection to the resolution on curriculum arose from the medical colleges, especially in relation to the six-month lecture period, on the grounds that most students could not continuously attend lectures for such a long period of time.

At its convention two years later, the AMA considered a number of additional resolutions about the medical education program, including requirements for student performance evaluation and grading. The convention also considered recommendations that students spend at least six months treating patients in "a well conducted hospital," that students engage in compounding medicines and putting up prescriptions, and that each state establish a board of medical examiners who would develop similar examinations based on common standards to determine a graduate's eligibility for licensure to practice medicine or surgery.[132] Of these various resolutions, however, the only one approved by the delegates was the recommendation regarding six months of hospital-based clinical experience.

The main objection to the resolution on curriculum arose from the medical colleges, especially in relation to the six-month lecture period, on the grounds that most students could not continuously attend lectures for such a long period of time.

Little would change regarding AMA standards for medical education during the latter half of the 19th century, as the organization turned its attention to other aspects of the profession such as the role of women in medicine, canons of ethics for medical practice, and establishment of state boards of health. The next major shift in the development of educational standards at the AMA would take place when it established its Council on Medical Education (CME) in 1904.

The Creation of the Association of American Medical Colleges and the Development of Membership Requirements

While the AMA focused its efforts on issues related to the profession and medical practice during the last half of the 19th century, the nation's medical schools were slowly taking steps to organize themselves and establish minimum expectations for medical education. As mentioned in Chapter 1, some medical school leaders had met on two occasions after the Civil War to discuss medical education standards, but it took the formal organization of an association of medical colleges in 1876 to spur the adoption of formal educational standards, under the guise of membership requirements for the fledgling organization.

Participants at the first meeting of the association reached agreement that medical schools should not offer students discounted tickets to lectures, nor issue blank diplomas that could be bought or sold to create false credentials. They also agreed that students must take examinations in person, to eliminate the use of paid surrogates to take a candidate's examinations. Most importantly, they endorsed a common standard for the length of the medical curriculum, set at a minimum of three courses of lecture during a continuous three-year period.[133] When the association met the following year to adopt

a constitution and bylaws, a majority of the attendees rejected the requirement for three courses of lecture over three years. Proposed instead was a three-year apprenticeship that included two formal courses covering the following topics:

- Anatomy
- Physiology
- Chemistry
- Materia medica and therapeutics
- Obstetrics
- Surgery
- Pathology
- Medical practice

The three-year requirement would prove to be an insuperable obstacle, as most medical schools continued to award the MD after a two-year program of study, and often less. Attendance at meetings in the following years continued to decline, and for all practical purposes, the association became defunct by 1883. The dormancy of the association did not last long, and the organization was officially resuscitated as the AAMC in 1890. When the association met in 1891, its members approved a resolution setting forth minimum requirements for membership in the organization that, like AMA standards, focused on premedical requirements and the medical curriculum. Those requirements included the following:

- A preliminary entrance examination that included
  - a composition written in English of not less than 200 words
  - translation of easy Latin prose
  - examination in higher arithmetic or the elements of algebra
  - examination in the elements of physics
- Three courses of lectures (at least six months in duration) over three years
- A "thorough course of laboratory instruction be maintained in Chemistry, Histology, and Pathology"
- Administration of both oral and written examinations for all students

The resolution also stipulated "that students, graduates, or matriculates of recognized colleges of Literature, Science, and Arts, or graduates of Normal Schools directly supported by the state, be exempted from these requirements" and that students would be allowed one year to remove the Latin requirement.[134]

When the association adopted its constitution in 1894, the membership requirements were incorporated under Article III. The constitution increased the length of the curriculum to four years, effective for students graduating in 1899 and thereafter. The requirement that students undergo written and oral examinations was rephrased to state that "… [no] member of this Association shall confer the degree of Doctor of Medicine upon any person who has not been first examined upon all the branches of the curriculum by the faculty of the college granting the degree"; no mention was made of the type of examination (oral or written) required.[135] The need for laboratory instruction in chemistry, histology,

and pathology was eliminated, and a new section was added specifying conditions under which students could be admitted for advanced standing. Revisions to the AAMC constitution in subsequent years amplified admission requirements, added criteria for student grading, and expanded on the content and structure of the curriculum. The AAMC also established standards for the minimum equipment needed to support the medical education program.

Other AAMC requirements adopted during its early years included the following:

Admissions

Constitutional changes in 1903 set the minimum standard for admission as a high school diploma and either four years of study at a college or university or an equivalent achievement as demonstrated on external examination.[136] The AAMC also demanded that its members require medical school applicants to successfully complete either an entrance examination in the subjects of English, Latin, arithmetic, algebra, and physics or certification from a licensing board or institution of higher education that a prospective student had completed a course of study in such subjects.

Grading

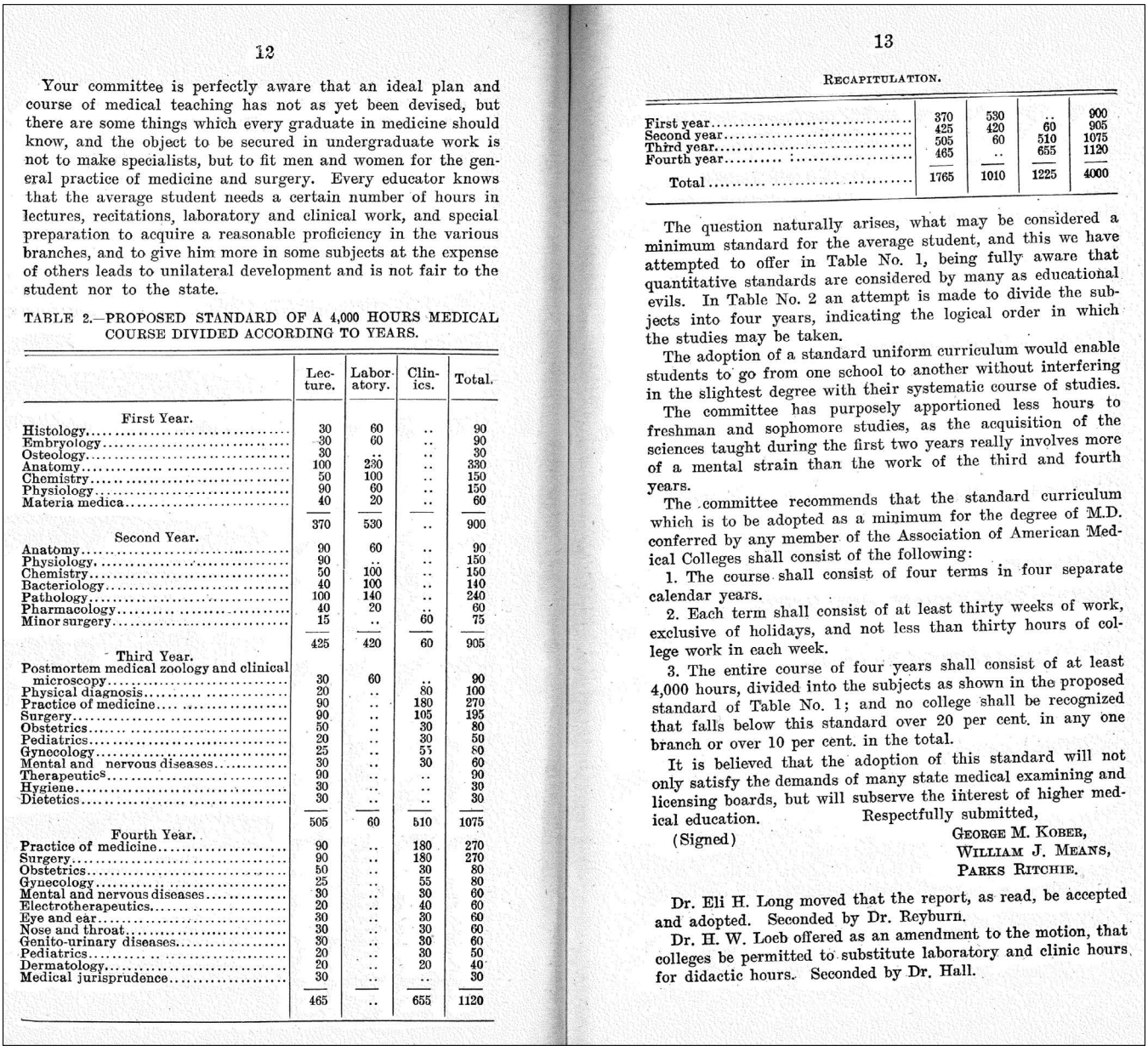
Student grading criteria were adopted by the AAMC in 1903 when the bylaws were amended to include requirements for student records, imposing an expectation that schools record student grades on a certificate (transcript) for each course taken. The bylaws stipulated the grading system as well: A (excellent), B (good), C (passed), D (failed and must retake the examination), and E (failed and must repeat the course); the latter two grades were to be color coded differently from the passing grades on the certificate, and the certificate also needed to indicate if a student exhibited dishonorable conduct.[137]

The AAMC constitution and bylaws were amended in 1907, adding an attendance requirement and a minimum performance threshold for passing courses. As the newly established Section 8 of Article III in the constitution stipulated, "Each student shall be obliged to attend 80 percent of the exercises in every annual course of study for which he seeks credit. No student shall be given credit on examination unless he attains a grade of at least 70 percent, or its equivalent in any other marking system. And no student shall be graduated unless he shall have attained a passing grade in each and all subjects of the required curriculum."[138]

Curriculum

As mentioned in Chapter 1, the AAMC in 1900 considered, but ultimately rejected, an amendment to its constitution that would have required member institutions to provide at least 3,300 hours of study. By 1905 several medical schools had adopted curricula that exceeded the proposed requirement, and the AAMC therefore proposed a new curriculum standard, consisting of at least 4,000 hours, broken down by year, subject, and method of instruction. Thus, for example, the first year of the curriculum was to include 90 hours of histology (30 for lecture and 60 for labs) and the third and fourth years were to include 80 hours for obstetrics (50 hours of lecture and 30 hours in clinics). See Figure 4. Parenthetically, the minutes of the 1905 meeting also acknowledged that "quantitative standards are considered by many as educational

evils."[139] Nevertheless, to meet its requirements, the AAMC recommended denying membership to any school in which the instructional hours were 80% or less than the standard instructional hours in any one branch (subject) or 90% or less than the total required hours. Medical schools were also allowed to substitute lab hours or clinic hours for didactics. These details were codified in a new Article V of the constitution (although the hour requirements for each subject listed in Article V were not broken down by year).



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Your committee is perfectly aware that an ideal plan and course of medical teaching has not as yet been devised, but there are some things which every graduate in medicine should know, and the object to be secured in undergraduate work is not to make specialists, but to fit men and women for the general practice of medicine and surgery. Every educator knows that the average student needs a certain number of hours in lectures, recitations, laboratory and clinical work, and special preparation to acquire a reasonable proficiency in the various branches, and to give him more in some subjects at the expense of others leads to unilateral development and is not fair to the student nor to the state.

TABLE 2.—PROPOSED STANDARD OF A 4,000 HOURS MEDICAL COURSE DIVIDED ACCORDING TO YEARS.

	Lecture.	Laboratory.	Clinics.	Total.
First Year.				
Histology	30	60	..	90
Embryology	30	60	..	90
Osteology	30	..	..	30
Anatomy	100	230	..	330
Chemistry	50	100	..	150
Physiology	90	60	..	150
Materia medica	40	20	..	60
	370	530	..	900
Second Year.				
Anatomy	90	60	..	90
Physiology	90	..	..	150
Chemistry	50	100	..	150
Bacteriology	40	100	..	140
Pathology	100	140	..	240
Pharmacology	40	20	..	60
Minor surgery	15	..	60	75
	425	420	60	905
Third Year.				
Postmortem medical zoology and clinical microscopy	30	60	..	90
Physical diagnosis	20	..	80	100
Practice of medicine	90	..	180	270
Surgery	90	..	105	195
Obstetrics	50	..	30	80
Pediatrics	20	..	30	50
Gynecology	25	..	55	80
Mental and nervous diseases	30	..	30	60
Therapeutics	90	..	..	90
Hygiene	30	..	..	30
Dietetics	30	..	..	30
	505	60	510	1075
Fourth Year.				
Practice of medicine	90	..	180	270
Surgery	90	..	180	270
Obstetrics	50	..	30	80
Gynecology	25	..	55	80
Mental and nervous diseases	30	..	30	60
Electrotherapeutics	20	..	40	60
Eye and ear	30	..	30	60
Nose and throat	30	..	30	60
Genito-urinary diseases	30	..	30	60
Pediatrics	20	..	30	50
Dermatology	20	..	20	40
Medical jurisprudence	30	..	..	30
	465	..	655	1120

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RECAPITULATION.

First year	370	530	..	900
Second year	425	420	60	905
Third year	505	60	510	1075
Fourth year	465	..	655	1120
Total	1765	1010	1225	4000

The question naturally arises, what may be considered a minimum standard for the average student, and this we have attempted to offer in Table No. 1, being fully aware that quantitative standards are considered by many as educational evils. In Table No. 2 an attempt is made to divide the subjects into four years, indicating the logical order in which the studies may be taken.

The adoption of a standard uniform curriculum would enable students to go from one school to another without interfering in the slightest degree with their systematic course of studies.

The committee has purposely apportioned less hours to freshman and sophomore studies, as the acquisition of the sciences taught during the first two years really involves more of a mental strain than the work of the third and fourth years.

The committee recommends that the standard curriculum which is to be adopted as a minimum for the degree of M.D. conferred by any member of the Association of American Medical Colleges shall consist of the following:

1. The course shall consist of four terms in four separate calendar years.

2. Each term shall consist of at least thirty weeks of work, exclusive of holidays, and not less than thirty hours of college work in each week.

3. The entire course of four years shall consist of at least 4,000 hours, divided into the subjects as shown in the proposed standard of Table No. 1; and no college shall be recognized that falls below this standard over 20 per cent. in any one branch or over 10 per cent. in the total.

It is believed that the adoption of this standard will not only satisfy the demands of many state medical examining and licensing boards, but will subserve the interest of higher medical education.

Respectfully submitted,

(Signed) GEORGE M. KOBER,
WILLIAM J. MEANS,
PARKS RITCHIE.

Dr. Eli H. Long moved that the report, as read, be accepted and adopted. Seconded by Dr. Reyburn.

Dr. H. W. Loeb offered as an amendment to the motion, that colleges be permitted to substitute laboratory and clinic hours for didactic hours. Seconded by Dr. Hall.

Figure 4. Curriculum requirements for AAMC membership.
Details of the curriculum structure needed by AAMC member institutions and AMA-approved medical schools in the early 20th century. By the mid-1920s adherence to these restrictive requirements led to major homogenization of the MD curriculum at most U.S. medical schools. As a result, both the AAMC and AMA Council on Medical Education relaxed details of hours for teaching each subject, but lists of subjects to be included in the curriculum persisted as a mainstay of accreditation standards in later decades. Source: *Association of American Medical Colleges Minutes of Fifteenth Annual Meeting* (Chicago, IL: American Medical Association Press, 1905).

Equipment

At the 1908 AAMC meeting, the organization adopted an equipment requirement for medical schools, based on a report by Secretary Fred Zapffe on the essential equipment needs for medical education. The requirement was incorporated in the 1910 bylaws "as a tentative working basis for further development." It included not only physical equipment but statements about student clinical experiences. Thus, inpatient clinics were expected to provide at least two beds (equivalent to 16 patients) for each senior student, dispensaries had to provide at least 50 patients per senior student, and senior students also had to have access to at least five obstetric cases. Cadavers and living animals needed to be available for learning operative surgery; for clinical diagnosis instruction, schools were expected to have equipment for examining "exudates, secretions, excretions, blood and tissues." An accessible, cataloged library was required with at least one publication on general medicine and one publication devoted to the work of each medical school department. Schools needed to maintain a museum that included anatomic, pathologic, and embryological specimens in addition to items such as charts, models, and bones. For anatomy instruction, each student was required to dissect at least one lateral half of the human body. Each basic science subject also included a list of required equipment.[140]

In closing, it should be noted that the AAMC's efforts to establish and update these requirements for membership did not occur in isolation. There was close collaboration with the national organizations for state medical boards, noted in the proceedings of the AAMC's annual meetings. There was also a keen awareness of the work being done by the AMA CME. Representatives of the AAMC had attended initial meetings of the CME in 1905, and the 1906 report of the Committee on Medical Education to the AAMC membership rather boldly stated, "The Council on Medical Education of the American Medical Association apparently also appreciated the work done by this association [the AAMC], because they adopted, in part, its requirements."[141]

AMA Standards Before the 1910 Adoption of *Essentials of an Acceptable Medical School*

Revival of the AMA's interest in medical education became clear in the 1903 report of its Committee on Medical Education, which acknowledged that the organization had "lost sight of" its founding purpose of elevating medical education. However, the committee also felt that the structural reorganization of the AMA by way of its representative House of Delegates provided an opportunity to return to its roots: "With the new reorganization of the Association into a compact representative body, representing the medical profession of each county and state, your committee feel that the American Medical Association has become the best national instrument to supervise and elevate medical education."[142] The committee did acknowledge the contemporaneous work of other organizations, including the AAMC. The committee's recommendations for standards to elevate medical education were rather simple: a high school education sufficient to allow a student to pass university entrance examinations and a four-year medical course of at least seven months in each year.

One of the first formal actions of the CME after its creation was the recommendation in 1905 for both an aspirational ideal standard of medical education and a more pragmatic version that could be applied immediately. The two versions were not greatly different, and like the AMA's original standards,

they covered premedical requirements and the medical curriculum. The practical standard contained five basic elements:

1. A high school education or its equivalent, such as would admit the student to a recognized university (similar to the language of the ideal standard, which did not, however, specify a high school education)
2. Verification of the premedical requirement by a state official and by an official of the medical college (the ideal standard required only verification by state authorities)
3. Four years of medical college training, with not less than 30 weeks in each year and 30 hours of work in each week (the ideal standard envisioned an overall program of six years, consisting of one year devoted to physics, chemistry, and biology offered in a school of liberal arts or by the medical school; a four-year graded medical curriculum with two years of laboratory-based basic science followed by two years of clinical study; and a sixth year internship in a hospital or dispensary)
4. Graduation from an approved medical college entitling the candidate to an examination before a state examining board (no such requirement was mentioned in the ideal standard)
5. Passing of a satisfactory examination before a state examining board (also not mentioned in the ideal standard)[143]

The recommendations of the CME were approved by the House of Delegates. At the 1906 AMA meeting, the council recommended, and the AMA approved, an additional standard requiring a year of study between high school and medical school devoted to physics, chemistry, biology, and languages (as originally suggested in the ideal standard). The council's report noted that a resolution embodying such a provision was adopted by the National Confederation of State Medical Examining and Licensing Boards.

When the CME began its program of medical school inspections in 1906, it used a 10-point scheme for evaluating the schools, with each of the 10 items scored on a 1–10 scale. The 10-point scheme as described in the 1907 AMA proceedings addressed the following:

1. Success of graduates before the examination boards
2. Standards and enforcement of entrance requirements
3. The general character and extent of the medical curriculum
4. Medical school buildings
5. Laboratory facilities and instruction
6. Dispensary facilities and instruction
7. Hospital facilities and instruction
8. Extent to which the first two years of the medical curriculum are offered by men devoting their time to teaching and the evidences of original research
9. Extent to which the medical school is conducted as an institution for teaching medicine rather than as a means for the profit of the faculty
10. Owning of a library, museum, charts, models, etc.[144]

While this 10-point system addressed the requirements of the educational standards that had been approved by the AMA (specifically, the first three items), it also incorporated several facilities requirements that would appear in the equipment standard proposed by the AAMC in 1908.

Chapter 7

Changes in AAMC Membership Requirements, 1908–1952

As mentioned in the preceding chapter, AAMC membership criteria, established in the organization's original constitution and bylaws, focused on the entrance requirements for medical school admission and the organization of the MD curriculum. Attendance and graduation requirements were added in 1907, and an equipment standard was adopted in 1908. Over the course of the next decade, the AAMC modified its admissions and curriculum requirements and added a new clinical equipment standard. Eventually the membership requirements would be whittled down so that—by the time the LCME began to function—AAMC expectations had been scaled back to minimal general statements about admissions and curriculum.

Entrance Requirements

In 1911 the AAMC admission requirements were revised to require that the applicant provide certification from an appropriate authority (a state licensing board, the academic department of a state university, or an accredited university or college) that the applicant met all premedical course requirements established in the AAMC constitution. Previously, schools were expected to verify the applicant's credentials but were not mandated to obtain certification of those credentials.

The minimum entrance requirements stated in the 1911 constitution included (1) a baccalaureate degree from an accredited college or university; (2) a diploma from a high school or equivalent documenting completed course work in mathematics, physics, history, English, and Latin (French or German could be substituted for the Latin requirement if a student demonstrated proficiency on a written Latin exam); and (3) successful completion of an examination covering those subjects and other, elective areas, administered by a state medical examining board or comparable alternative.[145]

The 1914 revision to the constitution modified the high school subject requirements, dropping the Latin requirement and adding course work in biology and chemistry, as well as French or German; the entrance examination included math, English, a foreign language, and history, in addition to elective subjects. In lieu of a baccalaureate degree, the constitution now required a minimum of one college year at least 32 weeks in length, with instruction in biology, chemistry, physics, and either German or French.[146] The language requirement could be waived if the student demonstrated comparable levels of high school study.

The requirement for college preparation was modified slightly in 1919 to include at least 60 semester hours of work (two college years), with required instruction in biology, chemistry, physics, and English composition and literature. Course work chosen from psychology, comparative vertebrate anatomy, social science, and a modern foreign language was recommended.[147]

High school requirements were eliminated in 1925, when the AAMC bylaws stipulated only those college subjects that were necessary (by successful completion of course work or examination) for entrance to medical school.[148] Mandatory subjects remained the same, although chemistry was now differentiated into separate requirements for general chemistry and organic chemistry. The bylaws also provided greater detail about the specific fields that were deemed necessary (e.g., general biology or zoology) or not acceptable (e.g., entomology). The bylaws no longer identified recommended course work. By 1932 the AAMC bylaws simplified the entrance requirements, stating only that college study must include no less than two academic years and encompass English as well as theoretical and practical courses in biology, general chemistry, organic chemistry, and physics.[149] Those entrance requirements would remain in force until a 1952 bylaws change that established a period of three to four years of college (while allowing superior students the possibility of meeting the prerequisites in two years).[150]

Curriculum

The original curriculum requirements described in the 1907 constitution and bylaws of the AAMC set a total number of hours for the curriculum at 4,000 and delineated the number of hours for each required subject, broken down by teaching method (lecture, lab, or clinical). The first change to this scheme took place in 1911, when the required subjects were reorganized into seven divisions, with each division allotted a percentage of overall curriculum time and a specific number of hours.[151] Within any division, the hours available for each course were further broken down by teaching method. The divisions resulting from this organizational structure are listed below:

Division 1 (720 hours, 18%): Anatomy, including
- Gross anatomy
- Histology and microscopic anatomy
- Embryology

Division 2 (600 hours, 15%): Physiology and Chemistry, including
- Inorganic chemistry
- Organic chemistry
- Physiologic chemistry
- Physiology

Division 3 (450 hours, 11.25%): Pathology, Bacteriology, and Hygiene, including
- Bacteriology
- Hygiene and general dietetics
- Pathology

Division 4 (240 hours, 6%): Pharmacology, Materia Medica, and Therapeutics, including
- Pharmacology
- Materia medica and pharmacology
- Therapeutics

Division 5 (970 hours, 24.25%): Medicine and Medical Specialties, including
- General medicine, including clinical microscopy
- Pediatrics
- Nervous and mental diseases
- Jurisprudence, ethics, and economics
- Dermatology and syphilis

Division 6 (720 hours, 18%): Surgery and Surgical Specialties, including
- General surgery
- Orthopedic surgery
- Genitourinary diseases
- Eye
- Ear, nose, and throat

Division 7 (300 hours, 7.5%): Obstetrics and Gynecology, including
- Obstetrics
- Gynecology, including some abdominal surgery

The most notable change in the 1936 revision was the elimination of all references to curriculum hours, both for the curriculum as a whole and for individual subjects.

While the overall length of the curriculum remained the same at 4,000 hours, the amount of time reserved for the specific subjects varied from the allotments established in the 1907 constitution. The 1911 constitution allowed schools to reduce contact hours in any particular subject by as much as 20% as long as the total number of hours for the division did not change. They also allowed for subjects to be transferred between divisions and for lab hours to be substituted for didactic hours within a subject.

The next substantive change in AAMC curriculum requirements appeared in the 1919 constitution and bylaws. In this version, the divisional structure remained the same, but the total number of required hours was reduced from 4,000 to 3,600. The reduction was generally proportional for each division, with the largest decrease in Division 2 (from 15% to 13% of total curriculum hours) and the largest increase in Division 3 (from 11.25% to 13%). Specification of hours for subjects within each division was replaced by the use of percentages; the previous allowance for up to a 20% reduction of time for subjects within a division was eliminated. Some of the identified subjects within divisions were simplified. Division 2 in the new scheme, for example, consisted simply of physiology and biochemistry. Notable new topics listed in the 1919 document were preventive medicine and public health, added to Division 3, and roentgenology, added to Division 6. Ethics and economics were no longer mentioned in relation to Division 5.[152]

Curriculum requirements were liberalized a little more in the 1923 AAMC constitution and bylaws. The overall length of the curriculum was now specified as a range (3,600–4,400 hours) rather than a fixed amount, with a range of 900–1,100 hours allowed for each year within the curriculum. The 1923 revision also reorganized the divisions, splitting Division 2 into two separate divisions, one each for

biochemistry and physiology. Similarly, the subject of hygiene and sanitation was broken out into a separate division from its original locus within Division 3. Each division was now allocated a range of total curriculum time, as follows:

Division 1. Anatomical Sciences: 14%–18.5%
Division 2. Physiology): 4.5%–6%
Division 3. Biochemistry: 3.5%–4.5%
Division 4. Pathology, Bacteriology, and Immunology: 10%–13%
Division 5. Pharmacology: 4%–5%
Division 6. Hygiene and Sanitation: 3%–4%
Division 7. General Medicine (Pediatrics, Neurology and Psychiatry, Dermatology, and Syphilis): 20%–26.5%
Division 8. General Surgery and Surgical Specialties: 13%–17.5%
Division 9. Obstetrics and Gynecology: 4%–5%

Jurisprudence was no longer mentioned as a subject within the general topic of medicine, but otherwise the content within divisions remained the same. The range of curriculum time summed across all divisions now varied between 76% and 100%. Schools now had the option of substituting elective courses if they chose to use less than the maximum percentage within any division, thus allowing as much as 24% of the curriculum to be reserved for electives.[153]

In 1925 the AAMC added a statement in its bylaws regarding a combined six-year curriculum, which included the course prerequisites from the college years as well as the medical school curriculum outlined earlier in those bylaws.

These requirements remained in place until 1936, when the bylaws were amended to broaden the standards related to the MD curriculum. The most notable change in the 1936 revision was the elimination of all references to curriculum hours, both for the curriculum as a whole and for individual subjects. The divisional organization of topics was replaced by a simple listing of subjects to be included in the curriculum, which was expected to span a period of at least four academic years. The subjects remained largely the same as before, with a few additions: psychobiology and anesthesia were added as new topics, and physical therapy was added to the study of therapeutics.

In addition to the simplification of content coverage, the 1936 bylaws also introduced language about the goal of the curriculum:

> The entire course [of study] should be designed to train the student in the practice of medicine, including the cultivation of health and the prevention and treatment of disease.
>
> The main purpose of the undergraduate curriculum should be to provide the student with a sound foundation in the fundamentals of medicine on which he can build in the future in general or special practice or in scientific investigation. He should have acquired such habits of mind and thought that in addition to profiting by his professional

> experience, he will continue to educate himself throughout his life. By the end of undergraduate medical courses the student should have matured sufficiently to assume the responsible duties of his profession.[154]

No further changes to the AAMC curriculum requirements occurred until 1948, when the bylaws were modified to remove references to any specific subjects. The bylaws simply stated that the curriculum should extend over a period of at least four academic years. The statements about the goals of the curriculum remained the same.

Equipment

While AAMC standards for membership always addressed entrance requirements and curriculum, they also covered other topics at various times. As noted in Chapter 6, the AAMC adopted a general equipment requirement in the 1908 version of the constitution and bylaws, followed by an additional section for clinical equipment included in 1914. The clinical equipment standard set the following minimum requirements:

- A general hospital owned or controlled by the medical school, with an average daily inpatient census of at least 100 and facilities for clinical teaching
- A dispensary or outpatient department with at least 40 visits daily and at least 120 visits available for junior and senior students across the school year
- At least one competent instructor for every six students
- Rooms, equipment, and facilities for microscopic, chemical, and bacteriologic examination of clinical material
- Rooms and equipment for X-ray work and electrotherapeutics
- Equipment and materials for operative surgery on cadavers and animals
- Sufficient facilities to allow each student to assist in at least six major operations and administer anesthesia at least six times under appropriate supervision
- Clinical facilities that allow each senior student to witness at least 12 obstetrical confinement cases (under appropriate supervision) and to have entire charge of at least 3 of those 12 cases before, during, and after labor (again, under proper supervision)
- Equipment and facilities that allow each student to observe and participate in at least 12 complete autopsies
- A working medical library with modern texts and reference books, the *Index Medicus*, and 30 or more leading periodicals representing the major clinical disciplines[155]

Both the general equipment standard and the clinical equipment standard were eliminated from AAMC bylaws in the 1919 revision.

Student Records, Attendance, and Grading

The AAMC constitution and bylaws established expectations for student records in 1903; an attendance requirement and grading scheme were added in 1907 (see Chapter 6). In the 1919 bylaws, the language about attendance and a grading system was eliminated, and the section on student records no longer specified the grades to be included on the student transcript. The requirement for maintaining student records was eliminated in 1925.

Catalog

In 1919 the AAMC amended its bylaws to add a new requirement that member medical schools publish an annual catalog or equivalent material, to include the following:

- The academic calendar for that year
- A list of the members of the board of trustees, with occupations and terms of office listed
- A list of faculty members, with rank
- A brief history of the institution and an overview of its organizational structure
- A summary of the institution's equipment
- A financial statement showing institution income, expenditures, and revenue sources
- Requirements for admission and advanced standing
- Rules for student promotion and requirements for graduation
- Student fees and expenses, as well as scholarships and other financial aid
- State examining board requirements
- An overview of the curriculum, including a brief description of each required course
- A list of the previous year's graduates, including any honors or prizes awarded
- A list of enrolled students[156]

The catalog requirement was short-lived, however, and was eliminated in 1925.

Chapter 8

Evolution of the AMA's *Essentials of an Acceptable Medical School*

The observations obtained from CME inspections of medical schools in 1906 and 1910 provided the basis for development of the AMA's first formal statement of the minimum requirements needed to qualify as an approved medical school. The statement was presented to the House of Delegates with the title of *Essentials of an Acceptable Medical College* (*Essentials*), outlining "in the majority of points a line considerably below the average of conditions existing in all the colleges of the United States and Canada."[157]

This first version of *Essentials,* like earlier AMA standards, addressed admissions requirements and details of the educational program; it also included statements about student records and educational facilities, similar to the AAMC's membership requirements of the period (see Figures 5a and 5b). New topics included in the first *Essentials* addressed medical school leadership, the faculty, and informational materials. The standards also incorporated and expanded upon the 10-point scheme that had been used to classify medical colleges in the CME inspection program.

Essentials listed 25 separate requirements, summarized as follows:

1. Each college to enforce all AMA standards and requirements and be held responsible for any instances where those standards and requirements are not enforced

2–3. Medical school admissions requirements, specifying a four-year high school education superimposed on eight years of grammar school work and an expansion of that requirement to include at least one year of college work in physics, chemistry, biology, and a modern foreign language, "as soon as conditions warrant"

4–5. Attendance requirements for enrolled students, including no credit be given for less than 80% attendance for any course (with an exception for good cause such as sickness)

6. Terms for admissions with advanced standing, available only to students of other acceptable colleges

7. Leadership of the college to fall under a dean or other executive officer with the authority to carry out fair ideals of medical education

8. Student records reflecting credentials, attendance, grades, and accounts

9–11. Curriculum requirements, including a graded curriculum over four years, with 30 weeks per year and 30 hours per week, documented in a printed schedule of lectures and classes two years of lab work in all of the basic sciences two years of clinical work largely in hospitals and dispensaries, covering all of the major clinical disciplines (both generalist and specialty), as well as hygiene and medical jurisprudence

12–14. Faculty and teaching quality, including at least six salaried, expert instructors in the laboratory branches devoted to instruction and research; provisions that these instructors rank sufficiently high to have some voice in the college and be provided with enough assistants in each department to look after less important details; that medical teaching should be comparable in quality to that seen in liberal arts colleges and technical schools; and that there be minimum qualifications for faculty members, specifically graduation from recognized medical colleges, training in all medical departments, and an ability to teach

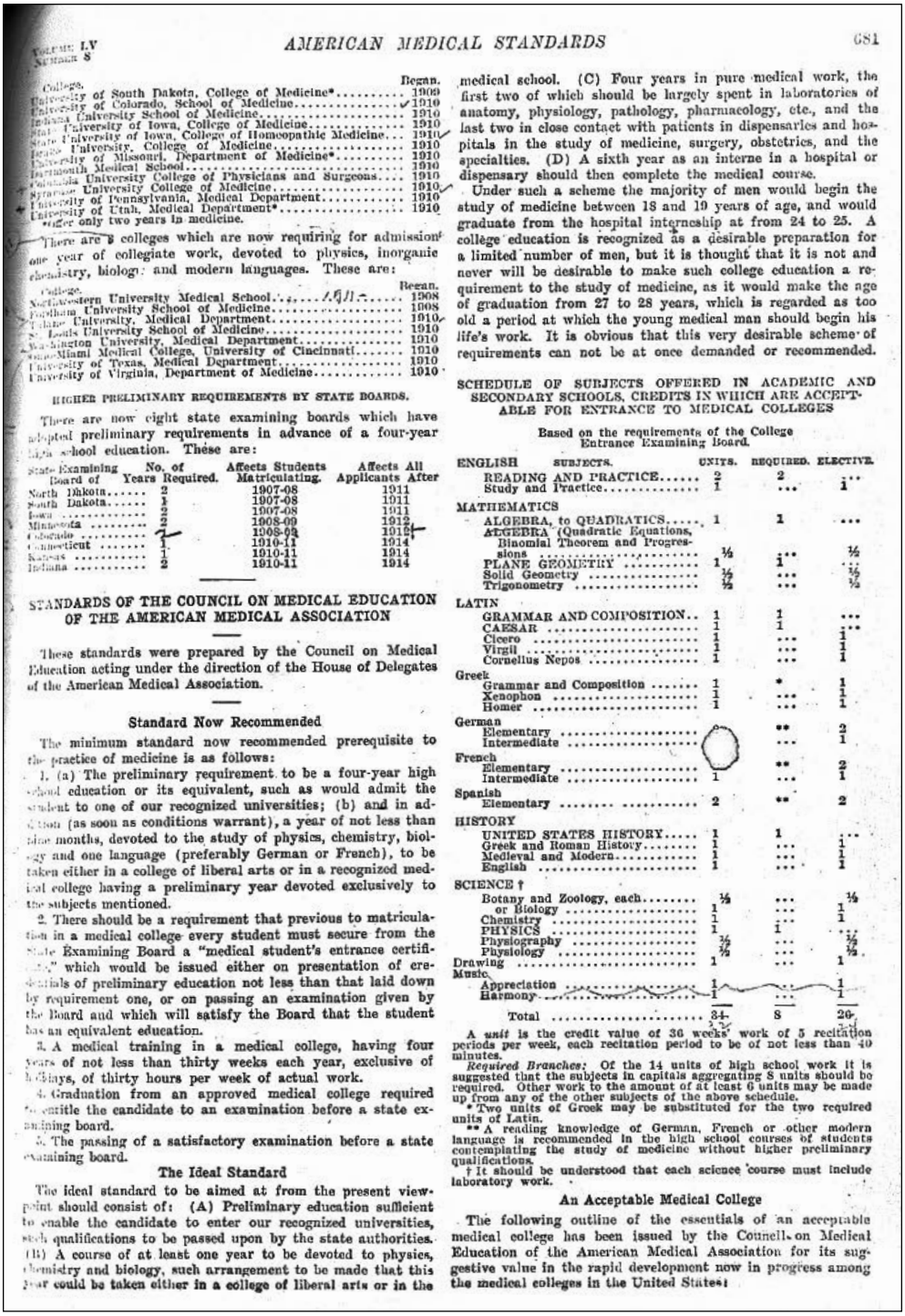
15–17. Hospital facilities, owned or operated by the college, with a sufficiently large patient census to permit students to see and study common surgical and medical cases as well as "a fair number" in each specialty; easily accessible hospital facilities for not less than 200 patients usable for clinical teaching, to accommodate 100 or fewer students, with conditions representing all medical departments; and additional hospital facilities for "children's diseases, contagious diseases, and nervous and mental diseases"

18–19. Specific clinical conditions to be seen by students: at least five maternity cases per student, with the student responsible for patient care under the supervision of an attending physician, and 30 autopsies (for 100 or fewer students)

20. Outpatient facilities, controlled by the college, with a daily average of at least 60 cases per 100 or fewer students

21–24. Educational facilities and equipment, including a medical library, medical museum, appropriate teaching apparatus, and evidence that equipment and facilities are being used in medical student education

25. A published catalog to include requirements for admission, tuition, attendance, a list of matriculated students, and the most recent graduating class[158]



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College.	Began.
University of South Dakota, College of Medicine*	1909
University of Colorado, School of Medicine	1910
Indiana University School of Medicine	1910
State University of Iowa, College of Medicine	1910
State University of Iowa, College of Homeopathic Medicine	1910
Tulane University, College of Medicine	1910
University of Missouri, Department of Medicine*	1910
Dartmouth Medical School	1910
Columbia University College of Physicians and Surgeons	1910
Syracuse University College of Medicine	1910
University of Pennsylvania, Medical Department	1910
University of Utah, Medical Department*	1910

*Offer only two years in medicine.

There are 8 colleges which are now requiring for admission one year of collegiate work, devoted to physics, inorganic chemistry, biology and modern languages. These are:

College.	Began.
Northwestern University Medical School	1908
Fordham University School of Medicine	1908
Idaho University, Medical Department	1910
St. Louis University School of Medicine	1910
Washington University, Medical Department	1910
Miami Medical College, University of Cincinnati	1910
University of Texas, Medical Department	1910
University of Virginia, Department of Medicine	1910

HIGHER PRELIMINARY REQUIREMENTS BY STATE BOARDS.

There are now eight state examining boards which have adopted preliminary requirements in advance of a four-year high school education. These are:

State Examining Board of	No. of Years Required.	Affects Students Matriculating.	Affects All Applicants After
North Dakota	2	1907-08	1911
South Dakota	1	1907-08	1911
Iowa	2	1907-08	1911
Minnesota	2	1908-09	1912
Colorado	1	1908-09	1912
Connecticut	1	1910-11	1914
Kansas	1	1910-11	1914
Indiana	2	1910-11	1914

STANDARDS OF THE COUNCIL ON MEDICAL EDUCATION OF THE AMERICAN MEDICAL ASSOCIATION

These standards were prepared by the Council on Medical Education acting under the direction of the House of Delegates of the American Medical Association.

Standard Now Recommended

The minimum standard now recommended prerequisite to the practice of medicine is as follows:

1. (a) The preliminary requirement to be a four-year high school education or its equivalent, such as would admit the student to one of our recognized universities; (b) and in addition (as soon as conditions warrant), a year of not less than nine months, devoted to the study of physics, chemistry, biology and one language (preferably German or French), to be taken either in a college of liberal arts or in a recognized medical college having a preliminary year devoted exclusively to the subjects mentioned.

2. There should be a requirement that previous to matriculation in a medical college every student must secure from the State Examining Board a "medical student's entrance certificate," which would be issued either on presentation of credentials of preliminary education not less than that laid down by requirement one, or on passing an examination given by the Board and which will satisfy the Board that the student has an equivalent education.

3. A medical training in a medical college, having four years of not less than thirty weeks each year, exclusive of holidays, of thirty hours per week of actual work.

4. Graduation from an approved medical college required to entitle the candidate to an examination before a state examining board.

5. The passing of a satisfactory examination before a state examining board.

The Ideal Standard

The ideal standard to be aimed at from the present viewpoint should consist of: (A) Preliminary education sufficient to enable the candidate to enter our recognized universities, such qualifications to be passed upon by the state authorities. (B) A course of at least one year to be devoted to physics, chemistry and biology, such arrangement to be made that this year could be taken either in a college of liberal arts or in the medical school. (C) Four years in pure medical work, the first two of which should be largely spent in laboratories of anatomy, physiology, pathology, pharmacology, etc., and the last two in close contact with patients in dispensaries and hospitals in the study of medicine, surgery, obstetrics, and the specialties. (D) A sixth year as an interne in a hospital or dispensary should then complete the medical course.

Under such a scheme the majority of men would begin the study of medicine between 18 and 19 years of age, and would graduate from the hospital internship at from 24 to 25. A college education is recognized as a desirable preparation for a limited number of men, but it is thought that it is not and never will be desirable to make such college education a requirement to the study of medicine, as it would make the age of graduation from 27 to 28 years, which is regarded as too old a period at which the young medical man should begin his life's work. It is obvious that this very desirable scheme of requirements can not be at once demanded or recommended.

SCHEDULE OF SUBJECTS OFFERED IN ACADEMIC AND SECONDARY SCHOOLS, CREDITS IN WHICH ARE ACCEPTABLE FOR ENTRANCE TO MEDICAL COLLEGES

Based on the requirements of the College Entrance Examining Board.

ENGLISH — SUBJECTS.	UNITS.	REQUIRED.	ELECTIVE.
READING AND PRACTICE	2	2	...
Study and Practice	1	...	1
MATHEMATICS			
ALGEBRA, to QUADRATICS	1	1	...
ALGEBRA (Quadratic Equations, Binomial Theorem and Progressions	½	...	½
PLANE GEOMETRY	1	1	...
Solid Geometry	½	...	½
Trigonometry	½	...	½
LATIN			
GRAMMAR AND COMPOSITION	1	1	...
CAESAR	1	1	...
Cicero	1	...	1
Virgil	1	...	1
Cornelius Nepos	1	...	1
Greek			
Grammar and Composition	1	*	1
Xenophon	1	...	1
Homer	1	...	1
German			
Elementary	2	**	2
Intermediate	1	...	1
French			
Elementary	2	**	2
Intermediate	1	...	1
Spanish			
Elementary	2	**	2
HISTORY			
UNITED STATES HISTORY	1	1	...
Greek and Roman History	1	...	1
Medieval and Modern	1	...	1
English	1	...	1
SCIENCE †			
Botany and Zoology, each, or Biology	½	...	½
Chemistry	1	...	1
PHYSICS	1	1	...
Physiography	½	...	½
Physiology	½	...	½
Drawing	1	...	1
Music			
Appreciation	1	...	1
Harmony	1	...	1
Total	34	8	26

A *unit* is the credit value of 36 weeks' work of 5 recitation periods per week, each recitation period to be of not less than 40 minutes.

Required Branches: Of the 14 units of high school work it is suggested that the subjects in capitals aggregating 8 units should be required. Other work to the amount of at least 6 units may be made up from any of the other subjects of the above schedule.

* Two units of Greek may be substituted for the two required units of Latin.

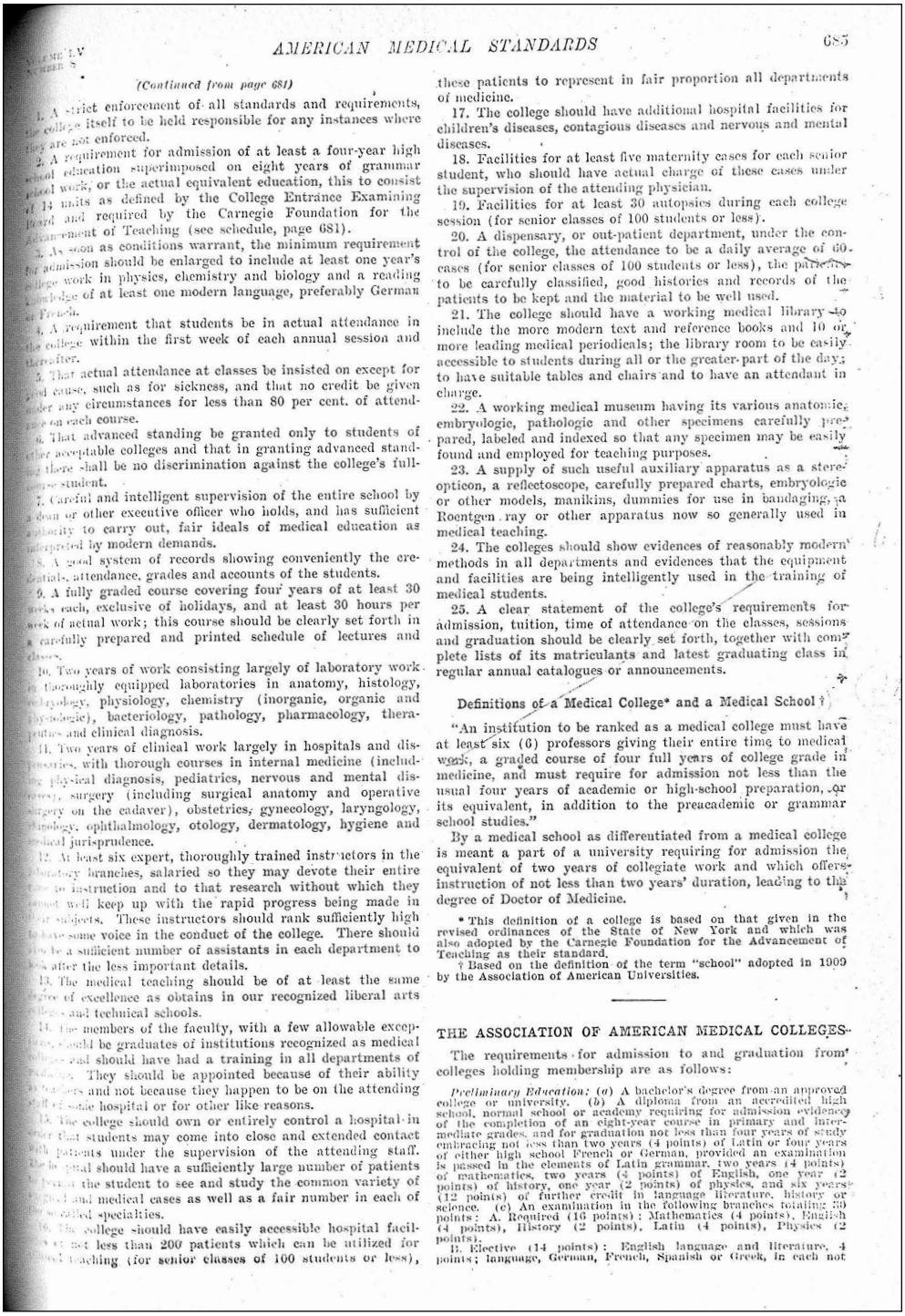
** A reading knowledge of German, French or other modern language is recommended in the high school courses of students contemplating the study of medicine without higher preliminary qualifications.

† It should be understood that each science course must include laboratory work.

An Acceptable Medical College

The following outline of the essentials of an acceptable medical college has been issued by the Council on Medical Education of the American Medical Association for its suggestive value in the rapid development now in progress among the medical colleges in the United States:

Figure 5a. ***Essentials of an Acceptable Medical College*, page 681.**
Standards for the evaluation of medical schools developed by the AMA's Council on Medical Education. They were first published as *Essentials of an Acceptable Medical College* in 1910 and periodically revised over a period of nearly half a century. The last version of *Essentials of an Acceptable Medical School* (the name changed in 1927) was adopted in 1951 and continued in use until 1957, when the LCME developed *Functions and Structure of a Modern Medical School* as the common statement of accreditation standards approved by both the AMA and the AAMC. Source: *Journal of the American Medical Association* (August 1910): 681.



AMERICAN MEDICAL STANDARDS 685

(Continued from page 681)

1. A strict enforcement of all standards and requirements, the college itself to be held responsible for any instances where they are not enforced.

2. A requirement for admission of at least a four-year high school education superimposed on eight years of grammar school work, or the actual equivalent education, this to consist of 14 units as defined by the College Entrance Examining Board and required by the Carnegie Foundation for the Advancement of Teaching (see schedule, page 681).

3. As soon as conditions warrant, the minimum requirement for admission should be enlarged to include at least one year's college work in physics, chemistry and biology and a reading knowledge of at least one modern language, preferably German or French.

4. A requirement that students be in actual attendance in the college within the first week of each annual session and thereafter.

5. That actual attendance at classes be insisted on except for good cause, such as for sickness, and that no credit be given under any circumstances for less than 80 per cent. of attendance on each course.

6. That advanced standing be granted only to students of other acceptable colleges and that in granting advanced standing there shall be no discrimination against the college's full-course student.

7. Careful and intelligent supervision of the entire school by a dean or other executive officer who holds, and has sufficient authority to carry out, fair ideals of medical education as interpreted by modern demands.

8. A good system of records showing conveniently the credentials, attendance, grades and accounts of the students.

9. A fully graded course covering four years of at least 30 weeks each, exclusive of holidays, and at least 30 hours per week of actual work; this course should be clearly set forth in a carefully prepared and printed schedule of lectures and classes.

10. Two years of work consisting largely of laboratory work in thoroughly equipped laboratories in anatomy, histology, embryology, physiology, chemistry (inorganic, organic and physiologic), bacteriology, pathology, pharmacology, therapeutics and clinical diagnosis.

11. Two years of clinical work largely in hospitals and dispensaries, with thorough courses in internal medicine (including physical diagnosis, pediatrics, nervous and mental diseases), surgery (including surgical anatomy and operative surgery on the cadaver), obstetrics, gynecology, laryngology, rhinology, ophthalmology, otology, dermatology, hygiene and medical jurisprudence.

12. At least six expert, thoroughly trained instructors in the laboratory branches, salaried so they may devote their entire time to instruction and to that research without which they cannot well keep up with the rapid progress being made in their subjects. These instructors should rank sufficiently high to have some voice in the conduct of the college. There should also be a sufficient number of assistants in each department to look after the less important details.

13. The medical teaching should be of at least the same degree of excellence as obtains in our recognized liberal arts colleges and technical schools.

14. The members of the faculty, with a few allowable exceptions, should be graduates of institutions recognized as medical colleges and should have had a training in all departments of medicine. They should be appointed because of their ability as teachers and not because they happen to be on the attending staff of some hospital or for other like reasons.

15. The college should own or entirely control a hospital in order that students may come into close and extended contact with patients under the supervision of the attending staff. The hospital should have a sufficiently large number of patients to permit the student to see and study the common variety of clinical and medical cases as well as a fair number in each of the so-called specialties.

16. The college should have easily accessible hospital facilities of not less than 200 patients which can be utilized for clinical teaching (for senior classes of 100 students or less), these patients to represent in fair proportion all departments of medicine.

17. The college should have additional hospital facilities for children's diseases, contagious diseases and nervous and mental diseases.

18. Facilities for at least five maternity cases for each senior student, who should have actual charge of these cases under the supervision of the attending physician.

19. Facilities for at least 30 autopsies during each college session (for senior classes of 100 students or less).

20. A dispensary, or out-patient department, under the control of the college, the attendance to be a daily average of 60 cases (for senior classes of 100 students or less), the patients to be carefully classified, good histories and records of the patients to be kept and the material to be well used.

21. The college should have a working medical library to include the more modern text and reference books and 10 or more leading medical periodicals; the library room to be easily accessible to students during all or the greater part of the day; to have suitable tables and chairs and to have an attendant in charge.

22. A working medical museum having its various anatomic, embryologic, pathologic and other specimens carefully prepared, labeled and indexed so that any specimen may be easily found and employed for teaching purposes.

23. A supply of such useful auxiliary apparatus as a stereopticon, a reflectoscope, carefully prepared charts, embryologic or other models, manikins, dummies for use in bandaging, a Roentgen ray or other apparatus now so generally used in medical teaching.

24. The colleges should show evidences of reasonably modern methods in all departments and evidences that the equipment and facilities are being intelligently used in the training of medical students.

25. A clear statement of the college's requirements for admission, tuition, time of attendance on the classes, sessions and graduation should be clearly set forth, together with complete lists of its matriculants and latest graduating class in regular annual catalogues or announcements.

Definitions of a Medical College* and a Medical School†

"An institution to be ranked as a medical college must have at least six (6) professors giving their entire time to medical work, a graded course of four full years of college grade in medicine, and must require for admission not less than the usual four years of academic or high-school preparation, or its equivalent, in addition to the preacademic or grammar school studies."

By a medical school as differentiated from a medical college is meant a part of a university requiring for admission the equivalent of two years of collegiate work and which offers instruction of not less than two years' duration, leading to the degree of Doctor of Medicine.

* This definition of a college is based on that given in the revised ordinances of the State of New York and which was also adopted by the Carnegie Foundation for the Advancement of Teaching as their standard.

† Based on the definition of the term "school" adopted in 1909 by the Association of American Universities.

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The requirements for admission to and graduation from colleges holding membership are as follows:

Preliminary Education: (*a*) A bachelor's degree from an approved college or university. (*b*) A diploma from an accredited high school, normal school or academy requiring for admission evidence of the completion of an eight-year course in primary and intermediate grades, and for graduation not less than four years of study embracing not less than two years (4 points) of Latin or four years of either high school French or German, provided an examination is passed in the elements of Latin grammar, two years (4 points) of mathematics, two years (4 points) of English, one year (2 points) of history, one year (2 points) of physics, and six years (12 points) of further credit in language literature, history or science. (*c*) An examination in the following branches totaling 30 points: A. Required (16 points): Mathematics (4 points), English (4 points), History (2 points), Latin (4 points), Physics (2 points).

B. Elective (14 points): English language and literature, 4 points; language, German, French, Spanish or Greek, in each not

Figure 5b. ***Essentials of an Acceptable Medical College,*** **page 685.**
Standards for the evaluation of medical schools developed by the AMA's Council on Medical Education. They were first published as *Essentials of an Acceptable Medical College* in 1910 and periodically revised over a period of nearly half a century. The last version of *Essentials of an Acceptable Medical School* (the name changed in 1927) was adopted in 1951 and continued in use until 1957, when the LCME developed *Functions and Structure of a Modern Medical School* as the common statement of accreditation standards approved by both the AMA and the AAMC. Source: *Journal of the American Medical Association* (August 1910): 685.

Comparison of *Essentials* with contemporaneous AAMC membership requirements, as articulated in the AAMC's 1910 constitution and bylaws, discloses numerous similarities between the two. The AAMC had adopted comparable admission requirements, albeit with much greater specificity in terms of the subjects in which candidates needed to demonstrate achievement; also, the AAMC made no mention of an expanded admissions requirement for a year of college-level course work in sciences or foreign languages. The AAMC requirement on advanced-standing admissions and transfers was also much more detailed and included a clause precluding transfers during the fourth year of study. Both documents stipulated an attendance requirement with a threshold of 80% attendance, but the AAMC also maintained a requirement that students obtain at least a 70% grade to receive credit for any course.

The AAMC minimum for curriculum length was based on four academic years of 32 weeks rather than the 30 weeks specified in *Essentials*. The AAMC and AMA generally required the same subjects to be taught in the curriculum, yet the AAMC requirements went further in specifying minimum numbers of contact hours by teaching type; the only notable differences in content were AAMC requirements for instruction in genitourinary diseases (60 hours), electrotherapeutics (60 hours), and dietetics (30 hours).

On the matter of clinical conditions and teaching facilities, the AAMC required two beds per student in the hospital (equivalent to the *Essentials* requirement of 200 beds for each 100 or fewer students) but only 50 patients (compared with 60 in *Essentials*) for learning in the dispensary. The standards of both organizations required care for at least five maternity cases, but the AAMC did not have any requirement for observation of or participation in autopsies. In the AAMC membership requirements, equipment needs were described in much greater detail and were organized by course. The AAMC did not have any standards relating to the authority of the dean, student records, or published catalogs and was silent on faculty requirements and hospital ownership.

The publication of the first version of *Essentials* coincided with the publication of *Medical Education in the United States and Canada* (the Flexner Report) and was undoubtedly influenced not so much by the Flexner Report itself, but by the information collected during the round of medical inspections conducted by CME members with Abraham Flexner. It also seems likely that the content of *Essentials* took into account the AAMC membership requirements, given the general similarity between the two sets of standards. While the Flexner Report proved to be a landmark event in the history of medical schools and medical education, it had little demonstrable influence in subsequent years on the educational standards of the AMA. Apart from a modest revision in 1913, the *Essentials* approved in 1910 remained intact for another 17 years.

Later Revisions of *Essentials*

Apart from some mostly minor changes in language during the next few years, *Essentials* would not undergo appreciable modification until 1927. This major revision introduced a different format, with a prose structure and subject headings to guide the reader, as well as several new and revised standards.[159] This new version of *Essentials* did not remain intact for long, as the Council on Medical Education and Hospitals (CMEH) adopted a series of revisions from 1933 through 1938, likely influenced by the findings of the council's comprehensive inspection of medical schools in the early part of that period.

The most distinctive feature of the 1930s revisions was a new section of requirements on medical school governance. The 1933 revision changed the title of the document from *Essentials of an Acceptable Medical College* to *Essentials of an Acceptable Medical School.*

Essentials would undergo two more substantive revisions. The most notable feature of the 1945 revision was the inclusion of some broad statements about the purpose of medical education.[160] *Essentials* underwent one more revision in 1951, nine years after the origin of the LCME.[161] This version added several new requirements but also simplified or eliminated several of the statements contained in its predecessor. In terms of overall organization, the only notable change was the separation of facilities requirements, formerly clustered in a section on "Plant," into three distinct sections titled "Plant," "Library," and "Teaching Materials and Specimens."

Medical Student Standards

Like preceding versions, the 1927 update of *Essentials* focused on medical school admissions issues, under two separate headings: "High School Requirements" and "Premedical College Course." Little was new on high school requirements, apart from one that the medical school maintain a statement of attendance at the secondary school and a transcript of each enrolled medical student's work. The high school education requirement was eliminated entirely in the 1933 revision, although language about schools maintaining "documentary evidence of the student's preliminary education" continued in later versions.[162]

Much more detail was provided in the 1927 *Essentials* in its description of requirements for collegiate work. The original 1910 requirement for one year of college was expanded to 60 semester hours, spanning two years of 32 weeks each; in 1951, the minimum requirement increased to three years of college.

A minor 1912 revision of *Essentials* required chemistry, physics, biology, and a modern foreign language for the premedical curriculum of potential medical students. The 1927 version added English composition and literature and other nonscience subjects to the requirements, while several other subjects—a modern foreign language, advanced botany or zoology, psychology and logic, advanced mathematics, and additional chemistry courses—were strongly urged. Still other subjects (e.g., economics, history, sociology, Greek, Latin, and even drawing) were suggested as electives. The subjects of English, chemistry, physics, and biology would continue to be required through the final version of *Essentials* in 1951, but the list of recommended and elective topics was abandoned in the 1933 revision.

The 1927 *Essentials* added a new wrinkle concerning medical school admissions, namely that decisions about admissions "must be in the hands of a responsible committee or examiner whose records shall always be open for inspection." This requirement persisted through the final version of *Essentials.* The 1927 version reiterated an attendance requirement for students, by noting, "Actual attendance at classes should be insisted on except for good cause, such as for sickness, and no credit should be given for any course when the attendance has been less than 80 per cent of the full time."[163] The reader might recall that the AAMC had eliminated its student attendance requirement in 1919; *Essentials,* on the other hand, preserved the attendance requirement through its last iteration in 1951. In 1938, *Essentials* established for the first time a requirement that medical schools adopt "qualitative standards

for admission" in addition to subject and credit hour requirements.[164] That language was amplified in the 1951 version, which stated that "it is desirable that qualitative standards with reference to academic performance, character, motivation and health also be imposed."[165]

Requirements associated with student records were provided under the heading of "Supervision, Equipment, Teachers" in the 1927 revision of *Essentials* and in later revisions were listed under the heading "Administration." The requirements themselves did not change much from the 1910 version of *Essentials* and continued to focus on credentials, attendance, and grades. Later revisions preserved these elements, although the final revision in 1951 eliminated specific references to documentation of student attendance at hospitals, dispensaries, and maternity and postmortem cases.

Educational Program Standards

The original curriculum requirements in the 1910 version of *Essentials* were straightforward: a four-year curriculum consisting of two years with lab work in the basic sciences, followed by two years of clinical instruction in hospitals and dispensaries. (Note: While this "2+2" model of basic science and clinical education is often attributed to the Flexner Report and its explicit admiration for the European medical curriculum that employed such a design, the astute reader may recall from Chapter 1 that the AMA had promulgated study of the basic sciences before clinical learning as early as 1853.) The list of topics to be covered in this course work was extensive, although there were no specific requirements for the time devoted to any particular subject area. The 1912 revision of *Essentials* included a recommendation that the curriculum include a fifth, internship year provided under the supervision of the medical school.

When *Essentials* was revised in 1933 the list of curriculum topics was dropped, and the AMA simply adopted the schema as described in the AAMC constitution and bylaws, which included the subjects, and the percentage of total curricular time devoted to those subjects (details can be found in Chapter 6). That framework remained in place until 1945, when *Essentials* returned to a list of required topics, with no mention of the time needed for any of the topics. The 1945 list of subjects added instruction in several areas not mentioned in earlier versions, including neuroanatomy, psychobiology, physical medicine, and anesthesia. Medical jurisprudence had been eliminated as a required subject when the AMA adopted AAMC curriculum requirements in 1933.

> The final revision of *Essentials* in 1951 was the first to address the curriculum as a whole, noting that "the entire course should be designed as an integrated program of instruction."

While lists of subjects to be taught remained a staple element of *Essentials* throughout its many iterations, the 1945 revision introduced for the first time a series of statements about the purpose of the curriculum. Those statements codified the scope of medical education as training in the science, art, and practice of medicine, including the understanding and cultivation of health and the prevention and treatment of disease. The main purpose of the curriculum was to provide the student with a sound foundation in the fundamentals of medicine. *Essentials* acknowledged the continuum of medical

education through various assertions: "[The student] should have acquired such habits of mind and thought that in addition to profiting by his professional experience, he will continue to educate himself throughout his life" and "By the end of undergraduate medical courses the student should have matured sufficiently to assume the responsible duties of his profession."[166]

The 1910 *Essentials* established minimum medical student engagement in the study of certain clinical conditions, requiring students to participate in at least five maternity cases and have access to at least 30 autopsies for every 100 students. These were revised in 1927, with the number of maternity cases increasing to six. That number ramped up to 15 in the 1933 revision of *Essentials*, which also stipulated that students should now have access to 50 necropsies. By 1951 the number of maternity cases declined to six, and although the study of necropsy was still required in 1951, there was no longer a specification of how many were to be provided for students.

The final revision of *Essentials* in 1951 was the first to address the curriculum as a whole, noting that "the entire course should be designed as an integrated program of instruction." This version also entered new territory by introducing educational program evaluation as a requirement: "No rigid curriculum for accomplishing these objectives can be prescribed. On the contrary continuous study of the curriculum by the faculty with the introduction of modifications and new methods and materials to take proper cognizance of advances in medical science and changing conditions of medical practice is essential in the conduct of an acceptable medical school."[167]

Finally, the 1951 *Essentials* set expectations for pedagogy, with a focus on bedside instruction: "In the clinical years, there is no substitute for the 'case method' of clinical instruction, in which individual students work up individual cases in the hospital wards and outpatient clinics under guidance … Lectures and demonstrations of patients to large classes are important, but only as adjuncts to the direct study of patients by the students … The student should be made to feel a real responsibility as part of a team of physicians studying the patient, and not as a classroom student with prescribed hours of work."[168]

Faculty Standards

The "Faculty" section of the 1927 *Essentials* increased the minimum number of needed professors "trained in the laboratory branches" from six to eight. It also recommended that such faculty should have expertise primarily in anatomy, physiology, pathology, and pharmacology and secondarily in histology and embryology and internal medicine or surgery. For medical schools with 60 or fewer students, at least one salaried assistant (rather than a professor) was recommended in each of the primary fields mentioned above. The 1933 revision of *Essentials* upped the minimum requirement for full-time basic science faculty to 10, with one salaried assistant for every 25 medical students. Quantitative requirements for the number of faculty members were eliminated in 1951. That version of *Essentials* simply required an "adequate number of instructors" in the basic sciences, and a "nucleus of full time instructors" in major clinical areas. However, the 1951 document acknowledged that the majority of clinical faculty would likely consist of part-time and volunteer teachers.

As in the 1910 version, the 1927 edition of *Essentials* required that faculty be graduates of recognized medical colleges trained in all departments of medicine. It also stipulated, "Nonmedical men should be selected as teachers in medical schools only under exceptional circumstances and only when medical

men of equal special capacity are not available." The 1933 revision introduced specific qualifications for faculty appointment, namely "thorough training, successful teaching experience, ability in research, and willingness to pursue an academic career." Those requirements remained in place until 1951, when the research requirement was relaxed: "It is recognized…that occasionally outstanding teachers are encountered who are not themselves productive in scientific investigation."

Expectations for faculty compensation first surfaced in the 1933 version of *Essentials*, which noted that salaries should be sufficient for faculty members to support themselves and their families without having to devote time and energy to other occupations. The financial security of medical school faculty was strengthened with the 1933 addition of a statement that medical schools must assure reasonable security of tenure.

The 1933 revision introduced specific qualifications for faculty appointment, namely "thorough training, successful teaching experience, ability in research, and willingness to pursue an academic career."

The procedures for faculty appointment were first specified in 1933, noting that nominations should originate in the faculty and be concluded by the dean in consultation with department heads or a committee of the faculty. The 1951 *Essentials* recognized that appointments at lower ranks could be made by a department head "after thorough discussion of the nominees by the entire department."[169] The 1951 version also suggested that appointments at the associate and full professor level could be profitably supplemented or supplanted through a college-wide nominating committee.

Resources and Facilities Standards

Compared with the initial 1910 version of *Essentials*, the 1927 revision is perhaps most noteworthy for its expanded coverage of resources and facilities. The later document introduced finances as a medical school requirement for the first time, not in terms of having sufficient funding, but in terms of having "a generous income from [the] state and in private endowment in addition to students' fees."[170] The 1933 revision retained this stipulation, but instead of specifying funding sources it simply stated that a school should have a substantial income in addition to student fees. It also intensified the requirement for diversified funding for some medical schools, asserting, "This statement carries double weight if the school finds it necessary to maintain its own teaching hospital."[171] The language regarding finances remained unchanged in subsequent revisions.

The 1927 revision expanded on the facilities requirements laid out in the original 1910 standards. Regarding clinical facilities, it went beyond the previous version first by specifying that bedside and ward clinics be developed for sections of 5 to 10 students, and second by calling for a clinical clerk system to be employed for senior students when assigned to medicine, surgery, and the specialties. In addition, it noted that student participation in patient care should be strictly supervised by the

intern or attending medical staff, and patient histories written up by students should be made a part of the patient record in the hospital. It stipulated that the attending medical staff should consist of good teachers who should be prompt and regular in attendance.

The 1933 revision of *Essentials* included some relatively modest changes in facilities requirements. This version addressed, for the first time, hospitals not operated or controlled by a medical school and required, for such cases, that the school and hospital negotiate an agreement that the teaching faculty be appointed to positions as hospital staff. The 1933 revision also suggested that schools use municipal or state hospitals for teaching purposes. There were no substantive changes to clinical facility requirements in 1938 and 1945. The only noteworthy modification in the 1951 revision of *Essentials* included more detailed statements of the needed patient census for teaching purposes: "[There is to be] a sufficient number of patients so that each student on a hospital clerkship can be assigned from 3 to 5 new cases of teaching value per week" and "For students serving outpatient clerkships two new cases should be available for each student each day."[172]

The final section of the 1927 *Essentials* came under the heading of "Other Teaching Facilities and Finances." This section expanded substantially on most of the facilities requirements included in the 1910 *Essentials*. The library requirements were broadened and called for at least 30 leading periodicals (compared with 10 in the previous version); the library should also be properly lighted and heated, open during the greater part of the day, with a competent librarian in charge. The medical museum requirement provided greater detail as well, particularly regarding postmortem pathology specimens, to include information about the clinical history of the patient and microscopic slides illustrating the disease in addition to the gross specimen. In keeping with the AAMC equipment requirements developed in 1908, the 1927 *Essentials* now required enough dissecting material to allow each student to dissect at least one lateral half of a cadaver, as well as to prepare cross sections and other material to be used in a course for seniors on operative surgery. A new requirement for a humanely managed supply of animals was incorporated. The remaining items reiterated the 1910 criteria regarding equipment and a medical school catalog.

The major change in teaching facilities that appeared in the 1933 revision of *Essentials* was a requirement that medical schools "own, or enjoy the assured use of, modern fireproof buildings sufficient in size to provide lecture rooms, class laboratories, small laboratories for the members of the teaching staff and advanced students, administrative offices and a medical library."[173] No other substantial changes in teaching facility requirements appeared in the 1933 revision nor in the succeeding revisions of 1938 and 1945. The 1951 revision retained most of the details but placed them under three distinct subject headings: "Plant," "Library," and "Teaching Materials and Specimens."

The catalog standard from the 1910 *Essentials* appeared under the heading "Other Teaching Facilities" in the 1927 revision, with no change in the specific requirements. In 1933 the standard was placed under the "Administration" heading and was expanded to require that a medical school's bulletin also include a list of faculty members and their qualifications. These requirements remained in place through the final, 1951 revision of *Essentials*.

Organization and Administration Standards

The only standard in the 1910 *Essentials* dealing with medical school administration specified the authority and leadership of the dean. The topic was expanded significantly in the 1933 revision, which added an entirely new section under the heading "Organization." That paragraph established the following new requirements:

- The school should be organized as a nonprofit institution.
- The governing board should consist of "public spirited" individuals with no financial interest in the operations of the school and any associated hospitals.
- Trustees should serve long and overlapping terms.
- Officers and faculty members of the school should be appointed by the board.

The 1933 revision also created a new section titled "Administration," which included the standards related to the dean (largely the same as the 1910 language); student records, including policies and documentation regarding student attendance; catalogs; and admissions criteria. In 1938 *Essentials* adopted a new standard about class size in relation to resources. The class size/resources requirement stated simply that the number of students should be related to the laboratory and hospital facilities available and to the size and qualifications of the teaching staff. Later revisions to *Essentials* did not change appreciably in the requirements for organization and administration, although the 1951 revision did add a stipulation that board members should not also serve as administrators or faculty members in the medical school.

Chapter 9

The LCME Adopts Its Own Accreditation Standards

Many of the revisions that came about in the final, 1951 version of *Essentials of an Acceptable Medical School* (*Essentials*) presaged present-day thinking, especially in the area of curriculum with its recognition of the curriculum as an integrated program of instruction, the need for continuing review of the curriculum to remain current in the face of change, and the emphasis on team-oriented, patient-based learning. This final version of *Essentials* remained in place for six years until it was replaced by the first accreditation standards for medical schools employed by both sponsoring organizations of the LCME.

The First LCME Standards; Endorsement of *Functions and Structure* by the AMA and the AAMC

At the February 1956 meeting of the LCME, Edward Turner, secretary of the Council on Medical Education and Hospitals (CMEH), informed the LCME that the council had agreed to revise *Essentials* in consultation with the AAMC. Speaking on behalf of the latter, President Robert Moore affirmed the AAMC Executive Council's endorsement of the proposal. To initiate the process, Herman G. Weiskotten and Moore suggested the creation of a committee consisting of three members representing each sponsoring organization. Weiskotten stated that if the revision developed by the committee was not approved by the AMA House of Delegates, it would be returned to the CMEH for further study. At the June meeting that year, a committee of four was appointed for the task, consisting of Victor Johnson and James Faulkner from the CMEH and John Bowers and George Aagaard from the AAMC. The stated goals of the revision were to bring the AMA *Essentials* into alignment with the AAMC membership criteria and to incorporate standards on the objectives of medical education. Stipulated in this initial statement of goals was that the resulting document would remain a CMEH property. A draft document was expected to be ready for review by the LCME sometime in September.

The draft was ready by September but with a new title, *Functions and Structure of a Modern Medical School* (*Functions and Structure*).[174] Over the next several months each sponsoring organization provided some additional editing of the initial draft, and the document received final approval from the sponsors late in 1957.

This first joint venture in development of accreditation standards differed in several substantial ways from its AMA predecessor. *Functions and Structure* accomplished its original stated purposes of aligning *Essentials* with AAMC membership regulations. It established a clear emphasis on integration, collaboration, and active learning as key elements of medical education. It also adopted requirements for medical education objectives. The first task was not too difficult, since the differences between AAMC requirements and *Essentials* were not substantial. The shift of emphasis regarding medical education was likely influenced by the various kinds of experimentation in curriculum design taking place at several medical schools during the period, including combined baccalaureate-MD programs at Northwestern University and Boston University; "comprehensive medicine" curricula at Cornell

University, University of Colorado, Temple University, and University of North Carolina; and the integrated curriculum developed by Western Reserve University.[175]

The third change was accomplished by incorporating an entire new section into *Functions and Structure* under the heading "The Responsibilities and Objectives of a Medical School." The section laid out three inherent responsibilities of medical schools as institutions of higher education:

- Providing students with a sound, basic education in medicine and fostering the development of lifelong habits of scholarship
- Contributing to the advancement of knowledge through research
- Contributing to the development of teachers, investigators, and practitioners through programs of graduate education, including residency training

In addition to these essential responsibilities, the section also described additional responsibilities that a school should undertake to the degree that its resources would permit, specifically:

- Developing adequate opportunities for the continuing education of practicing physicians
- Providing professional services to patients, primarily to fulfill its educational and research obligations
- Participating in the educational programs of other health professions and university programs
- Training technical personnel in paramedical fields

The actual requirements for objectives were stated in detail and in language familiar to anyone who has had to meet the requirements in recent years:

> A medical school should develop a clear definition of its total objectives, appropriate to the needs of the community it is designed to serve and the resources at its disposal. When objectives are clearly defined, they should be made familiar to faculty and students alike, so that efforts of all will be directed toward their achievement.[176]

The remainder of this section consisted of selected passages from a white paper on the objectives of undergraduate medical education that had been prepared by the AAMC and published in the *Journal of Medical Education*.[177] Among the tenets cited in these passages were the need to focus on learning principles and judgment as opposed to total mastery of content in all disciplines, the importance of active learning grounded in hands-on experience with problems of health and disease, and the development of appropriate attitudes, ethical morals, and principles essential to gain the confidence and trust of patients.

The new *Functions and Structure* also developed a modified taxonomy of accreditation requirements, reflected in subject headings different from those in the 1951 *Essentials*. The separate sections on "Organization" and "Administration" in *Essentials* were combined under the single heading "Organization and Administration," which now included accreditation criteria relating to faculty organization and finances. A new section was created with the heading of "Students," incorporating criteria that had previously been listed in part in the sections "Administration" (mainly relating to student records)

and "Requirements for Admission" (which in turn was eliminated as a separate heading). Previous sections on "[Physical] Plant," "Library," and "Clinical Facilities" were combined under the heading "Facilities." Finally, the *Essentials* heading "Curriculum" was replaced by a section titled "Educational Program." Thus, the major section headings in the new standards document read as follows:

I. Introduction
II. The Responsibilities and Objectives of a Medical School
III. Organization and Administration
IV. Faculty
V. Students
VI. Facilities
VII. Educational Program
VIII. Accreditation of Medical Schools

The final section provided a very brief summary of operating procedures, including such topics as the authority of the sponsoring organizations, the process and timetable for accreditation of new and established schools, accreditation documentation and site visit details, and LCME decision making based on survey reports.

Functions and Structure adopted a number of new accreditation requirements and eliminated others that were embodied in earlier versions of *Essentials.* New requirements included the following:

- Objectives (discussed above)
- Codification of medical school organization, governance, and functions in written bylaws
- Sufficiency of administrative staff in the dean's office
- Roles and responsibilities of departments and shared governance by way of an executive committee including administrators and department chairs
- Specification of needed medical school committees (admissions, promotions, curriculum, postgraduate medical education, library)
- Regular (at least annual) meetings of the entire faculty
- Authority of the admissions committee for the selection of students
- Desirability of selecting students with a variety of backgrounds in education and experience
- Qualitative evaluations of student performance, to be included in the student record
- Provision of counseling and health services for students
- Adequacy of clinical teaching space and clinical facilities for learning
- Required teaching of clinical laboratory diagnosis, physical diagnosis, medical ethics, legal medicine, biostatistics, and medical genetics
- Active learning by way of individual and small-group projects, conferences, seminars, and the case method of instruction
- Desirability of providing adequate, unscheduled student time for reading, research, or other independent pursuits

Apart from these new accreditation criteria, other statements from *Essentials* were amplified or expanded in scope, as follows:

- Emphasis was given to the importance of a medical school being part of a university.
- The role and functions of the dean were augmented to establish that the dean should have the respect and support of the faculty, as well as access to the university president. The dean was also encouraged to establish and maintain a congenial and productive relationship with the local medical profession.
- A rationale was given for the requirement to have funding sources beyond student tuition and fees, namely that many medical school activities were not directly related to medical student education and should not be funded through tuition and fees. There was also a call for the establishment of departmental budgets with ultimate budgetary authority vested in the dean.
- Greater emphasis was given to the importance of faculty research.
- The increased use of methods to promote active learning and engagement in interdepartmental teaching would likely increase the need for additional instructional staff.
- The basis for admissions decisions was broadened to include the applicant's personality and emotional characteristics, motivation, industry, resourcefulness, and health; the methods for evaluating such information were expressed in detail and included personal interviews, evidence from college records of academic and nonacademic activities, results of medical college admission tests, and pertinent letters of recommendation. Retention of admissions data and procedures for periodic review "in a search for better methods" was recommended.
- The location of basic science faculty should be in close proximity to clinical facilities, "to promote cooperative teaching efforts and allow all departments ready access to clinical materials."
- A preference was expressed for clinical learning based on long-term study of fewer patients rather than superficial observation of many patients.
- A full paragraph was added under the "Educational Program" heading with a detailed exegesis of the continuum of medical education as the context for undergraduate education.

Finally, several accreditation requirements from the 1951 version of *Essentials* were eliminated in this initial version of *Functions and Structure*, specifically

- Documentation of student attendance and denial of credit for any course that a student has not attended regularly except for good cause
- Issuance of a bulletin listing the names of faculty and their qualifications, course descriptions, entrance requirements, tuition and fees, and names of enrolled students
- The recommended student-teacher ratio for basic science faculty (at least one full-time teacher for each 25 students in a course)
- Ownership or control of a general hospital
- Requirements for sufficient dissection material to allow each student to dissect half a cadaver and a supply of animals for laboratory studies and medical research
- Specification of numbers and types of patients and clinical experiences in hospital and outpatient settings, along with minimum exposure to maternity cases and autopsies
- Requirements for content coverage in most clinical specialties, including anesthesiology, dermatology, neurology, ophthalmology, otolaryngology, physical medicine and rehabilitation, and urology

It should be clear from the summary above that this first iteration of LCME (rather than sponsor-specific) accreditation standards increased the overall number of requirements, although in many cases the new framework provided a more general statement of those expectations. This shift toward generalization at the expense of specificity would be apparent in the next major revision of accreditation standards.

The Second Version, 1973

The new *Functions and Structure* of 1957 proved remarkably stable, as the document served to guide medical school accreditation for the next decade. By the late 1960s, however, the LCME began to contemplate a major revision of the document. The need for updating the standards first surfaced at the March 1967 meeting of the LCME, although no meaningful action resulted at that time. The topic came up again during the May 1969 meeting. This triggered action on the part of the staff, and a first draft of the revised *Functions and Structure* was presented for review by the LCME in December of that year. Almost three more years would pass before the new version was finally approved by the AAMC (November 1972) and the AMA (June 1973). The 1973 revision removed the word "modern" from the title of the document, and henceforth the LCME standards document would be known as *Functions and Structure of a Medical School.*[178]

The most notable difference between the 1973 and 1957 versions of *Functions and Structure* was a substantial reduction in detailed requirements; that is, the 1973 document was written in a style that presented accreditation requirements in much more general language, albeit with some exceptions. The decreased specificity was perceived by the medical schools and would eventually result in the 1976 creation of a companion document, *Guidelines to Functions and Structure of a Medical School* (*Guidelines to Functions and Structure*), to fill in the missing detail.[179]

The other notable general change in the 1973 version was the elimination of some language from the previous version regarding objectives, curriculum integration, and active learning methods. Those elements were novel additions in the 1957 version, but their relevance had seemingly diminished as the 1973 revision developed.

The revised *Functions and Structure* began with an introductory statement that, although similar to the 1957 version, described the document's purpose in greater detail. Where the stated purpose of the previous version was to "assist in attaining medical education of ever higher standards,"[180] the 1973 revision elaborated on the beneficiaries of higher standards. Thus, in the new version the attainment of standards "provides assurance to society and the medical profession that graduates are competent to meet society's expectations; to students that they will receive a useful and valid educational experience; and to institutions, that their efforts and expenditures are suitably allocated."[181]

The first major section heading for the 1973 *Functions and Structure* was "Definition and Mission," replacing the section "The Responsibilities and Objectives of a Medical School" from the 1957 iteration. This section began with a new statement defining a medical school as "an aggregation of resources that have been organized as a definable *academic* unit to provide the full spectrum of education in the art and science of medicine in not less than 32 months, culminating with the award of the M.D.

degree." The curriculum length of 32 months incorporated into this definition replaced the previous requirement of four years, which had been included in the "Educational Program" section in the 1957 version. A somewhat subtle change in the 1973 revision was a requirement that the educational program be sponsored by an academic institution "appropriately charged within the public trust to offer the M.D. degree"; this language presaged the later requirement of appropriate chartering of a medical school and also precluded medical education under the auspices of any commercial enterprise.

The responsibilities that had been ascribed to medical schools in the original *Functions and Structure* were expanded in the 1973 revision. In the new version, the educational function was identified as the primary responsibility of the medical school. The research function was stated much more broadly, explicitly recognizing "studies related to cultural and behavioral aspects of medicine, methods for the delivery of health care, and the medical education process" in addition to biologically oriented studies. An additional core function of participation in continuing education was added to the initial areas of medical education, research, and graduate education; in the 1957 version, continuing education had been included as one of several functions that could be undertaken secondarily as resources permitted. The new *Functions and Structure* also adopted a cautionary statement admonishing schools not to "overextend themselves in the field of research or service to the detriment of their primary educational mission." Requirements regarding objectives remained much the same in the 1973 version, although the extensive citations from the AAMC statement on objectives were removed.

The new *Functions and Structure* also adopted a cautionary statement admonishing schools not to "overextend themselves in the field of research or service to the detriment of their primary educational mission."

Administration and Governance Standards

Much of the 1957 language about the organization and administration of a medical school was retained in the 1973 section called "Administration and Governance." The discussion of the board of trustees' role was elaborated somewhat in the revision, noting that long, overlapping terms "permit [board members] to gain an adequate understanding of the programs of the institution and to function in the development of policy in the interest of the institution and the public." A somewhat surprising omission in the 1973 revision of standards was the reference to the leadership abilities and character of the dean, which had always been a requirement in the AMA *Essentials*. The 1973 version was more specific about the types of individuals needed as members of the dean's administrative staff, however, identifying associate or assistant deans for academic affairs, research affairs, hospital matters, and continuing education in addition to the 1957 mention of those for student affairs, graduate education, and business.

The 1973 version added a new paragraph discussing medical school organization in universities with programs in other health professions under the authority of a vice president for health affairs; in such cases, the deans of each school (including the medical school dean, presumably) would be

expected to report to the vice president. Extended discussion of departments from the 1957 *Functions and Structure* was eliminated in the 1973 revision. References to committee structure were similar, the 1973 version adding animal care as a suggested committee. The 1973 revision also included a new statement that student representation on all committees "is both desirable and useful."

Educational Program Standards

The most striking change in the section on the educational program in the 1973 version was the elimination of nearly all mention of specific required subjects, which had been a staple of earlier standards documents and AAMC membership requirements. Rather than listing particular basic science and clinical disciplines, the new *Functions and Structure* simply required that students "acquire a foundation of knowledge in the basic sciences" and "be comfortably familiar with the methods and skills utilized in the practice of clinical medicine." The new document did note that attention should be given to the subjects of preventive medicine and public health and to the social and economic aspects of the systems for delivering medical services, but it was otherwise silent on what should be taught. The new *Functions and Structure* also differed from its predecessor in recommending that elective time be provided. Another notable addition was a statement that instruction should "stress the physician's concern with the total health and circumstance of patients and not just their diseases."

As noted earlier, multiple references to curriculum integration and collaboration in teaching that were adopted in the 1957 version of *Functions and Structure* disappeared in the new version. Various statements encouraging the use of teaching methods that facilitate active learning were also discarded. One other issue surprisingly lost in the 1973 revision was the requirement for periodic evaluation of the curriculum (although curriculum evaluation was included in the companion *Guidelines to Functions and Structure*).

Other topics from the 1957 version that were not retained in the section on the educational program included the teaching of emotional and environmental factors in health and disease; inclusion of medical ethics, legal medicine, biostatistics, and medical genetics in the curriculum; allotment of unscheduled time for students to read or do research; capture of student write-ups in hospital records; and emphasis on the student's role as a contributing member of the patient care team. While the teaching of medical ethics was not mentioned in the 1973 version of *Functions and Structure*, the revision did adopt a broader statement that encouraged development in students of "those basic intellectual attitudes, ethical and moral principles that are essential if the physician is to gain and maintain the trust of patients and colleagues, and the support of the community in which the physician lives."

Faculty Standards

The most notable differences in the 1973 standards on faculty were the removal of most details regarding the appointment process, teacher-student ratios, teaching methods to promote active learning, and interdepartmental teaching. The earlier pronouncement on the importance of tenure was replaced by a statement that faculty members should have "reasonable security and possibility for advancement in salary and rank." A new paragraph was added in the 1973 revision about the potential and desirability of using community physicians as teachers of medical students. Finally, the kinds of faculty needed by

the medical school now included those with a background in behavioral sciences, in addition to those with expertise in biological and clinical sciences.

Student Standards

In the section on students, as in several other sections of the 1973 *Functions and Structure,* many specifics were removed, especially in the section on admissions requirements. The requirement that admissions decisions be made by a faculty committee, which was the first statement in the 1957 section on students, was replaced with a more generic statement alluding to the responsibilities of the institution for determining the qualifications of medical students. The 1957 version singled out higher education institutions identified in a list prepared by the National Committee of Regional Accrediting Agencies as commendable premedical programs, with an admonishment that admissions committees "scrutinize with particular care the qualifications of applicants whose preparatory study has been done at other institutions"; in the 1973 revision, all references to where students did their premedical studies were removed. The list of subjects required in the 1957 version was replaced by a generic statement about restricting premedical course requirements to those "considered essential to enable the student to cope with the medical school curriculum." The new *Functions and Structure* retained the three-year minimum for college preparation for medical school but also made allowance for combined baccalaureate-MD programs that shortened the premedical period to less than three years. The 1957 reference to "a variety of backgrounds in education and experience" among applicants was recast as a statement of the desirability of having a student body that reflects "a wide spectrum of social and economic backgrounds." The 1973 *Functions and Structure* also added a new requirement on nondiscrimination in admissions with regard to sex, creed, race, or national origin. The recommendation in the 1957 *Functions and Structure* for periodic review of the admissions process was not carried forward into the 1973 revision.

The 1957 reference to "a variety of backgrounds in education and experience" among applicants was recast as a statement of the desirability of having a student body that reflects "a wide spectrum of social and economic backgrounds."

Requirements for student records, counseling services, and health care remained largely the same in the later version. The only noteworthy differences in the 1973 revision were statements that (1) counseling is especially critical for students who need remedial work, and (2) academic programs allowing students to progress at their own pace are desirable.

Finances and Facilities Standards

The discussion of finances, previously contained within the section called "Organization and Administration" in the 1957 *Functions and Structure,* now merited a section of its own in the 1973 revision. In addition to the earlier version's recommendations that schools have substantial sources of revenue other than student tuition and fees, the 1973 revision established a requirement that the school's funding sources be sufficient to conduct programs in a satisfactory manner and reflect the educational, research, and service efforts of the faculty. This section also added a new statement that "special attention

must be paid to providing financial aid for students since it is desirable that economic hardship not hinder the acquisition of an education in medicine." This latter statement represented a corollary to the new recommendation that the student body reflect varied social and economic backgrounds.

The section on facilities covered most of the same content in 1973 that it had in 1957. The 1973 language about the relationship between the medical school and its clinical partners now explicitly referred to affiliation agreements needed to define the rights of both the medical school and the hospital in the appointment of attending staff; the 1973 version also addressed the importance of supervision by medical school faculty when students learned from physicians in community settings. Consistent with other parts of the revised standards, the 1973 revision eliminated all references to the numbers and types of patients needed for clinical education, replacing them with a simple phrase referring to hospitals, as well as ambulatory care facilities, of sufficient capacity for the educational programs. The importance of technology in medical education first appeared in the 1973 revision. As the document noted, "The library or other learning resource should also be equipped to allow students to gain experience with newer methods of receiving information as well as with self-instructional devices."

The final section of the 1973 *Functions and Structure,* which summarized the accreditation process, added a new expectation for reporting of substantive change in either the constellation of the school's resources or the total student enrollment.

As noted earlier, the 1973 revision was so much broader in language than its predecessor that the LCME was eventually prompted to create a companion document, *Guidelines to Functions and Structure,* explaining precisely what the LCME expected of medical schools to meet accreditation requirements. Many of the guideline statements would be transformed as *Functions and Structure* standards in the next major revision in 1985. That transformation of guidelines into accreditation requirements would occur again later, when annotations that had been developed to clarify the meaning of 2002 accreditation standards converted to many of the elements contained within the accreditation standards of 2014.

The 1973 version of *Functions and Structure* underwent some minor revisions in 1976. The 1976 revision added a new paragraph in the section on the educational program. This paragraph required schools to develop and publicize procedures for student evaluation, advancement, and graduation, and it called for fairness and due process when considering any adverse action against a student. Also, the section on students included a new provision exhorting schools to ensure the confidentiality of student health records.

Detail Restored: The 1985 Revision of *Functions and Structure* and Subsequent Changes

As mentioned in Chapter 5, the discussion of the next revision of the LCME's standards document in the early 1980s coincided with major educational reform projects occurring at both the AAMC and the AMA: the General Professional Education of the Physician project at the AAMC, and the Future Directions in Medical Education initiative at the AMA. The 1985 revision of *Functions and Structure* was a wholesale change from its predecessor, and most of the language adopted in 1985 continues to be

recognizable in LCME standards thirty years later.[182] While the 1973 version of *Functions and Structure* was written so broadly that it required the creation of a companion guidelines document, the next major revision of the LCME document marked a return to more concrete language in the standards and obviated the need to maintain a separate set of explanatory guidelines. Some of the language in the 1985 version was either adopted or paraphrased from the 1976 *Guidelines to Functions and Structure.* Several sections, especially those related to the educational program, were greatly expanded. For the first time, the 1985 *Functions and Structure* revision drew attention to a distinction in the preamble between "must" (an absolute requirement) and "should" (highly desirable, and absence may compromise substantial compliance) in the verbiage of the standards.

The general structure of the 1985 revision resembled the 1973 version, albeit with some notable changes in the headings and subheadings that served as an informal classification of types of standards. The preamble to the 1985 version was much longer and included detailed descriptions of some basic elements of the accreditation process, including the composition of the LCME and its survey teams, types of accreditation actions, and the monitoring of accredited programs between full surveys. The "Objectives" heading was revived from the original 1957 version, replacing the section heading "Definition and Mission" from the 1973 version. New sections on geographically separated campuses were added under the headings "Administration" and "Medical Students." New subheadings were adopted for the section on the educational program: "Duration," "Design and Management," "Content," "Evaluation of Student Achievement and Due Process," and "Academic Counseling and Career Guidance." Similarly, the section on students was broken down by the subheadings "Admissions," "Financial Aid and Amenities for Students," and "Personal Counseling and Student Health." With some relatively modest shifting of content areas, the taxonomy of standards reflected in the headings and subheadings of the 1985 *Functions and Structure* would persist until the 2014 revision.

Objectives Standards

The section called "Objectives" provided greater clarity about the focus of objectives, in contrast to the 1973 document. Whereas the immediately preceding version of *Functions and Structure* stated that schools should develop a clear definition of their overall objectives (with no elaboration in *Guidelines to Functions and Structure*), the 1985 revision introduced a "must" requirement ("an essential objective … must be to meet the standards of accreditation by the LCME" and a separate "may" expectation ("a medical school may establish additional objectives for its medical education program"). This language shifted the focus of the term "objectives" from its original use in the 1957 *Functions and Structure* (i.e., objectives of the educational program) to a distinct emphasis on the objectives of the medical school itself. The 1985 version retained the previous requirement that objectives be made known to faculty and students. This section of the 1985 *Functions and Structure* also included the expectations regarding the need to maintain a balance between student enrollment and medical school resources, which had been stated in the "Accreditation" section of the 1973 version.

Governance and Administration Standards

The section on governance in the 1985 *Functions and Structure* retained most of the requirements from the corresponding section of the 1973 version. The most notable change was the addition of

a statement that schools not connected with regionally accredited institutions should seek their own accreditation from the appropriate regional association. Under the "Administration" heading, the accreditation requirement concerning the qualifications of the dean was restored in 1985 after being removed in 1973. The newer version expanded the list of areas meriting oversight by members of the dean's staff, which now included admissions, business and planning, and fund raising. The section also included a statement about the importance of collegiality among the medical school's faculty members, hearkening back to statements in the original 1957 document (not retained in 1973) about collaboration in faculty teaching.

The most visible change to the section on administration in 1985 was the addition of a paragraph on geographically separated campuses. This paragraph offered a condensed version of the administrative expectations that the LCME had articulated in a 1976 document titled *Supplemental Guidelines for Medical Schools with Branches or Multiple Campuses*. It addressed medical school responsibility for all educational activities and faculty appointment at branch campuses and the direct reporting relationship of the campus's chief academic officer to the chief academic officer of the medical school as a whole. It also added a standard regarding "functional integration" of faculty by administrative mechanisms that ensured comparability of educational quality at all sites. This would prove to be one of the most vexing LCME standards, since the phrase "functional integration" was never clearly explicated, and nothing related to the concept was mentioned in the 1976 *Supplemental Guidelines*.

In contrast to other sections of *Functions and Structure*, the standards described under the heading "Educational Program" were greatly expanded in 1985; whereas the 1973 version addressed such standards in 3 paragraphs, the 1985 revision contained 18 paragraphs under five subheadings.

Educational Program Standards

In contrast to other sections of *Functions and Structure*, the standards described under the heading "Educational Program" were greatly expanded in 1985; whereas the 1973 version addressed such standards in 3 paragraphs, the 1985 revision contained 18 paragraphs under five subheadings. The first notable change in this section was the replacement of the 32-month requirement for curriculum length with a new minimum duration of 130 weeks, "preferably scheduled over a minimum of four years." The 130-week requirement has persisted unchanged since this revision, although the four-year component was removed in later revisions.

Expectations related to curriculum evaluation had curiously disappeared from the 1973 *Functions and Structure* (though included in *Guidelines to Functions and Structure*), but they reappeared in full force in 1985, under a distinct subheading with two paragraphs of detailed statements. Curriculum management standards added in 1985 consisted of the following:

- Ongoing faculty responsibility for design, implementation, and evaluation of the curriculum
- Support for curriculum management provided by the chief academic officer and staff

- Focus of the curriculum on general professional education, which by itself is not sufficient to prepare the graduate for independent, unsupervised practice
- Curriculum committee responsibility for monitoring student academic workload
- Curriculum committee responsibility for monitoring content to ensure that objectives are achieved without attempting to provide comprehensive coverage of all disciplines

This section also adopted, with slight modification, the language from the 1973 *Guidelines to Functions and Structure* stating that the objectives, curriculum, and pedagogy used in each segment of the curriculum should be subject to internal and external review and evaluation. The 1985 revision also pointed out that curricular redundancies and deficiencies needed to be corrected.

The standards addressed under the subheading "Content" in the 1985 revision were even more dramatic in scope. The 1973 *Functions and Structure* dedicated two of its three paragraphs about the educational program to content issues, but in 1985 the subject required two and a half columns of standards. The section began with a description of broad content areas that the curriculum should address, including fundamental principles of medicine, skills of critical judgment based on evidence and experience, and use of such principles and skills in solving health problems. The section also required that the curriculum provide an understanding of scientific concepts underlying medical practice and include current advances in medical knowledge relating to therapy and technology, mechanisms of disease, and the effects of social needs and demands on medical care. For the most part, these requirements paraphrased statements from the 1973 *Functions and Structure.*

In a major departure from the 1973 version, the 1985 iteration restored listing of specific disciplines that had been included in most versions of accreditation standards dating to the origins of the AMA and the AAMC. Most of the language was adapted from similar content requirements described in the 1976 *Guidelines to Functions and Structure;* the most notable difference in 1985 was a stronger statement regarding family medicine, establishing that any school not offering a required clerkship in the discipline should ensure that students obtain an understanding of the subject sufficient to allow them to enter residency programs in family medicine or similar primary care fields. The 1973 and earlier requirements for students to learn in both ambulatory and hospital settings were retained in 1985. There were other specific clinical content areas explicitly addressed in the 1985 *Functions and Structure* as well:

- Medical ethics and human values
- Diagnostic imaging and clinical pathology
- Emergency medicine and the care of the elderly and disabled
- Acute, chronic, continuing, preventive, and rehabilitative care

The importance of laboratory instruction in the basic sciences was emphasized in the 1985 section on content, hearkening back to statements about the "laboratory branches" in early versions of the AMA's *Essentials.* Students were expected to learn about all organ systems. Students were expected to acquire skills of self-directed, independent learning that would serve them throughout their professional lives. Lifelong learning had been addressed in the 1976 *Guidelines to Functions and Structure*, but the reference to self-directed learning was new to the 1985 revision.

Other standards appearing for the first time in 1985 included the following:

- Student participation in faculty research
- Faculty supervision of student clinical learning experiences
- Opportunities for students to learn with resident physicians during required clerkships
- Equivalent educational experiences when students learned at alternative clinical sites
- Use of the fourth-year curriculum to complement and supplement earlier learning to ensure competence in general medical care
- Development and demonstration of scrupulous ethical principles for students engaging in patient care activities
- Faculty oversight of students' choices of electives

Finally, although they were not curriculum content issues per se, statements addressing centralized screening of extramural electives and processes for documenting the activities of visiting medical students were also included in this section of the 1985 *Functions and Structure*.

Student Standards

Like the section on the educational program, the 1985 section called "Medical Students" introduced subheadings that had not existed in previous versions of LCME standards. The section on admissions used very similar language to the 1973 version regarding the premedical qualifications of applicants. The 1985 revision reverted to the 1957 requirement that decisions about admissions be made by a committee of the faculty; this requirement had been omitted from the 1973 version of *Functions and Structure,* although *Guidelines to Functions and Structure* that accompanied the 1973 iteration did include it. A small but notable addition in 1985 was the inclusion of age as an additional factor in the nondiscrimination requirement regarding admissions; the diversity expectation from 1973 regarding social and economic backgrounds, however, was restricted only to economic diversity in the 1985 revision.

The admissions section included new requirements for students at geographically separated campuses, including medical school authority for admission to campus programs, opportunities for students to move between different programs at the various campuses, and assurance that students at branch campuses enjoyed the same access to services and privileges as students at the main campus. A subsection on transfer students retained requirements from the 1973 *Functions and Structure* but added details about the circumstances under which a student would be allowed to transfer into the final year of study. The 1985 revision adopted language from the 1976 *Guidelines to Functions and Structure* related to class size considerations, such as the types of resources needed to support a given class size, and the effect of faculty members' other responsibilities on their commitments to medical student education. A notable addition to the class size requirements of 1985 was the stipulation that the school have access to a sufficiently large applicant pool, with national-level qualifications, to fill its entering class. Finally, the 1985 version added another item under the "Admissions" subheading expressing concern about visiting students from unaccredited institutions; this item indicated that such students were likely to be less qualified for clerkship education and that acceptance of such students constituted grounds for reassessment of a school's accreditation status.

The new section called "Financial Aid and Amenities" incorporated several new requirements, namely provision of effective financial aid counseling, study and lounge spaces for students, personal lockers, and adequate security systems. The new section called "Personal Counseling and Student Health Services" expanded on 1973 requirements, including expectations for effective systems of personal counseling, availability of health insurance for students and their dependents, and confidential counseling services from mental health professionals.

Resources Standards

The last major heading in the 1985 revision of *Functions and Structure*, "Educational Resources for the M.D. Program," included separate sections for finances, general facilities, faculty, the library, and clinical teaching facilities. The section on finances was similar to the 1973 version, although the 1985 revision was explicit about the various funding sources needed to support a medical school: tuition, endowment, faculty earnings, parent university support, annual gifts, individual and organizational grants, and government appropriations. The section on general facilities added a new requirement that the school have an auditorium sufficiently large to accommodate the student body; it also added a requirement for humane treatment of animals used for teaching and research (mentioned briefly in the 1976 *Guidelines to Functions and Structure* but not in the 1973 *Functions and Structure*).

Paraphrasing of the 1976 *Guidelines to Functions and Structure* is also apparent in the 1985 section on faculty, which begins with the simple declarative statement that faculty members "must have the capability and continued commitment to be effective teachers." The 1973 *Functions and Structure* simply referred to faculty members having professional competence in teaching, while the guidelines noted that members of the faculty "have and maintain the responsibility to be effective teachers." The description of effective teaching that followed the first sentence in the 1985 revision employed language modified from the 1976 *Guidelines to Functions and Structure.* The faculty qualifications specified in the 1985 document—"achievements commensurate with their rank" and "commitment to continuing scholarly productivity"—also paraphrased the guidelines, as did the section describing the role of clinical faculty members in contributing to medical school missions.

In the standards on processes for faculty appointment and professional advancement, the language was again taken mainly from the 1976 guidelines; notably absent in the 1985 revision, however, was the reference in the 1973 *Functions and Structure* about providing "reasonable security and possibility for advancement in salary and rank." The 1985 paragraph describing the working environment for faculty ("close interaction among the faculty members") was taken almost verbatim from the 1976 guidelines, while the paragraph on faculty governance represented a close paraphrase of the 1973 version of *Functions and Structure.*

The 1985 section on the library incorporated language from the 1973 version with slight modifications and added statements from *Guidelines to Functions and Structure* about library staff members and the function of the library in support of continuing medical education. In the section on clinical facilities,

the 1985 revision drew on the previous version of *Functions and Structure* for its requirements about affiliation agreements and from the 1976 companion guidelines for details regarding the facilities themselves. The only notable new requirement in the 1985 version was reporting of any anticipated changes in the affiliation status of teaching hospitals.

In summary, the 1985 revision to *Functions and Structure* greatly expanded the section on the educational program with several new standards and augmented several other sections by paraphrasing language that had been used in the guidelines document that accompanied the 1973 version of *Functions and Structure*. This marked the last time that new standards were introduced as part of a comprehensive revision of *Functions and Structure*. From this point forward, new standards would be added episodically as issues came to the LCME's attention, rather than incorporating major content changes in wholesale revisions of standards. The next significant revision would not take place for nearly two decades.

Chapter 10

Format Changes and Incremental Creation of Standards

Over the course of its evolution from AMA and AAMC roots to an autonomous accrediting organization, the LCME modified the content of its standards mostly through major, comprehensive revisions. For reasons that are not apparent, the LCME changed its approach after the 1985 revision of *Functions and Structure of a Medical School* (*Functions and Structure*). From that time forward, the LCME would add or revise its standards whenever requests for standards changes took place, whether such requests originated from outside organizations—i.e., other than the LCME, the Committee on Accreditation of Canadian Medical Schools (CACMS), or their respective sponsors—or from within the LCME itself. There would be two more comprehensive revisions of LCME standards after 1985, but the major focus of those revisions was a change in format rather than content.

Post-1985 Standards Changes

There were few changes in LCME standards in the years immediately following the 1985 revision. At a February 1987 retreat, the LCME discussed standards related to clinical education, particularly the importance of student supervision during clinical training and the role of resident physicians in teaching and supervision, but no changes materialized from that discussion. The LCME also discussed standards for clinical campuses in October 1987 but, again, with no action taken. Standards issues surfaced once more at the June 1988 meeting, in part because a new LCME member asked pointed questions about how the organization was dealing with certain topics and in part to address the implications of summary data from the LCME's annual medical questionnaire, which had been compiled by a staff member for the meeting. These standards questions prompted a retreat in October 1988, where the LCME considered the following changes:

- A requirement for instruction in statistics, epidemiology, and health promotion, as well as immunology, genetics, nutrition, aging, and rehabilitation
- Restrictions on permissible educational activities for visiting students from non-LCME-accredited medical schools
- Revisions to the language of the standard on student diversity
- A requirement for medical schools to employ computer systems for medical education and patient care, and to support their information systems

The first two of these items were approved; the remaining two were not. At the June 1989 meeting of the LCME, its secretaries shared concerns about the extent to which student clinical activities were being documented in patient logs; this did not lead to any standards actions at the time but is mentioned here because it represents the first volley in the development of a later, somewhat unpopular, standard on student clinical experiences.

National calls for medical education reform in 1990 provided the initial stimulus for a spate of standards changes over the next few years. In February 1990 the LCME considered, but did not act on, a resolution from the AMA House of Delegates seeking the inclusion of sexual orientation in the LCME's nondiscrimination standard. The major push for standards changes came at an April 1990 retreat on the LCME's role as an agent of educational change. Some standards were revised immediately as a result of the retreat, while others were referred to the staff for further background and development. Concerned about the growing dependence of medical schools on licensure examination results for curriculum evaluation, the LCME diluted its language regarding medical school attainment of national norms for student performance, couching that language in a requirement that schools employ a variety of measures to evaluate educational program quality. It approved a separate standard requiring schools to document student achievement "in verifiable and internally consistent ways which demonstrate the extent to which institutional and program purposes are met."[183] The LCME also made a small but significant change when it added the word "final" to its standard about faculty authority over the medical curriculum, ensuring that the educational program was the province of the faculty. At the June 1990 meeting, the LCME approved additional standards on observation of student clinical skills by the faculty, equivalence of student assessment across multiple teaching sites, and policies for dealing with student exposure to infectious diseases and environmental hazards.

When the LCME met in October 1990, the members reviewed a report prepared by Barbara Barzansky summarizing the concerns that had been identified during survey visits in the preceding four years. Based on the findings from those surveys, the LCME asked its Task Force on Accreditation Policy and Validation and Reliability of Criteria to review existing standards on the integration of geographically remote campuses, assessment of medical student performance and associated due process issues, and visiting students from medical schools not accredited by the LCME. The task force prepared a response on the separate campus issue at the June 1991 meeting, noting potential problems with oversight of remote campuses, comparability of teaching quality and student performance assessment across sites, and supervision of student clinical experiences. The task force also directed the Secretariat to develop background information on diversity and minority access to medical education and on due process issues in relation to student academic progress. New standards in each of these areas were approved by the LCME at its next meeting. Also at the June 1991 meeting, the LCME considered a request from the CACMS secretary to create a standard requiring Canadian medical schools to have a department of continuing medical education; the LCME demurred, not wanting to create standards that applied exclusively to Canadian institutions. Finally, the LCME discussed a request from a medical educator to strengthen its standards on health promotion, disease prevention, and the social and community context of medicine; it decided to include the issue as part of its ongoing review of standards.

By 1992 standards changes had become a recurring topic at most LCME meetings. In February of that year, the LCME approved the inclusion of family medicine as a required clerkship, specified the conditions under which schools could admit transfer students, and adopted language admonishing schools not to let pressures for institutional self-financing compromise the educational mission. In June it adopted new standards dealing with graduate education in the basic medical sciences and with graduate

medical education. It deferred action on a standard for continuing medical education. In October the LCME revisited its new requirement for a family medicine clerkship and revised the language based on feedback received from the AMA Council on Medical Education. During that meeting, it also decided not to create a standard on continuing medical education, noting that the issue was sufficiently well covered by its standard requiring schools to inculcate skills of lifelong learning among medical students.

In February 1993 the LCME modified its standard on visiting students from non-LCME-accredited schools, shifting the locus of responsibility for reporting about such students and their effect on the education of the school's own medical students to the medical school dean. It also denied a request from the American Medical Student Association to adopt a standard promoting student well-being (which it felt was already addressed in its standards on student support). In April the LCME renewed discussion of its student diversity standard, now discussed as a standard on affirmative action and informed by AAMC support for the Project 3000 by 2000 initiative to increase enrollment of medical students from historical minority populations. That discussion led to the June approval of revised standards language calling on schools to develop policies and practices to address student diversity and asking schools to consider the diversity of the student body when considering faculty recruitment and development. The June meeting also included LCME consideration of a standard regarding medical school policies on the United States Medical Licensure Examination, with no action taken. At the September 1993 meeting, the LCME approved a new standard on required immunizations for medical students and considered another standard on library resources. The September meeting also elicited discussion of two topics that would later become grist for new accreditation standards. One was a request from an LCME member for more information on how students are prepared to communicate with culturally diverse populations, and the other was the adequacy of patient resources for medical student education (spurred by studies conducted by another LCME member).

National calls for medical education reform in 1990 provided the initial stimulus for a spate of standards changes over the next few years.

Over the next three years, the LCME would approve or modify several additional standards. A student communication skills standard first suggested in September 1993 was finally approved in April of 1995. In the summer of 1994 the LCME adopted a new standard on policies for tuition refunds to comply with U.S. Department of Education regulations. In October 1995 the LCME approved a new standard on faculty development, rejected a proposed standard on strategic planning, and referred a possible standard on the medical consequences of domestic violence to its task force. In June 1996 the LCME considered but rejected a standard on academic honesty and professional conduct among students, perceiving that its existing standards already addressed the matter satisfactorily. It also reviewed proposed language for a standard on student understanding of cross-cultural issues and determined that additional work was needed on the subject.

The February 1997 meeting of the LCME saw the introduction and approval of what would prove to be one of the most controversial standards in modern LCME history, the requirement that medical school faculty define clinical learning objectives and the criteria for student clinical interactions, as well as monitor student achievement of such objectives and adjust student experiences if needed. Later known by its code designation ED-2 in the 2002 revision of *Functions and Structure,* the standard quickly ignited a clamor from clerkship directors and their professional organizations, protesting that the rich clinical environments in which medical education took place were more than adequate to ensure a good clinical education and that the new standard would place intense demands on the time and efforts of clerkship directors to oversee completion of required student clinical activities. Also at the February meeting, the LCME approved a standard on the content of medical school catalogs or bulletins to satisfy Department of Education recognition criteria; the alert reader will recall that a catalog requirement had been present in *Essentials of an Acceptable Medical School* (*Essentials*) from 1910 through its final revision in 1951. No other major standards changes occurred that year.

At the February 1998 meeting, the LCME initiated work on a new standard to address growing awareness of medical student mistreatment. More notably, it decided to set aside time at its April meeting to review the findings from the Medical Education Standards and Assessment (MESA) project that had been initiated earlier by LCME Secretary Donald Kassebaum, as noted in Chapter 5. The work resulting from that project would eventually lead to the next major revision of *Functions and Structure.*[184]

The 2002 Revision of *Functions and Structure*: Adoption of a List Format

The seeds of the 2002 revision of *Functions and Structure* were planted at the April 1998 retreat of the LCME, where in-depth discussions about the MESA project results took place. The project had examined LCME accreditation standards using two distinct approaches. In the first, AAMC accreditation staff reviewed the survey reports and medical education databases for all medical schools that had undergone full reviews between 1994 and 1996; from those documents, the staff identified all instances in which each of 48 standards related to teaching, learning, and evaluation were adequately addressed by medical schools (in the database) and by survey teams (in survey reports). While medical schools generally did well in documenting the evidence related to the 48 standards, survey teams frequently failed to discuss nearly half of the selected standards in their reports. The authors concluded that the deficiencies could be attributed to "ambiguities in the construction and meaning of the standards" and "uncertainties about the meaning of the requirements and the quantities that need to be audited."[185]

The second approach taken in a later part of the project was to administer a national survey of stakeholder groups about the importance and clarity of 44 standards from the 48 that had been analyzed previously. To conduct this survey, staff extracted individual statements from the prose version of *Functions and Structure,* thereby introducing the medical school community at large to standards in a list format. (The LCME had created a checklist of standards by individualizing the prose statements in the early 1970s, but this was developed mainly for internal use.) Stakeholder groups in this survey included medical school

deans and senior educational administrators, current and former LCME members and surveyors, medical students and resident physicians, residency program directors, and practicing physicians. This study identified some standards that rated low in importance or clarity and also determined that most of the standards with low ratings were the same as those neglected in survey reports.[186]

The LCME review of the project's outcomes led it to three conclusions: (1) some standards should have explanatory annotations to clarify their meaning, intent, and/or interpretation, (2) survey teams should receive structured guidance to familiarize them with the standards, and (3) the *Guide for Writing a Survey Report* needed updating to ensure that it required survey teams to report on all standards. To provide follow-up to the retreat, the LCME recommended the creation of an ad hoc subcommittee to review the MESA project findings on the 48 standards that had been studied and to make any needed recommendations for change; the subcommittee was also expected to review other accreditation standards after completing its initial review and recommendations.

The subcommittee was formally appointed at the June 1998 LCME meeting, with Frank Simon (an LCME member at the time, later to become the AMA secretary to the LCME) as chair. The subcommittee began its work by focusing on 13 standards that had proven to be the most challenging in the analysis of the MESA project data. In October the subcommittee reported to the LCME that it was considering several approaches to correct the problems associated with the 13 problematic standards, including revisions to the language of those standards, development of explanatory annotations for them, and revision of the guidebooks used by schools and teams to evaluate compliance with the standards. The subcommittee indicated that it would address the other standards from the MESA project after submitting its recommendations on the initial batch of 13.

Also at this October meeting, the LCME created the groundwork for three new standards. One, based on an inquiry from a Canadian educator, dealt with coverage of end-of-life and palliative care in the medical curriculum. Another addressed cultural diversity and culturally competent care, brought back to the LCME for consideration in conjunction with the AAMC's Project 3000 by 2000 (a possible standard on this subject had been considered and rejected twice previously during the decade). Finally, the LCME directed staff to begin work on a standard regarding provision of mental health services for students. Draft language for standards on these topics was approved by the LCME in February 1999, with the addition of pain management to end-of-life and palliative care coverage to the first.

The ad hoc subcommittee submitted its first recommendations for standards changes in February 1999, in most cases developing annotations for the standards and in some instances making relatively modest changes to standards language. The LCME approved the recommendations, and the subcommittee then proceeded to examine the other standards discussed in the MESA project. Since the standards were published in a prose format, the LCME staff created an insert sheet for *Functions and Structure* to communicate the new annotations to schools and surveyors (echoing, in a small way, the development of guidelines as a companion document for the 1973 version of *Functions and Structure*).

The subcommittee underwent a reorganization of its membership in June 1999 and in October began the task of examining 31 other standards from the MESA project on teaching, learning, and evaluation. Meanwhile, AAMC accreditation staff planned to initiate another stakeholder survey on the importance and clarity of all accreditation standards dealing with medical students, as part of the LCME effort to comply with Department of Education recognition criteria; the information obtained from that survey was expected to provide the substance for the subcommittee's work in the 2000–2001 academic year.

Apart from the work of the ad hoc standards subcommittee, the LCME also approved new and revised standards during 1999. In April it revised its standard regarding educational program evaluation to require that schools include student evaluations of required courses and clerkships as part of their process for program evaluation. In October the LCME finally relented to long-standing requests to include sexual orientation as a dimension of its nondiscrimination standard; in doing so, it also expanded the scope of the standard so that it applied throughout a medical school's organization and not only to the student admissions process. The LCME then approved a new standard requiring medical schools to have adequate finances; up to that time, the standard related to finances required only that schools exhibit diversified revenue sources.

The new list-based framework of accreditation standards resulting from the 2002 revision of *Functions and Structure*, accompanied by a medical education database and survey report guide that linked accreditation data and reporting to individual standards, was quickly embraced by the medical education community as a more understandable and transparent approach to accreditation.

The LCME modified its organizational structure at the February 2000 meeting, renaming its Task Force on Accreditation Policy and Reliability and Validity of Standards as the Executive Committee. It also made the ad hoc subcommittee on standards a standing committee of the Executive Committee, now officially named the Subcommittee on Accreditation Standards (shortened to Subcommittee on Standards later that year). For its part, the Subcommittee on Standards reported that it continued its work on creating new annotations where needed but was also contemplating a reorganization of the entire section of standards on the educational program in *Functions and Structure* to address some of the redundancy and inconsistency that it had identified. As the subcommittee continued its examination of *Functions and Structure,* it concluded that a major reorganization of the entire document was needed to eliminate content overlap and provide greater clarity. At the June 2000 meeting, the LCME authorized the subcommittee to begin the reorganization, to be completed by October 2001, and it also imposed a moratorium on new standards until the subcommittee had completed its work on reorganization.

One of the first challenges that the subcommittee had identified in its work to reorganize *Functions and Structure* was that the medical education database used by schools to document compliance with accreditation standards was not organized in a manner consistent with the standards. For example, the database contained sections under the headings "Departments" and "Continuing Medical Education" that had no clear connection to corresponding standards (in fact, there were no standards specific to departments or to continuing medical education). In addition, the subcommittee discovered that the prose format of *Functions and Structure* did not accommodate the growing list of annotations being developed to clarify the meaning and application of standards.

By June 2001 the subcommittee had completed its resequencing of standards to be situated under the headings "Institutional Setting" and "Educational Program for the M.D. Degree" and anticipated that it would complete the relocation of remaining standards in time for the October meeting, as originally planned. The subcommittee presented its recommendations at the October meeting, producing a new version of *Functions and Structure* with five major subheadings: "Institutional Setting," "Educational Program for the M.D. Degree," "Medical Students," "Faculty," and "Educational Resources." The prose format was retained, but a list version containing annotations for selected standards was provided to complement the prose. Each standard was also coded according to its location in *Functions and Structure*; thus, the first standard listed under the "Institutional Setting" heading was coded as IS-1, and the second standard under the "Educational Program" heading became ED-2. The subcommittee was careful to point out that the new format did not change the content or meaning of standards and thus did not require sponsor review. The LCME approved the new framework and lifted the moratorium on new standards; nevertheless, the change in the organization of *Functions and Structure* was dramatic enough that the LCME felt compelled to obtain sponsor approval.

By April 2002 the sponsors had approved the new framework, and *Functions and Structure of a Medical School* had taken on a new look. The staff immediately began work on reorganizing the medical education database and other supporting documents to link standards directly with the data needed to document compliance with them. By placing database questions directly under each standard (and annotation, where appropriate), the LCME made it clear to medical schools what evidence it sought to indicate compliance with the standard. The linkage was completed by aligning the *Survey Report Guide* with the standards and database questions to ensure that survey teams documented the evidence supporting their findings. In an unrelated action, the LCME approved two new standards at the April meeting, one addressing organizational planning and the other linking overall educational program objectives to the physician competencies to be demonstrated when physicians undertook their residency education.

The 2014 Revision of *Functions and Structure*: A New Taxonomy of Standards and Elements

The new list-based framework of accreditation standards resulting from the 2002 revision of *Functions and Structure*, accompanied by a medical education database and survey report guide that linked accreditation data and reporting to individual standards, was quickly embraced by the medical education community as a more understandable and transparent approach to accreditation. In the ensuing decade the LCME would continue its practice of establishing new standards as needed, albeit much less frequently than it had done in the past. It would also become clear over time that there was still some overlap and redundancy of standards, as schools were sometimes cited for noncompliance with two, three, or more standards that all reflected a single underlying issue. This commonality of selected content in some accreditation standards eventually contributed, in part, to a decision to cluster standards.

Before the clustering process would begin, however, the LCME continued to adopt new standards and revise others when issues were brought to the organization's attention; it also devoted considerable effort to creating additional annotations to clarify standards. Almost immediately after the 2002 revisions were adopted, the LCME authorized a new standard at its June meeting requiring that the

environment for medical education include medical student exposure to graduate and continuing medical education. For the next few years, however, very few requests for new standards were presented and none were adopted; nevertheless, minor revisions to the language of standards continued, as did the development of annotations.

The next new standard to come under consideration was a requirement for medical student involvement in service learning, which had been proposed in the context of a recently published report on the social contract of Canadian medical schools.[187] In October 2005 the LCME instructed its Subcommittee on Standards to begin exploratory work on such a standard. At that same meeting, a task group that had originally been created in February 2003 to explore the negative effect of the "hidden curriculum" in medical education produced recommendations for a new standard on professionalism and the learning environment. Those two standards were approved by the LCME in June 2006, along with another standard requiring that students learn basic principles of clinical and translational research.

At the February 2007 meeting, the LCME heard a presentation from a senior AAMC staff member about AAMC diversity initiatives. The LCME had itself begun to reconsider its approach to diversity a year earlier when, in light of concerns about the number of schools being cited for noncompliance with diversity-related standards, it had created a working group to analyze the issue. As part of the February meeting, the working group on diversity presented a series of recommendations that included possible new standards on the subject. At the next meeting in June, the LCME gave its approval to a new standard on institutional diversity that replaced previous separate standards on student and faculty diversity, as well as another standard addressing the need to address diversity in the medical school applicant pool.

Meanwhile, the Subcommittee on Standards had taken note of several instances in which schools were being cited for noncompliance with multiple standards all tracing to a single problem; the notorious ED-2 standard, unloved by the medical education community, seemed to be particularly prone to this problem. To address the issue the subcommittee recommended, and the LCME approved, the use of annotations to indicate how such problems could be avoided.

In February 2008 the LCME approved a subcommittee recommendation to eliminate its standard encouraging faculty collaboration in teaching, research, and service, based on feedback from one of the LCME's periodic surveys of stakeholders. At the June meeting that year, the LCME decided to forsake the prose format that had been in use since the 1927 revision of *Essentials*, committing itself to the list format exclusively. In other standards-related actions at that meeting, the LCME ended its long-standing standards language listing specific basic science and clinical disciplines to be included in the curriculum, opting instead for more general statements about preparing students for further education; this decision ended a practice that had been in place for over a century. (Technically, the 1973 revision of *Functions and Structure* had also eschewed named disciplines, but those disciplines were included in the *Guidelines* document that accompanied the 1973 version of *Functions and Structure.*) The LCME also opted to add gender identity to the list of dimensions for which its standard on nondiscrimination would apply.

In June 2009 the LCME approved a new standard dealing with the appropriate supervision of medical student clinical learning to ensure patient safety. In a rather uncommon move, it also combined what had been two separate standards that shared a common theme, one dealing with the process for selecting medical students and the other dealing with informational materials describing the selection process. At the October meeting it again combined two standards, merging a standard on student educational exposure to graduate and continuing medical education with a standard on student interactions with learners from graduate programs and other health professions.

Little of note occurred during the next year in terms of major standards issues until the October 2010 meeting, when the report of a joint meeting of the LCME's standing subcommittees on standards and policies was brought to the full membership. Among the issues that emerged was recognition of a need to develop benchmark data to assist in the interpretation of compliance with standards and to understand the relative impact ("power" was the term used in the minutes) of standards versus annotations in the self-study process and survey team evaluation of medical education programs. The latter discussion was prompted by the increasing tendency of survey teams to treat failures to address the specifications of annotations as evidence for noncompliance with standards. Meanwhile, at its February 2011 meeting the LCME discussed the challenges posed by the Department of Education recognition requirement setting a two-year limit for accredited institutions and programs to achieve compliance with accreditation standards; a joint work group with members from the subcommittees on standards and policy was created to explore that issue in greater depth. These actions taken at the October 2010 and February 2011 meetings would provide the kernel for the next major revision of standards.

In closing this section on the development of accreditation standards, it should be pointed out that the last two major revisions of *Functions and Structure* highlight one of the basic, unresolved issues in accreditation—namely, what exactly is an accreditation standard?

The Subcommittee on Standards continued its usual practice of recommending various modifications to standards and annotations over the next year. The minutes of the June 2012 LCME meeting mentioned that the subcommittee would be meeting later in the summer to work on the clustering of standards, although the motivation for undertaking that effort was not stated. At the October meeting that year, the subcommittee presented its first draft of a framework where individual accreditation standards would be grouped into several clusters reflecting common themes (such as medical student services). After reviewing the subcommittee's work, the LCME approved the clustering concept and instructed the subcommittee to go forward with a plan and timetable to reorganize the standards into clusters. The LCME also approved a new standard on interprofessional learning at the October meeting.

By February 2013 the Subcommittee on Standards had elaborated a framework that introduced a new terminology for its accreditation criteria, with a core set of 12 "standards," each of which included a varying number of "elements" that captured the required components of the parent standards. It was surmised that this new nomenclature would help to address the Department of Education's two-year compliance criterion, since it would be possible, at least in principle, for a program to comply with a

standard even if it did not satisfactorily address every element within that standard. The issue of how to judge compliance with standards in this new framework was identified as a topic for extended discussion at the next meeting of the LCME.

The new framework for standards was discussed extensively at the June 2013 meeting, and the outcome was approval of the new approach as proposed by the standards subcommittee. A preamble to the new draft of *Functions and Structure* included the rationale for the reorganization, and cited the following issues that the new framework was intended to address:

- Enhancing the efficiency of the accreditation process by reducing the number of standards from 132 to 12
- Refining standards by creating meaningful groupings of elements within each standard
- Streamlining the standards by consolidating standards (now called elements) with similar purposes
- Eliminating unwanted redundancies and deleting standards for which measures of compliance were inadequate
- Incorporating critical portions of existing annotations into standards and/or elements when appropriate
- Replacing the language of "must" and "should" in standards with simple declarative statements
- Ensuring that the language of standards and elements remained consistent with the LCME's interpretation of those items[188]

Thus, the new version of *Functions and Structure* introduced a fundamental change in the format of accreditation criteria, while preserving the content of the previous version within this new framework. It should be noted that this framework of a nested hierarchy was not a novel invention of the LCME. Many regional and specialized accreditors had been using a similar approach for several years. Like the preceding major revision of 2002, this change would also require the reformulation of the LCME documents that accompanied *Functions and Structure* (the medical education database, now referred to as the data collection instrument, as well as guidebooks for institutional self-study and for writing the survey report). In February 2014 the new framework was approved for implementation effective at the beginning of the 2015–2016 academic year. A Canadian version, tailored to the unique circumstances of Canadian medical schools, was approved by the LCME in June 2014.

In closing this section on the development of accreditation standards, it should be pointed out that the last two major revisions of *Functions and Structure* highlight one of the basic, unresolved issues in accreditation—namely, what exactly is an accreditation standard? When LCME standards were written in a prose format, questions sometimes arose as to whether the "standard" was a specific sentence, a cluster of sentences, a paragraph, or some other unit. The supporting questionnaires provided no guidance, since they were not directly linked to specific statements except to the extent that the content of a question mapped to the content of a sentence or paragraph in *Functions and Structure.* The 2002 revision, switching to a list format, established that standards were single statements (sentences), albeit rather complex statements in some cases. The list format facilitated the linkage of accreditation data to standards, both by tagging questionnaire data to specific standards and by clarifying the requirements of individual standards by way of annotations.

The clustering approach of 2014, however, again muddied the waters of defining the term "accreditation standard." In this approach standards took on a very broad meaning, requiring a series of elements to specify the particular components or expectations embedded within the broader statements. For the LCME, the operational definition of a standard in the clustering framework would now depend on how elements were treated. If every element must be addressed satisfactorily, the elements function as de facto standards and the more encompassing "standard" in essence becomes a subject heading. If, on the other hand, it is possible to achieve compliance with a standard but not be required to address each element within a standard satisfactorily, then the standard establishes the ultimate requirements and the elements become more like annotations. Interestingly, many of the annotations from the previous version of *Functions and Structure* were converted to elements in the 2014 revision.

PART III

Development of Accreditation Procedures and Processes

Chapter 11

On-Site Evaluations and Size and Membership of Evaluation Teams

The core of the Liaison Committee on Medical Education (LCME) accreditation process is the on-site evaluation of a medical school, conducted on a recurring interval by a team composed mostly of volunteers from other medical schools. The team prepares a written report of its evaluation, which then serves as the main information source used by the membership of the LCME to determine a school's accreditation status. Selection of team members is one of the more challenging activities of the Secretariat staff, as they try to match the experience and background of team members with the distinctive characteristics of each school to enhance the team's understanding of the school's environment and practices.

From Inspections to Visits to Surveys

When the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) embarked on their programs to improve medical education quality, they did not initially conduct on-site evaluations of any medical schools. Although they promulgated standards for educational quality, the organizations did not examine the operation of individual medical schools firsthand to determine how well those standards were met. The first known efforts to evaluate individual medical schools took place shortly after the formation of the AAMC. In a review of the early history of the AAMC, the presidential address at the 1898 AAMC meeting noted that "judged by their annual announcements, the majority of the colleges in the country [during the 1870s and 1880s] did not show that they conformed to all the requirements for active membership."[189] Minutes from the 1893 AAMC meeting noted, "Upon motion the Judicial Council and the Secretary were instructed to investigate the character of the work being done by the various colleges suspected of laxity in their curriculum and report at the next annual meeting."[190] In 1902 the AMA began to publish the performance data of U.S. medical schools on state licensure examinations in the *Journal of the American Medical Association* (*JAMA*) as evidence of the current state of medical education quality.

This approach changed dramatically when the newly minted AMA Council on Medical Education (CME), under the leadership of Arthur Bevan, decided to visit every medical school in the United States in order to evaluate educational quality. While Bevan personally participated in some medical school visits, Morris Fishbein noted that most of the school inspection program was carried out by the council's secretary, Nathan P. Colwell, frequently in company with another member of the CME.[191] Colwell would later accompany Abraham Flexner in visiting every U.S. medical school in the second round of medical school inspections in 1909.

At about the same time as the CME inspection program began, the AAMC decided that it would also conduct on-site evaluations of its 67 member institutions. In 1904 the organization established a three-member "visitation committee" consisting of the association's president, secretary, and the chairman of the AAMC Judicial Council; it also agreed to provide $400 to defray the cost of medical school visits

and indicated a willingness to cooperate with the AMA or the national licensure organization in the conduct of visits.[192] Although the funds were not disbursed, AAMC Secretary-Treasurer Fred Zapffe went ahead and conducted visits to nine medical schools. In 1907 the AAMC adopted a policy that every member institution should undergo a visit once every five years, although the policy was never implemented fully for lack of adequate funding.[193]

In succeeding years, the AMA CME would conduct periodic comprehensive inspections of all medical schools and visit individual schools at any time at the school's request. Most of the comprehensive inspections took place in the early part of the century, with two of them (in 1911 and 1913) following closely on the heels of the Flexner Report's publication. The second comprehensive inspection (conducted jointly by Flexner and selected members of the council) was the first to include Canadian medical schools. The CME did another round of inspections from 1919 to 1922, this time in collaboration with the AAMC. The last round of comprehensive visits, with very limited AAMC participation, took place from 1934 to 1936.

The minutes of the November 1949 LCME meeting documented a concern that the effort required by many schools to complete extensive forms and questionnaires was growing increasingly burdensome; nevertheless, the inspection program continued.

The process for medical school inspections was revitalized by the formation of the LCME in 1942. An interesting side note to the renewal of joint inspections was the rationale cited in the AAMC annual meeting minutes from 1942: "[I]nspections of colleges … [should] be made jointly by the secretaries of the two groups, so as not to involve the dean of any medical college who might not find it to his liking to pass judgment on another medical college."[194] The statement clearly suggested that peer evaluation was not an intrinsic component of early accreditation activities for medical schools. Data from the annual proceedings of the AMA House of Delegates indicated that during the first five years of the LCME's existence, the number of schools inspected ranged from a low of 8 in calendar year 1942 to as many as 16 in 1944.

By 1949 the program of regular inspections was becoming problematic for schools. The minutes of the November 1949 LCME meeting documented a concern that the effort required by many schools to complete extensive forms and questionnaires was growing increasingly burdensome; nevertheless, the inspection program continued. Another issue, namely providing consultative advice during inspections, also surfaced at the same meeting. The minutes noted that "the question was raised as to whether the data collected by the survey team should be purely factual."[195] It was then pointed out that several schools had requested advice from the team. No conclusion resulted from that discussion.

The issue of consultation popped up again in June 1952. At that meeting, the LCME discussed the possibility of conducting shorter, more informal visits that would result in a memorandum of the visit

but not a report requiring action. The members agreed that such visits were not in conflict with prior practice and agreed that they could take place when appropriate. Minutes of the AAMC annual meeting in 1953 suggested that such visits began in the previous year: "[T]his past year we experimented with two types of visitations—full surveys and what might be called limited objective visits, the former requiring five or six days, the latter only one to four days."[196]

The shift toward visits as consultative activities became most apparent in the following quotation, from a letter sent in December 1952 by the secretaries of the CME and AAMC Executive Council (on LCME letterhead) to medical school deans about National Commission on Accrediting (NCA) proposals regarding accreditation:

> The Association of American Medical Colleges and the Council on Medical Education and Hospitals, however, firmly believe that their activities in the field of accreditation are based on sound principles and are conducted fairly and judiciously. It may be pointed out that the visits to the medical schools by the Council and the A.A.M.C. for many years now have been conceived primarily as a consultative and advisory service and only secondarily as a procedure for determining whether or not an institution meets the minimal standards for an approved medical school.[197]

The earliest insights into the structure of an LCME visit can be found in the minutes of a meeting between the LCME and representatives of the Middle States Association of Colleges and Secondary Schools, held in May 1953, to explore possible areas of cooperation. In response to a question from a Middle States Association representative about site visits, Joseph Hinsey of the AAMC noted that the ideal arrangement was to visit a school every five years, although some schools were visited more frequently. He went on to point out that formal visits (for approval) covered a period of four or five days. The school would complete a set of questionnaires in advance of the visit, and at the end of the visit an interview would take place with the institution's dean and its president to review the findings and make recommendations. A formal report of the visit would be prepared afterwards. When the LCME adopted *Functions and Structure of a Modern Medical School* as its own compendium of accreditation standards in 1957, the document also included a brief summary of the accreditation process and the on-site survey, as described above.

Additional information about the structure of visits next appeared in the minutes of the February 1959 LCME meeting. After reviewing the upcoming schedule of visits for the year, an AAMC representative to the LCME mentioned several changes that were being planned or considered. They included revision of the presurvey questionnaires; creating a "staff pool" from the sponsoring organizations, with one member selected from the pool to participate in the visit and to be responsible for the preparation of the visit report; limiting the length of the visit to three and one-half days (two days for follow-up visits); and reserving the second and third nights of the visit for a team review of findings to be included in the report. Apparently, before this time, reports were prepared by a single team member and did not necessarily incorporate the consensus of the team.

Much more information about the structure of accreditation visits was contained in documents developed by the LCME in response to a meeting held by "assistant secretaries" (i.e., team secretaries) in 1960. One of these documents, the *Guide for Medical School Visitation,* included some explicit details about the recommended structure and conduct of visits. The roles of survey team members were defined. Specifically, the chair served as the spokesperson for the team and the secretary (officially called "assistant secretary for the Liaison Committee survey team") was designated as the team member responsible for the report of the survey. Dual functions were ascribed to the survey: development of a team recommendation regarding the school's accreditation and provision of expert advice to the institution. A section in the *Guide for Medical School Visitation* titled "The Visitation" included the following statement:

> Members of the team are expected to be as critical as necessary and as helpful as possible. They should be aware that their advice may, for various reasons, be interpreted as implying official action of the Liaison Committee when, in fact, it is an individual or team suggestion. For these reasons the communications of the consultant team, whether given collectively or individually, should make the nature of the advice clear. There should be a formal oral presentation of the recommendations of the team to the responsible administrative officers of the institution at the end of the visitation.[198]

At the June 1962 meeting where the visitation guide was adopted, the LCME also approved a new presurvey questionnaire that schools were expected to complete in preparation for a survey. The questionnaire included details about the structure of a survey, including a prototype visit schedule. The first day of the visit began with a 9:00 a.m. meeting with the dean "for general orientation and discussion of special problems of administrative concern."[199] The remainder of the day was occupied by one-hour meetings with various medical school departments. Similar meetings with departments took place during most of the second day, which ended with a session about the medical school library. On the third day meetings with additional departments took place in the morning. During the afternoon the schedule called for two hours of meetings to discuss student clerkships; these meetings took place on the wards with two to four students in attendance. The day ended with two more hours for review of student admissions and records, student guidance, and other student-oriented topics. The prototype schedule also noted that the team expected to meet with a representative group of students (two from each medical class), either during lunch or at the end of the day at some point during the visit. On the morning of the final day, the visit concluded with exit conferences with the dean and university president.

In early 1966 the LCME considered but rejected a proposal to expand the size of the survey team to six members; it also rejected a recommendation to include a meeting with the board of trustees during the course of survey visits.

The structure of surveys underwent little change during the 1980s and 1990s. The length of visits was shortened by a half day in 2002, allowing teams to conclude their work by the end of the third day. The last noteworthy change in survey structure took place in 2010, when the LCME authorized its

survey teams to provide a written report of their summary findings to the medical school dean and to the senior university official. Before that time, team findings were shared orally during exit conferences with the dean and university leader, and the dean of the medical school had an opportunity to discuss or seek clarification of the team findings. The problem with this approach was that the dean had little time to take notes on the team findings as they were read during the exit conference and was therefore unable to capture much of the nuance that was often expressed in the language of the team's findings regarding compliance with standards. Also, some schools used the exit conference as an opportunity to contest the findings of the team. To address these problems, the LCME agreed to allow its teams to provide the dean with a written copy of its summary findings, along with a disclaimer stating that the findings of the LCME could ultimately differ from those of the team. Since the detailed language of the findings was now accessible to the dean, the LCME also determined that there was no longer a need for discussion of the team's findings during the exit conference.

The prototype schedule also noted that the team expected to meet with a representative group of students (two from each medical class), either during lunch or at the end of the day at some point during the visit.

Survey Teams

When the AMA CME and the AAMC began their programs of medical school inspections, the evaluation teams typically consisted of the chair or secretary of the corresponding organization, occasionally both. During the early years of the CME, inspections were conducted mainly by Colwell, its first secretary; AAMC inspections were carried out by Zapffe, its first secretary-treasurer. Other members of the CME would occasionally substitute for Colwell on inspections, while Zapffe always represented the AAMC for its inspections. Of course, the most notable inspector to participate in the second round of CME inspections was Flexner.

By the 1920s the AAMC Executive Council had assumed responsibility for oversight of the organization's medical school inspection program, and minutes from the AAMC proceedings during those years indicated that various members of the council participated in the school visits. When the AMA's Council on Medical Education and Hospitals (CMEH) undertook its last comprehensive survey of all U.S. medical schools during the early 1930s, it enlisted the services of Herman G. Weiskotten to lead the effort, with the support of other CMEH members.

When the LCME was formed in 1942, it continued the practice of sending the secretaries of the respective AMA and AAMC councils to visit medical schools. As noted above, the LCME at its inception expressed an aversion to involving medical school deans as part of the inspection process. Nevertheless, some medical school deans did participate in medical school inspections when asked by the AAMC. By 1952 the number of deans willing to participate in inspections was declining, and in June of that year the

LCME authorized associate deans to serve on inspections, subject to approval by the individual dean. Review of LCME survey reports revealed that the typical size of teams had increased to four during the early 1950s and remained that way until the LCME formalized a "faculty fellow" program in 1987. The minutes of the 1958 AAMC annual meeting describe the composition of survey teams:

> A survey team consists of four or five persons. Two individuals must represent the Council of Medical Education and Hospitals of the AMA, one being the Secretary or Associate or Assistant Secretary of the Council, and the other being a member of the Council. Two individuals represent the Association of American Medical Colleges, one being the Assistant Secretary or the Secretary, and the other being a dean, who is usually a member of the Executive Council. A representative of the Regional Accreditation Association is also often invited by the surveyed university. This individual acts as a "generalist" and consultant.[200]

Teams of four were employed for both new and established medical schools, although in 1958 an LCME member questioned the need for four members to evaluate new schools; the minutes of that meeting do not indicate any action, however, regarding team size.

At the February 1959 meeting of the LCME, AAMC Executive Council Secretary Richard Young recommended that the two sponsoring organizations develop a pool of their respective staff members, with one member of the pool selected to represent the LCME as the secretary of each survey team. Although this recommendation was not adopted, later that year the LCME conferred the title of "assistant secretaries to the Liaison Committee" on four medical school leaders who were not members of the LCME but functioned as secretaries of survey teams. The minutes of the 1959 AAMC meeting indicated that two additional assistant secretaries had been appointed, bringing the total to six.[201] Among the initial cohort of assistant secretaries was the future first president of the AAMC, John A.D. Cooper, and a future LCME secretary, James R. Schofield.

When the LCME adopted its first *Guide for Medical School Visitation* in 1962, team structure and roles were formalized. The team secretary was now rechristened as an assistant secretary of the Liaison Committee survey team, responsible for all logistical preparations for the on-site evaluation and for preparation and distribution of the report. The team chair was established as the official voice of the team during and after the survey. Those roles and functions continue through the present day.

No further changes in team composition or size would take place for several years. In February 1966, the LCME considered but rejected a recommendation from its Committee on Accreditation Procedures that the size of teams be increased to six members. A fifth member was incorporated as a regular participant on survey teams in 1987, when the Secretariat recommended the designation of a "faculty fellow" to be added to each team. The underlying concept of the faculty fellow was to add to each team a neophyte evaluator, nominated by his or her medical school, who would gain firsthand experience with the accreditation process and thus enhance the sponsoring medical school's knowledge base for LCME accreditation.

As noted above, LCME survey teams occasionally included an observer, typically from a regional accrediting organization or a state-level education department. In 1980 the LCME authorized its student members to participate as observers on a site visit during their term of service. In 2001 the LCME adopted a procedure to appoint an LCME representative (member or professional staff) to each survey team whenever possible, to enhance the consistency of the team in its interpretation of standards.

As early as 1958 the LCME provided a $500 honorarium to its team secretaries in recognition of their responsibilities for preparing survey reports; no other team members have ever received any form of compensation for their service. The secretary honorarium was increased to $1,000 in 1985. Five years later the payment was again adjusted, providing $1,250 for secretaries of teams on full surveys and $750 for secretaries of teams for limited surveys. Another increase in the honorarium took place in 1997: $1,500 for full surveys and $1,000 for limited surveys.

For most of its history, the performance of survey team members was not subject to any formal evaluation process. That changed in 1992 when the LCME agreed to a procedure that allowed deans of schools being surveyed to provide a written evaluation of a team's performance. Results of such evaluations were sent directly to the LCME Secretariat and shared with the LCME only in cases involving exceptionally positive or negative comments. The team secretary was also asked to provide a formal evaluation of the faculty fellow, for discussion with the fellow and the team chair at the conclusion of the survey visit. Training sessions for survey team chairs and secretaries were first offered by LCME staff in 1985, in conjunction with the contemporaneous major revision of LCME accreditation standards. The first workshops for other team members were conducted in the late 1980s but fell into disuse in succeeding years; they were revived in 1997 and continue today.

Chapter 12

Accreditation Data: Questionnaires, Databases, Data Collection Instruments

The success of any accreditation process depends on the quality of the data used to evaluate an institution or program's compliance with accreditation standards. The primary source of such data is information provided by the institution or program. It comes in two forms: documentation prepared in advance of an on-site accreditation survey, and annual reporting of selected information to the LCME or its sponsors. During the early years of medical school accreditation, the instrument used to collect data for an on-site evaluation was referred to as the "presurvey questionnaire," and in later years it was called the "medical education database." In the last few years the nomenclature was revised again, and it is now designated as the data collection instrument (DCI).

Documentation Prepared for an Accreditation Survey

The oldest known copy of the presurvey questionnaire was published by AAMC Secretary Fred Zapffe when he summarized his visits to nine medical schools in the 1904 proceedings of the AAMC.[202] The 40 items constituting that questionnaire are reproduced in Chapter 1. The questionnaire was remarkably detailed and covered every major aspect of medical school operation: history, administration, educational and clinical facilities, students, faculty, and curriculum.

The AMA gathered similar information. The Council on Medical Education (CME), describing its work in the 1906 AMA proceedings, included the following as one of its activities:

> Compiling of facts regarding medical colleges to be issued in book form, giving seat, history, hospitals, dispensaries, buildings, equipment, teaching force, preliminary requirements, admission to advance standing, medical curriculum, requirements for graduation, fees, number of graduates for the current year, length of college year and the name of the dean of each medical college in the United States.[203]

The information collected as described above was included in the AMA's *American Medical Directory,* first published in 1906. The council also expressed its intention of "securing, tabulating, and publishing of statistics regarding medical students in the medical colleges of the United States and the graduating classes for the last year" and "collecting and filing any other obtainable information bearing on medical education."[204] While much of this information was collected in conjunction with the CME's inspection program, some was obtained by securing reports from individual medical schools.[205]

The presurvey questionnaire continued to serve as the primary source of information for medical school accreditation after the creation of the LCME. At its October 1958 meeting, the LCME decided to review the questionnaire, with a view to refining or simplifying its content. Further work on the presurvey questionnaire was reported at the LCME's October 1960 meeting. A recommendation that

had emerged from an earlier meeting of assistant (i.e., survey team) secretaries had been development of a more abbreviated previsit questionnaire, with the expectation that much of its content could be incorporated directly into the report of the survey. As the minutes of the October meeting noted, "This should cut down upon a great deal of the writing and secretarial work that is involved in preparing these reports." Such reports were typically 25–30 single-spaced pages.

A complete copy of the presurvey questionnaire employed by the LCME was included as part of its *Guide for Medical School Visitations,* approved in 1962. The questionnaire was organized into a series of discrete forms, each of which included several questions and tables to be completed by the medical school. Separate forms were provided for the following subject headings:

- Organization
- Budget and Finances, including itemized departmental budgets
- Students
- Plant (physical)
- Library
- Clinical Facilities
- Outline of Curriculum
- Continuing Education (postgraduate)
- Other Educational Programs (such as graduate programs and residency programs)
- Basic Science Departments
- Clinical Departments
- Roster of Active Departmental Personnel (to be completed for each medical school department)
- Clinical Clerkship

This structure remained in use, for the most part, as the medical education database until the 2002 revision of *Functions and Structure of a Medical School* (*Functions and Structure*). At that time, a comprehensive reorganization of the medical education database was undertaken to align the questions with specific accreditation standards. The revised database subsumed each of the previous database headings and its associated questions under a specific standard within one of the five major topical areas of *Functions and Structure.* For example, database questions about the library that had been included within that section of the previous database were placed under the specific library standard within the "Educational Resources" section of the new database. This allowed the reader to see the database questions listed directly below the standard for which the questions were relevant.

In addition, each of the five major headings of the new database began with a section of "key quantitative indicators" incorporating information that medical schools had been providing annually to the LCME via other questionnaires administered by the AMA and the AAMC. For example, in the database section on students, schools were asked to provide data on the average debt of indebted students for each year since the last full accreditation survey of that school as one of the key quantitative indicators. This section on key quantitative indicators preceded questions related to specific standards within each of the five major database sections.

In the 2014 reorganization of *Functions and Structure,* the database, now referred to as the DCI, was once again aligned to place specific questions under the appropriate headings and elements used in the standards document. The sections on quantitative indicators from the previous version of the DCI were incorporated within the relevant elements rather than being set apart within subject headings (standards).

One of the more distinctive approaches of the LCME in collecting accreditation data, compared with the practices of many other accreditors, is its extensive use of information provided by medical students directly as part of the documentation used for on-site evaluation. Beginning in the early 1980s, the LCME asked students at schools to be reviewed to conduct their own survey of student opinion about the school, including questions on its organization, curriculum, student assessment policies, and support services. The LCME provided students with guidance on the development of a questionnaire to collect such data that were then summarized in a report, the "Independent Student Analysis," to accompany the DCI as part of a school's previsit documentation. This student-based information was further buttressed in the late 1990s when the LCME began requiring schools to include a copy of the most recent graduation questionnaire (an AAMC-administered questionnaire completed by graduating medical students each year) given to their students as part of that documentation.

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Annual Questionnaires

Distinct from the information provided by a medical school in preparation for an on-site evaluation, the LCME's sponsoring organizations also have a long history of collecting information about medical schools that was available to the AMA CME and the AAMC Executive Council (before the creation of the LCME), or to the LCME itself, to assist in the evaluation process. Both the AMA and the AAMC collected data about medical students during the early 20th century, and providing such information was one of the requirements for membership in the AAMC. The AAMC constitution required that each member medical college submit an annual list of all students matriculated since the school's previous report, showing "the character and extent of the credentials for entrance, the conditions entered against said student and the standing accorded him."[206] However, this requirement was eliminated in 1912, when the AAMC ceded the responsibility for collecting student information to the AMA, which was doing the same work and was willing to share its information with the AAMC.

More detailed information gathering by the LCME sponsors continued in ensuing years. For its part, the AMA developed an annual questionnaire sent to all U.S. medical schools, collecting data used as the basis for the annual medical education issue of *JAMA*. The AAMC, meanwhile, appointed John Stalnaker as

director of studies in 1951; his primary responsibility in that role was to conduct statistical studies of medical schools and medical education on behalf of the AAMC. In his first report to the AAMC membership, Stalnaker stated, "As medical education is a field in which public interest is growing, and probably will continue to grow in the next few years, the A.A.M.C. should gather for its own information and for public enlightenment as much factual data about certain aspects of medical education as possible, and devise means for presenting such information so that the public will understand it."[207]

Recognizing the duplication of effort in data collection by both the AMA and the AAMC, the LCME in 1957 discussed data collection activities between the two organizations and agreed to develop jointly an annual questionnaire on medical education for use in succeeding years. In 1958 the AAMC articulated a long-perceived need for providing accurate information about the finances supporting medical schools; as early as 1953, the LCME discussed the desirability of conducting a study of medical schools' financial needs. Over the course of the next year, under the leadership of Stalnaker, the LCME circulated a questionnaire on medical school finances to all U.S. schools and provided a summary report to the LCME in June 1954. This was not an ongoing activity, however, and the AAMC proceedings for 1958 included an announcement that it had received a grant from the W.K. Kellogg Foundation to finance a one-year study of medical college financing.[208]

The increased data collection efforts of the LCME and its sponsoring organizations were proving to be burdensome to medical schools, however, and the October 1958 LCME agenda included an item called "Problems of Multiple Questionnaires and Surveys Directed at Schools of Medicine." This led to further streamlining of questionnaires by the organizations involved and eventually to the differentiation of an LCME questionnaire on finances (the "Part I Annual Financial Questionnaire") and another on medical education (the "Part II Annual Medical School Questionnaire"). In later years the Part I questionnaire on finances would be further subdivided into Part I-A (on medical school finances) and Part I-B (on medical student financial aid). In a long-standing mutual agreement, the AAMC has maintained responsibility for collecting data for the Part I-A and I-B questionnaires on behalf of the LCME, while the AMA oversees the collection of Part II data.

Chapter 13

Decision Making: LCME Scope, Term of Accreditation, Actions

Over the course of its history, the LCME has been very careful to circumscribe what kinds of institutions and programs it accredits, although at several points it has flirted with accreditation of osteopathic educational programs, graduate and continuing medical education, graduate programs in basic sciences, and even other health-related professions. Within its scope of accreditation for MD-granting programs, the LCME has varied over time in its approach to the duration for which a program can be accredited and the options available for dealing with identified deficiencies when schools or programs fail to meet accreditation standards.

The Reach of the LCME

The focus of the inspection activities of the AMA Council on Medical Education (CME) and the AAMC Executive Council during their early history was clearly U.S. and Canadian medical schools. The early inspections of the CME included homeopathic and eclectic medical schools in addition to traditional MD-granting programs; other types of medical schools, particularly osteopathic educational institutions, were considered to be cult institutions and therefore outside the scope of the CME's efforts. From its inception, the AAMC did not offer membership to schools providing homeopathic or eclectic educational programs. That particular dam was breached in 1928, when the AAMC admitted the New York Homeopathic College of Medicine to its membership. In 1936 the college abandoned its titular commitment to homeopathy and was rechristened the New York Medical College.

Shortly after creation of the LCME, the possibility of approving osteopathic schools was brought to its attention. The so-called osteopathic situation appeared as a discussion item on the agenda of the June 1943 LCME meeting, likely in response to some interest in the osteopathic community to obtain AMA approval. However, no osteopathic schools had formally requested AMA consideration or AAMC membership, and the LCME took no action at the time. The LCME had another brief flirtation with osteopathic accreditation in 1952. That year, the president of the AMA in his address to the House of Delegates had raised the possibility of elevating the quality of osteopathic schools, if the schools were willing to abandon their commitment to osteopathic principles. This issue was brought to the LCME's attention at its June meeting, but again no action was taken.

In succeeding years the LCME would periodically revisit the issue of osteopathic medical school accreditation, but without any change in its long-standing policy of accrediting only MD-granting institutions. The most recent discussion of this issue took place in June 2015. The national osteopathic accrediting organization approached LCME representatives about potential areas of collaboration, particularly sharing of clinical teaching sites; in response, the LCME agreed to continue discussions with the osteopathic accrediting agency about issues and challenges that both accreditors face.

The LCME was also approached about taking on the responsibility for accrediting graduate medical education programs. This possibility surfaced initially in 1956, when a U.S. medical school dean approached the LCME about the organization's interest in accrediting graduate (post-MD) programs in occupational medicine being offered by graduate schools. The LCME concluded that the locus for such an accreditation activity should more properly reside with the sponsors of the Residency Review Committee for Preventive Medicine—the CMEH, the American Public Health Association, and the American Board of Preventive Medicine.

Discussions of graduate medical education (GME) continued frequently at LCME meetings in later years, since both sponsoring organizations had distinctive, long-standing interests in that segment of the medical education continuum. The possibility of the LCME undertaking a formal role in the accreditation of GME resurfaced at its January 1969 meeting. The members took no action at the time, but when the topic came up again at the May meeting that year, the notion of a commission on medical education was brought forward. Such a commission would use the LCME framework and provide a vehicle for evaluation of graduate and continuing medical education programs, as well as some allied health professions. Discussions about the proposed commission became a regular agenda item for the LCME over the next two years, culminating in the decision in July 1971 to establish the LCME Task Force on Graduate Medical Education. In the AAMC president's report to the organization's membership that year, John A.D. Cooper summarized plans for a number of association activities, including "incorporating the accreditation of graduate medical education into an expanded LCME."[209]

Ensuing discussions by LCME sponsors over the course of the next year about the LCME's role in accreditation of graduate medical education led to the creation of a separate Liaison Committee on Graduate Medical Education (LCGME), parallel to but distinct from the LCME. The new group was jointly sponsored by the AMA, AAMC, American Hospital Association, American Board of Medical Specialties, and Council of Medical Specialty Societies. In addition, the activities of the LCME and the proposed LCGME would be overseen by yet another body, the Coordinating Council on Medical Education (CCME). In a separate and unrelated matter, the LCME Task Force on Graduate Medical Education suggested in 1972 that the LCME assume responsibility for the accreditation of educational programs for physician assistants; that recommendation failed to elicit a positive response, and the LCME continued to focus exclusively on accreditation of the educational program leading to the MD degree.

The LCGME would eventually become, in 1981, the Accreditation Council for Graduate Medical Education (ACGME). The CCME, focused mostly on graduate medical education issues, would continue until 1981, at which time it was reconstituted as the Council for Medical Affairs, with no oversight role regarding accreditation. From that time forward, the LCME and ACGME would operate completely independently of each other.

One other element of the scope of LCME accreditation needs to be mentioned here, and that is its federal designation as a specialized, or programmatic, accrediting agency. The distinction between programmatic and institutional accreditors traces back to the early days of accreditation, when professional organizations such as the AMA and the American Dental Association began evaluating

professional education programs at schools or departments designated for that purpose, while regional higher education associations established accreditation programs for their member institutions. The distinction became meaningful when the U.S. Congress reauthorized the Higher Education Act (HEA) in 1992. As part of that reauthorization, the government was required to develop a more formal process for conferral of its recognition on accrediting organizations. One of the key elements emerging from that process was a criterion that imposed important requirements on institutional accreditors that did not apply to specialized, or programmatic, accreditors.

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In the new process, the U.S. Department of Education criteria required that agencies which accredited higher education institutions, and therefore conferred eligibility to participate in HEA programs (notably Title IV federal financial aid), must meet the department's criteria for being "separate and independent." Agencies that accredited educational programs (which did not entail eligibility for HEA-defined federal aid) were exempted from the separate and independent criterion. In 1992 most of the medical schools accredited by the LCME were parts of colleges or universities that held institutional accreditation from a regional accreditor, and for those schools the LCME could be considered as a programmatic accrediting agency. However, the LCME also accredited a small number of freestanding medical schools that depended on LCME accreditation to receive Title IV federal funding for their students. Thus, the LCME was also an institutional accreditor. A provision in the regulations allowed an institutional accrediting agency to obtain a waiver of the separate and independent requirement if (1) the agency had been listed by the Department of Education as a nationally recognized accrediting agency on or before October 1, 1991, and continuously since that date; (2) the related association or membership organization of the accreditor played no role in making or ratifying accreditation decisions or policies; (3) the accreditor had sufficient budgetary and administrative autonomy to act independently of the related association or membership organization; and (4) the accrediting agency shared with the related association or membership organization only the information it also made available to the public.

When the LCME petitioned for renewal of federal recognition in 1992, it sought and obtained a waiver of the separate and independent requirement, which it otherwise might not have been able to satisfy. However, when the LCME was due for renewal of recognition in 1997, the Secretariat staff had reservations about the organization's ability to obtain another waiver. Since the number of freestanding medical schools was quite small, the LCME opted instead to declare itself an exclusively programmatic accreditor and therefore not subject to the Department of Education's separate and independent requirement. In the year leading up to the petition for renewal of recognition, the LCME instructed the freestanding medical schools to begin applying for institutional accreditation from their corresponding regional accreditor, thus allowing them to maintain Title IV eligibility after the LCME made the switch to programmatic accreditation. Since 1997 the LCME has been recognized by the Department of Education as a programmatic accrediting organization.

Accreditation Term

Before creation of the LCME, AAMC policy called for all member medical schools to undergo an inspection every five years. However, the policy was not enforced, and the more common practice was to visit only those schools that either requested a visit or had known problems with educational quality, typically indicated by being on the AMA's Category C list of schools. The AAMC's enthusiasm for medical school visits waxed and waned throughout the pre-LCME period, and there is no evidence to indicate that it ever rigorously pursued its policy of revisiting member medical schools every five years.

The strategy of the AMA CME in its early years was to conduct comprehensive inspections of all medical schools, with no fixed schedule for revisits. Like the AAMC, it would inspect a new medical school seeking AMA approval or an established school that requested an inspection, but it otherwise limited its activities to nationwide inspections. From its beginnings through 1936, the CME carried out six rounds of such nationwide inspections.

When the LCME began operation in 1942, it continued the policies of its parent organizations regarding the frequency of visits to or inspections of established medical schools. The first evidence for discussion of the frequency of LCME visits appeared in the minutes of a joint LCME meeting with a regional accrediting organization in May 1953. At that meeting, the LCME invited representatives of the Middle States Association of Colleges and Secondary Schools to discuss potential collaboration between the two organizations. Collaboration between regional and specialized accreditors was being promulgated at the time by the fledgling National Commission on Accrediting as a way of controlling accreditation costs and eliminating duplication of effort for universities and colleges. During the meeting, one of the Middle States Association representatives asked how often medical schools were visited. The response from an AMA member of the LCME was that "situations vary so much that it is difficult to say, but the ideal arrangement would be to visit a school every five years although some schools may be visited several times in a five year period."[210] Thus, the AAMC's visiting policy had continued for at least a decade after the formation of the LCME.

The LCME first discussed a specific term of accreditation at its February 1955 meeting. At that time, it agreed that all approved medical schools should be revisited at least once every 10 years, not including any follow-up visits. It instructed the secretaries from the AMA CME and AAMC Executive Council to review the impact of that decision on future visit schedules, and at the next meeting the members were informed that a schedule of regular surveys, using a cycle of 7–10 years, would eliminate the backlog of planned visits that had accumulated.

The issue of term length resurfaced when the LCME met in November 1962. A year earlier, the LCME had commissioned its first standing committee, the Committee on Accreditation Procedures, to make recommendations to the full LCME regarding its procedures. The report of that committee in November 1962 included a recommendation, which was approved, that medical schools be surveyed at intervals of 10–12 years, with sooner visits to take place if needed; it also recommended that schools placed on confidential probation be given a maximum of 5 years to address their problems. In practice, however,

no medical school ever received more than a 10-year term, and many medical schools were accredited for much shorter periods, often only 2 or 3 years. The following table summarizes the variability in length of terms for accredited medical schools, based on data from full surveys of U.S. medical schools in the period from 1957 to 1974 that was summarized in the minutes of the October 1974 LCME meeting.

Term of Accreditation Granted to LCME-Accredited Medical Schools, 1957–1974

Term	1–2 years	3–4 years	5 years	>5 years	Probation
Total	32	41	11	152	20

In February 1968, the LCME considered but rejected a recommendation from the AAMC's LCME secretary that the maximum term of accreditation be limited to seven years; however, the issue resurfaced and was approved at the next meeting. The seven-year term would remain in place until 1977, when the LCME adopted institutional self-study as part of its accreditation process. At the February 1977 meeting, the LCME decided to restore the maximum length of accreditation to 10 years for schools that completed a self-study (with a 5-year interim report required for such schools). Two years later the Association of Canadian Medical Colleges requested, and the LCME approved, a proposal that Canadian medical schools be limited to a maximum term of seven years.

By the beginning of the next decade, the combination of a 10-year variable term of accreditation and the steady increase in new medical schools was creating serious budgetary and logistical challenges for managing the workload of site visits. This prompted the LCME to modify its policies in February 1981, when it switched to a simplified system in which schools would be reaccredited for either 3, 4, 6, 7, or 10 years. To facilitate consistency, the LCME adopted formal guidelines in October 1981 to be used by its survey teams to recommend specific terms when a school's accreditation status came up for reconsideration.[211] The guidelines began with a few general points:

- The term could be adjusted by one year to accommodate regional accreditation schedules and the LCME's commitments.
- Self-study would be required every 7–10 years, regardless of the term of accreditation.
- The LCME would conduct annual statistical reviews of every medical school.

The guidelines then established criteria for various term lengths. For the maximum 10-year term, a school should have "only a few minor, solvable problems touching the quality of the educational program. The institution is stable and has a well maintained custom of quality in all its various programs." To obtain a six- or seven-year term, a school should have a few "significant" rather than "minor" problems, and its leaders were expected "to appear ready to correct problems and deficiencies noted by the LCME." Stepping down to the next level, schools that received a three- or four-year term would exhibit "a number of significant, but solvable problems," and the ability of the schools' leadership to address and resolve the problems was in question.

At the low end of the spectrum, a school could receive accreditation for two years if it demonstrated serious problems that appeared to affect educational program quality and if the future stability of the school was thought to be in jeopardy unless matters improved quickly. A one-year term was reserved for schools with major, serious problems that began to affect program quality in a quantitatively demonstrable manner and could grow worse rapidly. Regardless of accreditation term, the school was expected to provide a progress report on addressing its problems, with the length of time allowed to complete the report varying with the length of the accreditation term. The guidelines also established criteria for probation and for removal of accreditation (discussed in the next section of this chapter).

Over the next few years the guidelines were reviewed and modified on several occasions, the last revision taking place in late 1985. A 1985 revision of these guidelines adopted the system of ranges initially approved early in 1981, with the following choices:

- 7–10 years for stable schools with a few minor problems
- 4–6 years for schools with significant but solvable problems
- 2–3 years for schools with serious problems, which if not resolved quickly could place the educational program in jeopardy
- 1 year for schools with major problems that could rapidly grow worse[212]

A notable difference in this version of the guidelines was that the LCME reserved the option of conducting a limited follow-up survey if its review of the progress report indicated continuing problems. In 1987 the LCME revisited the issue of accreditation terms once again and opted to establish a maximum, fixed seven-year term, subject to shortening if a school evinced notable problems subsequent to the award of the seven-year term. This term remained in place until 2002.

The last change in accreditation term, extending the maximum to eight years, was the direct result of gyrations in the annual number of medical schools scheduled for full accreditation surveys. By 2002 the number of schools scheduled for visits in a given year ranged from a low of 8 to a high of 34. At the high end of that range, Secretariat staff found it increasingly difficult to identify sufficient numbers of qualified team members to provide appropriate expertise for a full on-site review, especially when the staff also had to assemble teams for limited accreditation surveys during such years. At the opposite end of the scale, the staff risked losing the commitment of volunteers who might go two or three years without an opportunity to participate in an accreditation survey. A review of the problem indicated that shifting to an eight-year cycle, with some schools receiving a one-time, one-year extension of their existing seven-year term, would allow leveling of the annual workload to a range of 16–18 surveys per year. To ensure appropriate continuing oversight within the longer accreditation term, the LCME agreed to expand the number of items it reviewed in its annual statistical monitoring of all medical schools. Thus, the eight-year term was approved in February of 2002 and has remained in effect since that time.

Accreditation Actions

In the era preceding the LCME, the two sponsoring organizations adopted their own systems for determining a medical school's status in regard to educational quality. For the AAMC, meeting its criteria led to a school being offered or retaining full membership in the organization; thus, its accreditation system was a simple pass or fail approach. While the AMA approved medical schools, it used a graded system for classifying them. The classification scheme underwent several changes during the early years of the CME. The first system, based on the performance of medical school graduates on state licensure examinations, employed four distinct categories based on the percentage of students who failed the examinations. Three of the four categories (Classes 1–3) consisted of failure rates within specified ranges (Class 1 <10% failure rate, Class 2 10%–20%, Class 3 >20%), with the fourth category reserved for schools with very small numbers of graduates or insufficient information.

That system was replaced when the CME conducted its first national survey of medical schools in 1906, using the 10-point scale it had devised to evaluate each institution (see Chapter 2). The composite score for each school was then converted to a grade from A (90–100 points) through F (composite score <50). Schools with grades of A–C were thought to be worthy of acceptance by state medical boards; D and E schools could become acceptable if they made improvements that would raise their scores to 70 or more; F schools were considered unworthy of acceptance by the states. The ratings from the first survey were not published, however.

In the next survey of medical schools, conducted in collaboration with Abraham Flexner, the CME adopted an ABC scale by collapsing the previous A–F categories: Class A schools scored 70 or more, Class B scored between 50 and 70, and Class C schools scored lower than 50. Class A schools were considered to be acceptable, Class B schools were deemed marginal, and Class C schools were unacceptable. In the following survey of medical schools in 1911, the highest category was differentiated to include an A+ group that was interpreted as "very acceptable." That distinction was eliminated in 1918, when the CME reverted to a simple ABC system that persisted until the late 1920s. By 1928 the use of Class C was abandoned, and by that time there was only one U.S. medical school still listed in Class B. The classification system was completely eliminated in 1932.

With the elimination of the ABC system, the AMA's annual listing of medical schools now shifted from designation by class to a listing of approved schools, a practice which would continue for the next half century. This was not a pure pass or fail system, however, as the CME had also introduced the practice of placing deficient medical schools on confidential probation, the equivalent of the old Class B medical school; the main difference from the old system was that schools on confidential probation were not publicly identified in the annual *JAMA* list of approved medical schools. The AAMC adopted probation as a component of membership when it revised its constitution and bylaws in 1938; in this case, the designation of probation was public.[213]

The probation policies of both sponsoring organizations remained the same during the first decade of LCME operations. In 1952 the AAMC amended its bylaws to authorize confidential probation, while continuing to retain public probation as an option.[214] As part of its discussion about confidential probation, the LCME determined that any school placed on probation should undergo a follow-up visit within two years, with the possibility of withdrawal of accreditation if sufficient improvement was not evident at the time of the follow-up visit.

No significant changes in LCME or sponsor policy regarding probation took place until November 1962, when the LCME considered recommendations of its newly minted Committee on Accreditation Procedures. One of those recommendations, which was approved by the LCME, stipulated that a school on confidential probation would have a maximum of five years to address its problems, after which the school would either be restored to full approval status or placed on public probation. This revised policy remained in place for five years.

The general concept of confidential probation surfaced again at the LCME meeting of June 1967. With accrediting organizations now undergoing more rigorous public scrutiny as a consequence of federal approval of the HEA of 1965, the LCME was becoming increasingly concerned about its obligations to the public. The issue of confidential probation was discussed extensively at the June 1967 meeting, and the LCME staff was instructed to develop specific proposals to capture LCME thinking on the subject. In February 1968 the LCME reversed course on confidential probation, concluding that the public had a right to know about any medical school whose problems were sufficiently serious to merit being placed on probation. Henceforth, any school placed on probation would be so indicated in the listings of approved schools published by the AMA and the AAMC.

When the LCME developed guidelines for accreditation terms in the early 1980s, it also provided a more detailed explication of the criteria for placing a medical school on probation. The guidelines stated:

> [The] school has critical problems which have not been resolved or addressed successfully. The educational program is expected to fall below the minimum standards of the LCME in the near future. Evidence has been lacking that solutions will be forthcoming.[215]

The guidelines also implied, but did not directly state, that removal of accreditation would entail having been first placed on probation. They stated that removal would occur when a school "has not satisfactorily resolved the critical problems causing the program to be placed on probation, and the educational program no longer meets the minimum standards of the LCME. There is insufficient evidence that progress will be made to resolve the problems and deficiencies in the proximate future." However, when the LCME approved policy guidelines for medical school closure or removal of accreditation in 1988, the new procedure clearly stated that removal of accreditation would not necessarily take place only when the school had undergone a period of probation. It stipulated that removal was an option when there was evidence of declining quality, indicated in previous survey reports and/or annual questionnaire data, and "the LCME *may have* placed [the medical school's] M.D. program on probation for a specified term" (italics mine).[216]

The policies and criteria for probation remained largely unchanged until 2008. LCME members had become increasingly concerned in preceding years that some medical schools had evinced problems that were not sufficiently serious to warrant placement on probation but needed stronger corrective action than could be produced by conducting a follow-up limited survey. To address that perceived gap, the LCME approved a new action on accreditation status, "warning of probation." The new action was the functional equivalent of the confidential probation action that had been abandoned in 1968, and it remains as an option today. (It is now referred to simply as "warning" and is not necessarily linked to the possibility of impending probation.)

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Apart from actions relating to accreditation status, the LCME also has a choice of options for follow-up action based on a school's or program's status. Such follow-up actions can consist of submission of a written report by the school or an on-site visit to verify progress in addressing accreditation concerns. During the early years of the LCME, and in the era preceding its creation, the only follow-up action after a medical school's inspection was an additional visit, typically reserved for a school placed on probation. Such visits became much more common when the LCME adopted a fixed term of accreditation in 1987; thus, instead of accrediting a school for a one- or two-year term as had been possible with a variable accreditation term, the LCME now accredited the school and scheduled a follow-up ("limited") survey visit one or two years later, at which time the school's accreditation status was subject to reconsideration.

The first mention of a follow-up report, identified as a progress report, is found in the June 1952 LCME meeting minutes; at that meeting, a medical school that had been inspected by representatives of both the AMA and AAMC submitted—presumably voluntarily—a progress report to each organization to address issues identified in the inspection. The first evidence of an LCME-mandated progress report appeared in the minutes of the February 1954 LCME meeting, when a school on confidential probation that had been revisited was removed from probationary status and asked to submit an annual report of its progress every year for the following three years. Requests by the LCME for progress reports remained sporadic in succeeding years, invariably linked to schools that had been placed on probation. Progress reports became a regular agenda item for the LCME in the early part of the 1970s.

When the LCME adopted guidelines to help determine the length of an accreditation term, it also included recommended follow-up activities for varying lengths of accreditation. For medical schools with long-term accreditation (7 to 10 years), a progress report would be requested from 2 to 4 years after the survey, after which the LCME could reaffirm its original decision, request an additional report, or conduct a limited follow-up survey. For intermediate-length accreditation terms of four to six years, a progress report was to be requested within two years of the original survey (or one year after review of

a progress report); a report showing little evidence of progress would result in a limited survey, and an "outstanding" report could allow the LCME to extend the term of accreditation for several additional years. A short-term accreditation term of two to three years required a progress report within a year, which, if satisfactory, would allow the LCME to extend the accreditation term by one or two years. For schools receiving a one-year term of accreditation, a progress report was required within a year, followed by a limited visit by LCME members and staff if problems persisted. For schools on probation, a one-year progress report and a limited visit were recommended as follow-up. When the LCME adopted a fixed seven-year term of accreditation in 1987, it did not include any guidelines specifying the frequency of type of follow-up action.

Chapter 14

Organization: Membership, Staffing, Finances, Sponsor Authority

Every modern accrediting organization depends on a professional staff to manage its operations and sufficient financial support to maintain those operations. Because the LCME developed as a joint committee populated by its two sponsoring organizations, the distinction between LCME members and LCME staff was blurred during its earliest years of existence; the staff of the sponsoring councils of the LCME also served as members. As accrediting organizations became increasingly accountable to the federal government and other organizations—such as the National Commission on Accrediting (NCA)—the role and authority of the LCME's sponsoring organizations had to accommodate greater expectations for accreditor autonomy that would ensure fair and unbiased decisions about the accreditation status of institutions and programs.

LCME Members and LCME Staff

At the time of the LCME's creation, there were no formal requirements or policy for membership on the committee. The two sponsoring organizations each agreed to appoint three members to the LCME. The AMA appointees were selected from the membership of its Council on Medical Education and Hospitals (CMEH) and included CMEH Secretary Herman G. Weiskotten (Figure 6). The AAMC appointed a staff member, Secretary Fred Zapffe, in addition to the vice president and treasurer of the organization (elected, nonstaff positions.) The administrative support for the work of the LCME was provided jointly by the secretaries of the CMEH and the AAMC; the distinction between voting members and administrative staff for the LCME would not emerge for over two decades.

Weiskotten served as dean of the Syracuse University College of Medicine from 1922 through 1951 and was arguably the most influential figure within the U.S. medical education community since Nathan Davis. In 1928 he was appointed as the chair of the AAMC's Committee on Medical Education and Pedagogics and continued in that role through 1930. In 1931 he was elected as the vice president of the AAMC and was a member of its Executive Council from 1932 through 1936. In 1933 he was selected by the CMEH to lead what would prove to be the last comprehensive survey of all U.S. medical schools. From 1934 through 1936 he visited every approved medical school in the United States and Canada, as well as two unapproved schools. The results of that survey were published in *Medical Education in the United States, 1934–1939,* commonly referred to as the Weiskotten Report.[217] Weiskotten served as secretary of the CMEH from 1942 to 1943 and became the third chair of the council in 1946, continuing to serve in that capacity through 1957. He functioned on the LCME from its inception as a CMEH representative and attended his final LCME meeting in February 1957.

Figure 6. Herman G. Weiskotten, MD, PhD.
Dr. Weiskotten led the last round of medical school inspections conducted by the AMA Council on Medical Education and Hospitals from 1934 to 1936. He was a notable catalyst in the establishment of the LCME, providing leadership as a charter member of the LCME during its first 15 years of operation. Source: The Herman G. Weiskotten MD PhD Papers, Health Sciences Library, SUNY Upstate Medical University, Syracuse, NY.

Zapffe was elected as the secretary-treasurer of the AAMC in 1903 and continued to serve in that capacity, for the most part without compensation, through his retirement in 1948 at the age of 75. He was the founding editor for the *Bulletin of the Association of American Medical Colleges* (later retitled the *Journal for Medical Education* and finally as *Academic Medicine*), overseeing its publication from 1926 through 1951. For most of his career, Zapffe served as the sole professional staff member of the AAMC. As its secretary, he participated in the inspections of medical schools throughout the first five decades of the 20th century. Among his many accomplishments as AAMC secretary-treasurer, Zapffe developed the index card system used to catalog the names and credentials of medical students and also maintained meticulous records on the structure and functions of AAMC member medical schools. He was a member of the LCME from 1942 through 1947.

LCME minutes from the 1940s and 1950s generally indicated the attendees, and often the person chairing the meeting, but otherwise provided no information about how participants were chosen; presumably, those decisions were made within the CMEH and Executive Council that supported LCME operations. In the summer of 1950 the AMA began sending four representatives to LCME meetings, and the AAMC followed suit in February 1951. The practice of rotating the chairmanship of meetings between the two organizations was captured in meeting minutes beginning in 1952. The number of participants increased throughout the decade, frequently including anywhere from five to seven attendees from one or both sponsors.

The designation of six members of the LCME from each professional organization became established procedure by 1968. In 1970 the LCME agreed to the appointment of a federal participant; the first individual to serve in that capacity was John S. Zapp. The LCME also added a public member that year, appointing Nathan J. Stark to that role. A second public member was added in 1973, when Harriett Innskeep was appointed to the position; she was the first woman to serve as a voting member of the LCME. Other notable public members appointed to the LCME in subsequent years included the Honorable Sandra Day O'Connor, who served on the LCME in 1981 when she was an appellate court judge in Arizona; Walter Washington (1992–1994), who served as the mayor of Washington, D.C., from 1975 to 1979; and Harriet "Hattie" Babbitt (1985–1989), who later served as U.S. ambassador to the Organization of American States. The LCME authorized the appointment of a third public member in 2010, but to date no third public member has been appointed.

A Canadian representative first participated in an LCME meeting in 1964, when the executive secretary of the Association of Canadian Medical Colleges (ACMC) was invited to attend. The ACMC representative functioned as an observer for the next decade and received limited voting privileges (only for Canadian medical school accreditation decisions) in 1977; two years later, after the formation of the Committee on Accreditation of Canadian Medical Schools (CACMS), the ACMC representative was accorded full voting privileges. Medical student membership in the LCME (nonvoting) was approved late in 1977, with each sponsoring organization appointing a student member to serve a one-year term; student members received voting rights two decades later in 1997.

For most of the LCME's existence, the authority to appoint professional members rested with its sponsoring organizations, whose respective councils identified members to serve three-year terms, renewable once. AMA appointees were, for the most part, chosen from the membership of the Council on Medical Education (CME), while the AAMC Executive Council typically appointed medical school deans. Remarkably, neither of the LCME's sponsoring organizations appointed a female member until February 1986, when Carol Aschenbrener became a voting member; she would later serve as the AAMC secretary to the LCME. However, the first woman to attend an LCME meeting was Anne Tipner, an AAMC staff member who attended her first LCME meeting in June of 1959. With the change in LCME governance in 2012, authority for professional member nomination was ceded by the LCME sponsors to a nominating committee elected by the LCME membership.

In the early years of the LCME, any needed staff support was provided by the secretaries of the LCME's sponsoring councils, who were also voting members of the LCME. Meetings were led by the chair of one or the other sponsoring council, who would alternate that task at each meeting. That arrangement became unwieldy by 1958, when the LCME decided that henceforth the October meeting would be led by the AAMC Executive Council chair and the June meeting by the CMEH chair. Agendas and items for discussion would be determined jointly by the staffs of the two councils. The first inkling of staff differentiation surfaced in 1959, when the secretaries of the two sponsoring councils suggested "giving some thought to the possibility of a paid part-time secretary to assume the responsibility for the meetings and other activities of the Liaison Committee."[218] That suggestion was not supported by the sponsors, however, and no action resulted from it.

Problems of staff support for the increasing workload of the LCME arose again in November 1961. An ad hoc committee on the LCME's structure and function had been created that year to reexamine LCME organization and operation. The draft report of this committee, discussed by the LCME at the November meeting, presented two alternatives for a staffing model. One option echoed the 1959 recommendation to employ full-time an individual who would provide logistical support for all LCME activities, including oversight of all aspects of the medical school survey process. The other option was to designate a staff person from each sponsoring organization to take on administrative responsibilities. A majority of the LCME membership favored the latter option, but no actions were taken to implement it.

In 1962 the LCME's first standing committee, the Committee on Accreditation Procedures, recommended appointment of a full-time secretary who would be supported by one half-time staff person from each sponsoring council.

In 1962 the LCME's first standing committee, the Committee on Accreditation Procedures, recommended appointment of a full-time secretary who would be supported by one half-time staff person from each sponsoring council. In response, the LCME directed the committee to develop a more detailed proposal to address the need for centralized management of its activities. No action resulted, however, and the structure of the LCME staffing model continued unchanged. Although LCME minutes from the mid-1960s did not use the title of "LCME secretary" when listing meeting participants, the proceedings from the 1967 AAMC annual meeting indicated that the designation had been put in place during the preceding year, with Cheves McC. Smythe of the AAMC noted as the LCME secretary from September through December 1966 and C.H. William Ruhe of the AMA as the secretary for the following year.[219] In September 1969 the role of the LCME secretary came up for discussion at the LCME meeting, and the LCME agreed to grant its secretary signature authority for LCME decisions.

Several members of the AAMC and AMA staff attended LCME meetings in the 1960s and 1970s, without any formal titles associated with the LCME. During that period, the LCME periodically designated the secretaries of its site visit teams (who were not members of the LCME) as "assistant LCME secretary" or as "assistant LCME team secretary." Such individuals did not attend LCME meetings, although they played

important roles in precipitating strengthened LCME procedures during the early 1960s (see Chapter 4). The title "associate LCME secretary" was used sporadically during the 1970s and early 1980s for AMA staff members who provided extensive support to LCME operations. In 1997 the LCME recast that title as "assistant LCME secretary," as the designation for the primary professional staff member from the AAMC and AMA who worked with the LCME's secretaries to support its operations.

One of the characteristics distinguishing the LCME from all other accrediting organizations is the use of a "dual secretariat" to support its work, with staffing provided by both LCME sponsoring organizations. The administrative staff who support the LCME have always been employed members of the sponsoring organizations, with varying levels of responsibility to the LCME itself. Thus, the LCME has never had a distinct corporate structure with its own independent staff. The practice of annually rotating the primary responsibility for supporting LCME work between the AMA and AAMC offices dates back to the late 1960s. Each office alternated annually as the "principal secretariat," responsible for organizing LCME meetings and survey visits, reviewing draft reports, and preparing official correspondence. The other office always contributed a substantial effort in collaboration with the principal secretariat to maintain sufficient support for LCME work. However, the maintenance of the dual secretariat also entailed a considerable duplication of effort, including parallel record keeping in the LCME offices of both organizations, and often engendered confusion among the medical schools, who were uncertain about which office to contact when accreditation-related matters arose.

Much of that confusion and duplication of effort was ameliorated in 2012, when the LCME discontinued its alternating principal secretariat model. While the AAMC and the AMA continue to maintain separate offices supporting the operations of the LCME, the LCME offices established a division of labor and responsibilities among the professional staff, eliminating much of the confusion formerly associated with the "on-year, off-year" pattern of a dual secretariat. Henceforth, responsibility for activities such as meeting planning, document updates, survey scheduling and team assignment, and review of survey reports would be distributed among the LCME secretariat staff rather than concentrated in a particular office each year.

The Role of the LCME's Sponsoring Organizations

One of the most unusual dimensions of the LCME's structure is the persistence of the equal partnership between its two sponsoring organizations, even though the size, influence, and effort of the two sponsors for supporting the LCME have undergone substantial shifts over the course of the LCME's existence. Although at the time of the LCME's creation the AMA dwarfed the AAMC in size and public influence, there is nothing in the minutes of the LCME or the proceedings of its parent organizations to indicate a disparity in roles for the sponsors. Tensions and rivalries between the two sponsoring organizations did surface in 1950, when the LCME teetered on the verge of collapse, but the organization rebounded quickly in the face of a challenge to the partnership posed by the NCA, which sought to restrict the accreditation function exclusively to the AMA (see Chapter 3).

For its entire history, the LCME has had equal numbers of members appointed by the AMA and the AAMC, which have either directly absorbed the costs incurred by the LCME (during its early years) or shared the financial costs of LCME operations on an equal basis (since the early 1960s). Salaries for the staff members who support the LCME's operations have been borne directly by the sponsors, and the costs of meetings, surveys, and other activities have been divided equally between the AMA and the AAMC through an annual budget reconciliation process. Unlike most other accrediting organizations, neither the LCME nor its sponsors have ever assessed any fee for accreditation to the institutions accredited by it, apart from an application fee for initial accreditation of new medical schools. The lack of independent budgetary authority for the LCME became a potential sticking point in the recognition process of the U.S. Department of Education when the "separate and independent" requirement was established in 1992, but the LCME was able to obtain a waiver of the requirement until 1997, at which time it became an exclusively programmatic accrediting organization and therefore no longer subject to the separate and independent requirement.

It is no coincidence that early descriptions of the LCME from the 1940s frequently characterized the organization as being without power or authority, since for its first decade or so the LCME was functionally little more than a common meeting ground for the two sponsoring organizations to discuss issues of shared interest. Until 1957 the LCME did not have its own set of accreditation standards; before that time, medical schools needed to demonstrate that they met the separate criteria of the AMA and the AAMC so to maintain their approved status from the AMA or continue their membership in the AAMC. LCME inspections of medical schools always included representatives from both sponsoring organizations and produced a single report of the medical school visit, but decisions about accreditation were made by the sponsoring organizations after discussion within the LCME; although those discussions frequently led to a consensus decision acceptable to both sponsors, at times they did not. In that sense, the LCME did indeed lack any power or authority.

When the LCME learned of the NCA's deliberations, it flatly rejected the notion and strongly reasserted its function as the agency best suited to deal with accreditation, facilitating joint decisions about accreditation by its sponsors.

The first significant challenge to the authority of the LCME sponsoring organizations for accreditation decisions arose in 1951 and came from the NCA, a group established by the leaders of American universities and colleges two years earlier to rein in the excesses of accrediting organizations, especially the specialized or programmatic accreditors. During its first year of operation, the NCA conducted a thorough review of the various accrediting organizations. When it turned its attention to the accreditation of medical schools, it decided that the AMA CMEH should function as the exclusive agency for medical school accreditation, while the AAMC functioned better as a vehicle for promoting improvement in medical education quality. When the LCME learned of the NCA's deliberations, it flatly rejected the notion and strongly reasserted its function as the agency best suited to deal with accreditation, facilitating joint decisions about accreditation by its sponsors. The NCA relented and eventually accepted the LCME as the authority for accreditation of medical schools.

While the LCME would periodically reconsider its purpose and function in later years, it never questioned the authority of the sponsors for making final decisions about accreditation. That authority would be seriously challenged again during the 1970s, when various organizations took aim at the LCME by means of the federal recognition process for accrediting organizations. The first of those disputes occurred in 1971, when the Women's Equity Action League protested the renewal of LCME recognition by the U.S. Office of Education, citing LCME tolerance of the marked disparity in the gender ratio of enrolled medical students at the time. During the next cycle of recognition renewal in 1976, the LCME's status was challenged by the U.S. Federal Trade Commission (FTC), which petitioned the commissioner of education to deny LCME recognition because the LCME, as an organization sponsored by the AMA, was complicit in alleged AMA efforts to control the supply of U.S. physicians. Although the Office of Education ultimately dismissed this challenge, as it had done earlier in response to the Women's Equity Action League, it did express uncertainty about the impartiality and objectivity of the accreditation process as conducted by the LCME.

In response to these actions, the LCME and its sponsors adopted a number of changes in policy and procedure during the decade to reduce the perceived influence of the sponsors on LCME activity. In 1972 the AAMC Executive Council approved a proposal that, while retaining its authority to approve LCME policies, would limit its direct involvement in accreditation decisions to those which entailed a recommendation of probation or other adverse actions. The language of the AAMC constitution was modified in 1974 to clarify that its Executive Council would ratify, not approve, LCME accreditation decisions.

In 1975 the LCME modified its internal policies for review of survey reports by non-LCME representatives of the sponsors. Its traditional practice had been to circulate reports of accreditation surveys to select members of the CME and the AAMC Executive Council for comment, and those comments would be incorporated in the LCME discussion of a school's accreditation status. At its January 1975 meeting, the LCME voted to revise the comment sheets used by these outside reviewers, eliminating options to indicate approval or acceptance of the survey team recommendations.

After the 1976 FTC challenge, the LCME secretaries sent a letter to the sponsoring organizations requesting final LCME authority for all accreditation decisions, including probation and withdrawal of accreditation, as well as independent authority to establish its own policies and procedures, develop criteria for selection of LCME members, and present a formal budget for sponsor approval. The AMA and the AAMC acceded to these requests, relinquishing final authority for accreditation decisions to the LCME. The sponsors would continue to review survey reports, appoint LCME members from their ranks, approve new and revised accreditation standards, approve the LCME budget, and advise the LCME on policies and procedures. In 1984 the practice of sponsor review of survey reports was eliminated. No other significant changes in the role of the LCME's sponsors occurred until the 2012 Memorandum of Understanding between the AAMC and the AMA, which gave the LCME a direct voice in electing LCME members that were nominated by the AMA and the AAMC.

Chapter 15

Geographic Reach: Canada and Other Countries

The focus of LCME accreditation, and of the AAMC and AMA inspection programs before the formation of the LCME, has always been geared to medical schools located within the political jurisdiction of the United States. The inclusion of institutions outside of the United States in AMA inspections began before publication of the Flexner Report. Canadian medical schools were included when the AMA, in partnership with Abraham Flexner, visited eight medical schools in Canada as part of the second wave of inspections. The AAMC did not extend membership to any Canadian medical schools until 1924, when McGill University Faculty of Medicine became a full member of the organization. In 1957 a school based in the Middle East that had been chartered by the state of New York became the first and only foreign medical school (located outside the political jurisdiction of the United States and Canada) to obtain AAMC membership; the rationale for its membership was that the institution was chartered in the United States, even though it operated on foreign soil. While the AAMC considered it to be a U.S.-based medical school, the AMA Council on Medical Education (CME) did not, and the institution was never accredited by the LCME or listed as an AMA-approved school. The school's AAMC membership continued until 1981, when a change in AAMC bylaws precluded its continued membership.

The AMA, the AAMC, and Canada

Canadian medical schools have enjoyed a special relationship with the U.S. medical education system for over a century, attributable in no small part to the common language and culture of the two countries and the similarity in their respective educational systems. When the AMA CME began its system of inspections for medical schools, Canadian institutions were included in the second round of inspections in 1909 and again in the fourth round during 1913–1914. The justification for including Canadian medical schools in the inspections was stated in the 1910 proceedings of the AMA: "From the fact that the medical colleges of Canada furnish so many medical practitioners to the various states and requests for reliable information regarding them has been lacking, these colleges were included in the second tour of inspection so that now the Council has first hand information regarding all the medical schools of the United States and Canada."[220] As a result of those inspections, four Canadian schools were considered acceptable as Class A institutions. Three were placed in Class B, which denoted schools that could become acceptable with substantial changes. One Canadian school was considered to be a Class C (unacceptable) institution. The Flexner Report suggested that five medical schools were of sufficient quality to meet Canadian needs.[221]

As noted above, Canadian physicians in the early 20th century had relatively easy access to the United States for practice. U.S. physicians interested in Canadian practice, however, faced obstacles that were sufficient to draw the attention of the AMA. The 1916 proceedings of the AMA included a discussion of the Canadian issue in the CME report, noting that two provinces (Québec and Ontario) required U.S. graduates to take an additional year of study at a provincial medical school before obtaining Canadian licensure.[222] The rationale for the requirement was that the Canadian medical education system consisted of a five-year program of study, even though the first year of the program focused on

course work taken during premedical studies in U.S. medical schools. The council expressed optimism that the provinces involved would amend their licensure laws, but it also pointed out that the situation highlighted unresolved questions about U.S. credentialing and licensure requirements for graduates of foreign medical schools, particularly the absence of reciprocity agreements. Ontario did indeed modify its licensure requirements one year later, although Québec did not.

The AMA continued to include Canadian medical schools in its annual *JAMA* listing of approved medical schools until 1921. After that time, *JAMA* would include statistics of Canadian medical schools (such as numbers of students enrolled) in addition to those of U.S. schools, but no longer classified the schools as A, B, or C institutions. At the AAMC, meanwhile, McGill University Faculty of Medicine became the first Canadian medical education institution to apply for membership in 1923; it was accepted the following year. The 1925 report of the AAMC secretary-treasurer to the organization's membership noted that all "acceptable" U.S. medical schools as identified by the AMA were either members or had applied for membership and that it was "likely that several of the Canadian schools" could also qualify.[223] The University of Toronto Faculty of Medicine became the second Canadian medical school to obtain approval as an AAMC member at that same meeting. By 1942 the number of Canadian members of the AAMC had grown to seven. In 1949 the AAMC revised its constitution and bylaws, providing affiliated membership to medical schools in foreign countries (including Canada).[224] In 1953 the constitution and bylaws were revised again, narrowing the category of affiliate membership to include only Canadian medical schools.[225]

The LCME and Canada

The first Canadian medical school to undergo a review by the LCME was Dalhousie University Faculty of Medicine in 1947. It had requested a visit to judge its progress since its most recent inspection in 1939 and to seek assistance with a planned curriculum revision. No decision about the school's status was made, and the report of the AAMC secretary at the 1947 annual meeting noted that "what has been done and what is being done is most commendable."[226]

The first extended discussion of Canadian medical schools took place at the February 1952 meeting of the LCME. It began with an inquiry received from a representative of a school in Canada about the effect on Canadian institutions of the newly adopted AMA and AAMC requirement for three years of premedical study rather than two; some Canadian schools required only two years, and as noted earlier, the Canadian curriculum was five years in length with the first year representing the equivalent of college-level premedical studies in the United States. The LCME acknowledged the differences and indicated that it did not intend to influence well-established Canadian practice.

Immediately after that discussion, an AMA representative to the LCME shared a discussion from the recent meeting of the Council on Medical Education and Hospitals (CMEH) concerning the general relationship of the council to Canadian medical schools. The Canadian institutions had not been undergoing a regular schedule of inspections by the CMEH, and the Canadian Medical Association had expressed a reluctance to initiate a Canadian system for medical school accreditation. The CMEH decided in 1945 to include Canadian schools on its approved list only upon request of the schools; three

CMEH-approved Canadian schools had never applied for AAMC membership. In light of these issues, the LCME decided to invite representatives from the Canadian Medical Association and the Association of Canadian Medical Colleges (ACMC) to a conference later in the year to discuss the future of Canadian medical schools in the LCME accreditation process. The formal invitation was sent in June, and the LCME was informed at its June meeting that the two Canadian organizations had agreed to discuss the issue the day before the September ACMC meeting.

The proposed conference took place in Toronto, Ontario, on October 1, 1952. A summary of the discussion, recorded in the minutes of the November 1952 LCME meeting, indicated "general agreement that it was greatly to the advantage of the Canadian medical schools to be listed as approved medical schools by the Council [on Medical Education and Hospitals] and the Association of American Medical Colleges."[227] The Canadian schools that had not applied for membership in the AAMC were all scheduled for LCME visits within the next two years, and representatives from the LCME attended the 1953 meeting of ACMC. Thus, the LCME continued to include Canadian medical schools within its geographic scope of accreditation. Still, by 1955 there remained two Canadian medical schools that had not become members of the AAMC, presumably by their own choice, although they continued on the CMEH list of approved schools.

The LCME relationship with Canada received no further attention until November 1961. The precipitating event for the discussion was the establishment of a new ACMC headquarters led by a full-time executive secretary. LCME members reviewed the challenges associated with accreditation of Canadian schools (unfortunately, the minutes from this meeting do not specify what those challenges were) and directed the secretaries of its two sponsoring organizations, Walter Wiggins and Ward Darley, to meet with the new ACMC executive secretary and report on the outcomes at the next LCME meeting. Once again, the Canadians expressed their appreciation and satisfaction with the LCME process, and no actions resulted.

Another brief flirtation with a change in the LCME-Canada relationship occurred in November 1963, when an AMA representative inquired about transferring the authority for accreditation of Canadian medical schools to the ACMC. In the absence of any expressed desire by Canadian officials to undertake such a role, the LCME took no action. The genesis for the AMA request is unclear, since there is no mention of Canadian medical school accreditation in the proceedings of AMA meetings in the period preceding the November 1963 LCME meeting. Nevertheless, it seems to have provoked a renewed LCME interest in collaborating with Canada. In the summer of 1964, the CMEH requested, and the LCME subsequently approved, a motion inviting the ACMC secretary to attend LCME meetings as an observer. The minutes of the October 1964 LCME meeting indicate that the deans of Canadian medical schools had not only reaffirmed their support for LCME accreditation, but also had offered to provide additional manpower and financial support for such activities.

No further discussion of Canada took place within the LCME until March 1967, when the same questions about Canada's ongoing desire for LCME accreditation resurfaced. In 1968 the LCME was informed that the Canadian Medical Association had expressed an interest in partnering with ACMC in an accreditation process for Canadian medical schools. Once again, however, no concrete actions resulted and the status quo continued.

In October 1974 the LCME once again took up the issue of Canadian engagement. At that meeting, the LCME approved the principle that representatives from U.S. medical schools should be included on survey teams for the accreditation of Canadian medical schools and vice versa. It also endorsed the notion that the ACMC should have a vote on LCME decisions about Canadian medical school accreditation, if the ACMC desired it. At the next LCME meeting in January 1975, it approved a motion asking its sponsoring organizations to allow the ACMC to appoint a voting member to the LCME, and in June of that year an ACMC member was appointed, pending sponsor approval of voting privileges. Sponsor approval was not secured, however, and the AAMC representative to the LCME was listed as a "participant" in LCME minutes, rather than a member. A limited voting privilege was extended to the president of the ACMC Executive Committee in 1977, who as an LCME member was allowed to vote on the accreditation status of Canadian medical schools reviewed by the LCME.

The most notable change in the LCME relationship with Canada took place early in 1979 with the formation of the Committee on Accreditation of Canadian Medical Schools (CACMS), which would become a full partner with the LCME in medical school accreditation north of the U.S. border. The LCME was informed about this event at its February meeting that year. That meeting included an ACMC agreement to provide a $500 stipend to team secretaries for Canadian surveys, and LCME approval of an ACMC request to limit the maximum term of accreditation for Canadian schools to 7 years (the LCME at the time provided variable 1–10-year terms for U.S. schools).

Advantages of LCME accreditation for Canadian schools included access to graduate medical education programs in the United States and greater impartiality of judgment when accreditation teams include U.S. members who lack the familiarity that Canadians have with each other's medical schools.

LCME records preserve an excerpt from a 1979 ACMC newsletter summarizing the background and purpose of CACMS. The author of that newsletter acknowledged the extensive benefits that Canadian schools derived from LCME accreditation and asserted that not a single Canadian dean favored an exclusively Canadian accreditation system. Advantages of LCME accreditation for Canadian schools included access to graduate medical education programs in the United States and greater impartiality of judgment when accreditation teams include U.S. members who lack the familiarity that Canadians have with each other's medical schools. Several reasons were cited for the creation of CACMS, most notably the LCME accountability to the U.S. government through the latter's recognition process and to a private organization—the Council on Postsecondary Education—unfamiliar with the distinctive environment of Canadian medical education. Such oversight from organizations with no connection to Canada could in theory lead to LCME policies or actions contrary to the interests of Canadian medical schools. Other concerns underlying the decision to create a Canadian accreditor included major differences in the health care systems of the two countries, increasing LCME scrutiny by the Federal Trade Commission, and having only a single Canadian voting representative participating in decisions about accreditation of Canadian medical schools.

The CACMS structure was based on the LCME model, with representatives appointed by both the ACMC (which would designate six professional members and two public members) and the Canadian Medical Association (two members). All members would serve three-year terms, renewable one time. The executive secretary of the ACMC would serve as the CACMS secretary. The ACMC would continue to appoint one member of the LCME, and the LCME in turn would designate one of its members to serve on CACMS. CACMS would employ LCME standards and policies, with the expectation that over time there might be a need for some differentiation from the LCME to accommodate uniquely Canadian challenges. As the newsletter stated:

> As with most new ventures, one can expect this one to have some teething problems … It may be that with the passage of time, CACMS will undertake new and unique initiatives, and modify accreditation criteria to meet peculiarly Canadian needs. When and if this happens, it will be important that changes be made in such a way as to maintain the fundamental compatibility of the Canadian and U.S. systems.[228]

The LCME officially recognized CACMS at its June 1979 meeting and adopted formal procedures the following year for its evaluation of Canadian medical schools to accommodate the CACMS role in the decision-making process. Major differences from previous procedures involved the CACMS secretary's review of draft survey reports for Canadian schools and a procedure for reconciling different decisions by the LCME and CACMS. When the two organizations differed on an accreditation decision, the LCME would reconsider its action at the next meeting after being notified of the CACMS decision, with the CACMS secretary withholding notification to the school involved until a uniform decision was reached. If the LCME continued to disagree with the CACMS decision, a joint committee consisting of four members each from the two organizations would be authorized to make the final decision. The LCME also agreed to allow francophone Canadian medical schools to submit their materials (self-study summary report and medical education database) in French. From this point forward, the LCME and CACMS would function as closely intertwined, partner organizations.

No issues of major substance arose in the LCME-CACMS relationship over most of the next two decades. The LCME would occasionally consider a request from its Canadian colleagues for new standards, but otherwise there is little mention of CACMS in the minutes of LCME meetings during the period. Concerns about the LCME role with Canadian medical schools eventually surfaced in 1998. The issues arose during the CACMS meeting that year, with the principal problem being the conduct of accreditation surveys in the French language for the francophone Canadian medical schools. The LCME staff had found it increasingly difficult to identify fluent French speakers for its surveyor pool, handicapping its ability to appoint a U.S. member to survey teams for the francophone schools. The LCME and CACMS secretaries agreed to conduct those survey visits in English to accommodate the U.S. member, and the deans of the affected schools were willing to accommodate the change. However, CACMS members balked at this proposed solution, tossing the ball back into the LCME's lap. CACMS also questioned the appropriateness and relevance of LCME confidentiality and conflict of interest policies in the context of the much smaller community of Canadian medical schools, but those concerns did not trigger any LCME response. The LCME considered the language issue in April 1998 and decided that the surveys should continue

to be conducted in French. The LCME Secretariat staff was instructed to intensify its efforts to identify French-speaking potential surveyors.

The potential for discordant decisions about Canadian medical schools came up again in 2001, prompted by several recent decisions whereby one organization, but not the other, determined that limited surveys were needed to address accreditation concerns rather than having the schools submit written progress reports on the issues. The original LCME mechanism for addressing the problem—a joint committee of the two organizations—had apparently fallen into disuse at some point in the years since its original adoption. This time, the LCME approved a formal policy stipulating that (1) each organization would make an accreditation decision about Canadian schools without knowledge of the other organization's decision; (2) Canadian medical school surveys would continue to be conducted by teams consisting of both Canadian and U.S. representatives; (3) discrepant decisions about the timing of any follow-up actions would be negotiated between the CACMS and LCME Secretariats; (4) any discrepant decisions regarding the nature of follow-up actions would be resolved by negotiations of the Secretariat staffs, but they would also require the approval of the chairs of the two organizations (if the chairs did not approve, the original decisions would remain in place); and (5) any discordant decisions about the accreditation status of a Canadian school would require the LCME Executive Committee (which included the CACMS member) to review the decision and recommend an action appropriate to both organizations.

This solution appeared to address the concerns of both organizations, at least for a while. Six years later, however, the LCME Subcommittee on Policy expressed its intent to reexamine the processes for reconciling divergent decisions between the LCME and CACMS. At the same meeting, CACMS informed the LCME that it would begin meeting three times a year to parallel the LCME meeting schedule. In February 2008 the LCME and CACMS agreed to transmit a single letter of accreditation to Canadian medical schools, under the signature of the LCME and CACMS secretaries, to convey the accreditation status of those schools.

Under new leadership, CACMS had begun to initiate some of its own procedures separate from the LCME, including an interim accreditation review process for Canadian schools. This was discussed at length in a joint meeting of the two organizations in July 2011. When the LCME met afterward, CACMS Secretary Nick Busing informed it that the Association of Faculties of Medicine of Canada (AFMC) had initiated an independent review of the relationship between the two organizations. He explained that the review was part of ongoing quality assessment activities by AFMC and was not a reflection of any unhappiness with the relationship on the part of Canadian medical school deans. That decision stimulated a comprehensive review of the relationship in the following year, with participation from both accrediting groups and their sponsoring organizations. That review culminated in the development of a formal memorandum of understanding between the LCME and CACMS. The memorandum spelled out the details of the process for LCME review of Canadian medical schools. It ensured continued joint representation of both organizations on survey teams and on committees of the LCME and CACMS. It established protocols for review and approval of standards and procedures, and it reestablished a joint committee to address divergent decisions (the new committee consisting of the LCME chair and chair-elect and the CACMS chair). Finally, it established an affiliation oversight

committee charged with oversight and review of the accreditation processes of the two organizations at least once every three years. Both organizations and their sponsors endorsed the memorandum, thus finalizing the present relationship between the LCME and CACMS.

The LCME and Other Foreign Countries

The relationship of medical school accreditors and foreign institutions has focused on two distinct issues: accreditation of medical schools and credentialing of the graduates of foreign medical schools. In the early part of the 20th century *JAMA* routinely included descriptions of foreign medical schools in its annual medical education issue, but the CME showed no interest in conducting inspections of such schools. By the middle of the 1920s, however, the council began expressing concerns about the growing number of graduates of foreign medical schools seeking licensure in the United States. The CME's 1926 report to the House of Delegates noted that the number of such graduates (not including those from Canadian medical schools) had increased from 67 in 1919 to 519 by 1924.[229] The report expressed concern about the verification of credentials from foreign graduates and noted that some state medical boards either required foreign graduates to hold or actively seek U.S. citizenship or, in three states, to require those graduates to work for at least one year in a U.S. hospital or medical school as a condition of licensure. The council recommended that all state medical boards carefully investigate the credentials of foreign graduates, and "more important, that the credentials be not accepted at all unless positive information regarding the educational standard of the [foreign] medical school can be obtained."

In 1931 the CMEH introduced a resolution seeking authorization to develop a classification of foreign medical schools attended by students holding U.S. citizenship. The resolution was based on continued increases in the numbers of foreign graduates applying for U.S. licensure, which had led the states of New York and Virginia to petition the CMEH "to draw up a list of foreign medical colleges, which may be considered acceptable, or as giving the equivalent in medical education to that furnished by American schools."[230] The Reference Committee on Medical Education moved approval of the resolution, and the resolution was adopted by the House of Delegates.

The challenge of evaluating foreign medical schools became obvious in the CMEH report to the House of Delegates in the following year. The report noted that over 1,000 U.S. citizens attending foreign schools had been identified. It also cautioned, however, that "the attempt to classify schools in other countries than our own may lead to diplomatic complications."[231] The report stated that any classification based on documentary evidence alone was unreliable, so it recommended that the classification be based on personal visitation and study by a qualified representative of the council and that such a classification should be deferred until adequate funds were provided for that purpose. The House of Delegates adopted the recommendation, and the challenges of providing staff and funding effectively ended this effort to engage in the evaluation of foreign medical schools.

The problem of U.S. citizens attending foreign schools had not abated, however. The 1933 report of the CMEH claimed that no less than 2,000 U.S. students were enrolled in European medical schools, and the anticipated return of those students to the United States posed a serious problem.[232] The council therefore worked with the Federation of State Medical Boards (FSMB), leading the FSMB to adopt a

resolution requiring that U.S. graduates of European medical schools (1) obtain a certificate endorsed by either the AAMC or CMEH documenting completion of the premedical requirements established by those organizations and (2) provide documentation confirming graduation from a four-year course of study and evidence of successful completion of the licensure examination in the country where the medical school is located. The CMEH engagement with issues of foreign medical education dissipated over the next several years as council members undertook the comprehensive resurvey of U.S. medical education from 1934 to 1936, as well as a national survey of graduate medical education.

The AAMC for the most part exhibited little interest in foreign medical schools during the first half of the 20th century, not surprising since it was an organization of U.S. medical schools. The first clear evidence of potential AAMC involvement with foreign schools appeared in the proceedings of the 1929 AAMC meeting. The report of AAMC Secretary Fred Zapffe indicated that he had been visited by a faculty member from the medical school of National University in Mexico City, Mexico, inquiring about membership in the AAMC. Zapffe informed the faculty member that membership was possible; he also reported about a membership inquiry from the University of Havana in Cuba.[233] Notwithstanding such expressions of interest, no foreign medical school applied for AAMC membership in the years leading up to the formation of the LCME.

Concerns about the quality of foreign medical school graduates surfacing at the AAMC coincided with similar expressions taking place at the AMA. The minutes of the 1932 AAMC annual meeting included a resolution on the subject. The resolution asserted that in the past 10 years the achievements of foreign medical school graduates on licensure examinations were appreciably lower than those of U.S. and Canadian medical school graduates; it also noted that a growing number of U.S. medical school applicants who were denied admission had sought admission to foreign schools with the expectation of returning to the United States for medical practice. The resolution therefore called for "a prompt investigation of foreign medical education, particularly in reference to licensure in the various states."[234] The resolution was approved, and an extensive report on foreign medical students was presented the following year. The report recapitulated the new requirements adopted by the FSMB in 1933 and offered a detailed review of the experiences of U.S. citizens in European medical schools. It concluded with recommendations that no action be taken with regard to native Europeans seeking a license to practice in the United States and that a committee be appointed to advise and assist European authorities regarding the selection of American students.

In 1947 the AAMC secretary's report to the organization described the formation of the Committee on the Evaluation of Foreign Credentials, established after consultation with the CMEH.

Although the minutes of many early meetings of the LCME are not preserved, the proceedings of the AMA and AAMC annual meetings provide some insights into topics that were likely to have been discussed in the first few years after the creation of the LCME. The primary focus during the first

two years was on wartime issues, with no particular attention to foreign medical education. The first discussion of foreign schools appears in the proceedings from the 1945 AAMC meeting, when the Executive Council reported on its deliberations about applicants from foreign universities seeking admission to U.S. medical schools, either for the freshman class or for advanced-standing admissions. The Executive Council recommended, and the AAMC membership approved, a policy requiring that such applicants provide credentials from the home institution and meet the admissions requirements of the U.S. school. Any medical subjects previously taken would be evaluated by examination at the U.S. school, and no more than two years of credit could be granted for work done at a foreign school. The policy also required applicants to be advised that acceptance did not ensure eligibility for licensure in the United States and recommended that applicants to a freshman class complete a year of premedical study at a U.S. liberal arts college.[235]

In 1947 the AAMC secretary's report to the organization described the formation of the Committee on the Evaluation of Foreign Credentials, established after consultation with the CMEH. The committee would consist of representatives from the AAMC, the CMEH, and "other interested groups in education as well as government agencies," such as the FSMB, the National Board of Medical Examiners, the U.S. Office of Education, the U.S. State Department, and the New York State Education Department.[236] Proceedings of the 1947 AMA annual meeting provided additional insights into the intent of this committee. The CMEH report that year pointed out the ongoing difficulty in evaluating the quality and credentials of foreign medical schools and recommended a possible procedure for gathering information about such schools. The report noted, however, "Whether an approved list of foreign schools will emerge from this project is problematical."[237]

The Committee on the Evaluation of Foreign Credentials met during the following two years and collected relevant information about foreign medical schools. That effort led the CMEH to propose, in 1949, the development of a classification of foreign medical schools.[238] The CMEH representatives to the LCME reported at the June 1949 meeting that the council would be recommending that the AMA authorize it to develop a list of approved foreign medical schools; the secretary of the AAMC Executive Council, Dean Smiley, informed the group that his organization had voted to join the CMEH in exploring the possibility of preparing such a list. The AMA approved the CMEH recommendation at its annual meeting in 1949, and the AAMC Executive Council informed its membership of the project at its annual meeting that year. The Executive Council also began exploration of the possibility of providing affiliated, rather than full, membership for Canadian medical schools and of establishing an affiliated membership category for medical colleges in other countries that met AAMC membership requirements outlined in the association's constitution and bylaws. The latter recommendation was approved, and the AAMC constitution was modified to allow affiliated membership for foreign schools (with no specific mention of Canadian institutions).

The LCME membership was informed at the February 1950 meeting that a preliminary list of approved foreign medical schools had indeed been developed by the CMEH and sent to Smiley at the AAMC. This was the notorious meeting where the LCME nearly imploded because of long-standing

disagreements and distrust between the two sponsoring organizations, and these feelings surfaced again in the discussion of the list. An AAMC representative to the LCME inquired if the original intention was for the development of the list to be a joint effort. Herman Weiskotten from the CMEH then asked if the AAMC was interested in the list. The CMEH informed the LCME that the list would be shared with the FSMB after receiving approval by the CMEH, and the AAMC representative indicated that it would be presented to the Executive Council for action. At the1950 annual clinical session of the AMA House of Delegates, a list of 44 foreign schools was formally presented in the CMEH report. The report also noted that the list had been adopted as a guide by 17 state licensing boards and by the National Board of Medical Examiners (NBME). It mentioned, in passing, that future additions to the list would likely be slow to accrue because the council depended on the reports of qualified American educators who had visited the schools under consideration.[239]

Several foreign medical schools were discussed at the June 1950 meeting of the LCME, with no action taken by the members. At the October meeting that year, the secretary of the CMEH reported that the AMA's publication of the list had posed no problems, and the LCME discussed possible additions of medical schools from several other countries. Such discussions would continue through 1953 as a standing item on the LCME agenda, although none of the schools that appeared on the approved list became affiliated members of the AAMC. At the October 1953 LCME meeting, members learned that the AAMC Executive Council expressed misgivings about maintaining a list of acceptable foreign medical schools, rooted partly in concerns about the comparability of standards of other countries with those of the United States. Joseph Hinsey of the AAMC raised the possibility that the inspections recently conducted by LCME representatives to medical schools in Ireland could establish a precedent for other countries and questioned whether it was "advisable or our responsibility to look after medical education in all parts of the world." Responding for the CMEH, Weiskotten pointed out that his organization felt obligated to continue the program in order to maintain its role of assisting state medical boards.

The issue underwent extensive discussion again at the February 1954 LCME meeting. The debate focused on the appropriate basis for evaluation, either the school or the product of the school. Hinsey of the AAMC shared an Executive Council–approved resolution that stated "because of differences in culture, in traditions, and in objectives it is not desirable or feasible for Americans to undertake a comparable [to LCME] program of accreditation of schools in other countries."[240] The AAMC recommended instead that graduates of foreign medical schools submit their credentials to the appropriate state licensing authority and, if the credentials were found to be acceptable, to permit the applicant to take Part I of the NBME licensure examination for subsequent action by the state licensing authority. This discussion concluded with the LCME approving motions to (1) initiate a long-range study of the problem with the FSMB and other interested parties, (2) recommend to the sponsoring organizations of the LCME that no further additions be made to the list of approved foreign schools in the immediate future and that steps be taken to evaluate the whole program, and (3) have the secretaries of the two councils convene a meeting with representatives from each council, the FSMB, the NBME, and other interested parties. That meeting took place in April, and Weiskotten reported at the next LCME meeting that there was an emerging consensus for a joint committee to be established to evaluate the graduates of foreign medical schools. AAMC representatives to the LCME expressed

concern about AAMC participation in such a group, although the organization would be willing to provide any needed assistance. The Executive Council relented, however, and the LCME learned at the June 1954 meeting that the AAMC would appoint three representatives to join the CMEH and FSMB on the planned Cooperating Committee on Graduates of Foreign Medical Schools.

Reports on the progress of the Cooperating Committee continued over the next two years; meanwhile, the CMEH continued to publish its list of approved foreign medical schools. The LCME revisited that issue in February 1956 when it learned that the CMEH had received a resolution from the Virginia Board of Medical Examiners asking the CMEH and the AAMC to withdraw official approval of the list of foreign schools. Edward Turner of the CMEH shared with the LCME Council the thinking that withdrawal of the list was unwise at the moment, but the list could be discontinued when the plans of the Cooperating Committee became operational. The latter event happened shortly thereafter, as the LCME learned at its next meeting that the Evaluation Service for Foreign Medical Graduates had been formally incorporated and expected to begin operations in July 1956. The LCME therefore recommended to its sponsors that the listing of foreign medical schools should be cancelled if and when the Evaluation Service became effective.

Meanwhile, the AAMC had amended its constitution and bylaws in 1955 to restrict its affiliate membership category exclusively to Canadian medical schools rather than to all foreign medical schools. The next year the AAMC received an application for membership from a medical school in the Middle East. The AAMC expressed a willingness to consider the application because the university was chartered by the state of New York, even though the medical school operated in a foreign country. The problem came to the attention of the LCME because the CMEH had denied a request for approval of the school, raising the question of whether the two sponsoring councils should necessarily be completely consistent in the schools that they approved. The CMEH had rejected the school not on the basis of its educational quality, but because it was felt that approval would open the door to requests from military and other hospitals operating abroad, and the resulting situation would place the CMEH in the position once again of conducting inspections on foreign soil. The discussion concluded with the CMEH representatives to the LCME stating that the AAMC should accept the school for membership if it so desired, but that doing so could create problems associated with differing decisions by the two LCME sponsors. The AAMC did extend full membership to the school in 1957, and it continued as a member until 1981.

In the summer of 1957 the Educational Council for Foreign Medical Graduates became fully operational, under the leadership of Smiley, former AAMC secretary and LCME member. At the February 1958 LCME meeting, its members recommended that the listing of foreign medical schools be discontinued effective January 1, 1960. Henceforth, the LCME and its sponsors would no longer engage in the accreditation of foreign medical schools. Minutes of the LCME from the 1960s do not include any discussion of foreign medical schools or foreign medical school graduates. At the November 1971 LCME meeting, the members discussed a resolution from the AMA about the possibility of developing a joint accreditation process for medical schools in Mexico, similar to the system in place for Canada; the LCME offered to provide assistance or advice to Mexican medical schools, if the schools requested it, but declined to undertake development of a joint accreditation process with Mexico.

The LCME continued to eschew any involvement with foreign medical schools in succeeding years. In October 1977 the LCME considered but denied a request from the New York State Board of Regents to have an LCME representative participate in a proposed survey of the American University of Beirut Faculty of Medicine. Two years later the LCME declined an invitation from the U.S. surgeon general to participate in a planned federal effort to determine the comparability of foreign medical schools with the standards of quality for LCME-accredited medical schools. That effort languished until 1992, when federal reauthorization of the Higher Education Act led to the creation of a committee for that purpose, the National Committee on Foreign Medical Education and Accreditation (NCFMEA), operating under the auspices of the U.S. Department of Education. In the years leading up to the creation of the NCFMEA, the LCME rarely discussed issues associated with foreign medical education. The most notable instance took place in 1986, when the LCME extensively discussed its role in accreditation of foreign medical schools in response to federal legislation proposed by U.S. Representative Claude Pepper from Florida. The proposed legislation would have directed the secretary of the Department of Health and Human Services to establish a system of accreditation for courses of study at foreign medical schools. The LCME reiterated its hands-off stance in the accreditation of medical schools outside the United States and Canada.

The more prominent issue emerging during this period was the growing number of students from non-LCME-accredited schools who were doing clinical rotations at LCME-accredited schools. That problem was addressed by changes in the language of accreditation standards, to ensure that any school accepting students for clinical rotations from non-LCME-accredited medical schools provided sufficient resources for its own students (see Chapter 11). During the 1990s several foreign countries demonstrated an increasing interest in the LCME accreditation process, and representatives of those countries often requested, and were granted, an opportunity to observe an LCME meeting or an accreditation survey visit. Secretariat staff provided informal consultative assistance when circumstances allowed, but in general the LCME maintained its distant relationship with foreign medical schools.

A new twist on the accreditation of medical schools surfaced in 2001, when the LCME learned that a U.S. medical school planned to establish a four-year MD educational program in a foreign country, with the diploma issued by the U.S. school. The LCME had also received an inquiry from a Caribbean medical school, heightening concern about the possibility that it would be drawn into medical school evaluations conducted on foreign soil. The foreign-based program at a U.S. medical school resembled, to a degree, the earlier LCME challenge posed by the AAMC membership afforded to a Middle Eastern medical school, which operated the degree program in another country but was chartered in the United States. The solution this time, based on extensive discussion at the October 2001 LCME meeting, was to redefine the scope of LCME accreditation, limiting it to complete and independent MD-granting programs operated by universities or medical schools chartered in the United States or Canada and with those educational programs conducted within the geographic limits of those two countries. This definition precluded the LCME from considering educational programs operating in foreign countries no matter where the sponsoring institution was authorized to operate.

The issue did not disappear, however, as the U.S. school renewed its request to obtain LCME accreditation for the foreign program in 2008; the request was denied, as the LCME reaffirmed its existing policy and definition of scope. In October 2013 the LCME established a Working Group on International Branch Campuses to revisit LCME policy in that arena. That working group developed a set of guiding principles, and shared with the LCME membership at the February 2014 LCME meeting, that would permit a U.S. school to include a foreign campus within its scope of accreditation as long as all LCME standards were met; the international campus would not receive independent LCME accreditation. Later that year, however, the LCME Council, which was responsible for the organization's oversight, concluded that the LCME should not become involved with the accreditation of international campuses.

A new twist on the accreditation of medical schools surfaced in 2001, when the LCME learned that a U.S. medical school planned to establish a four-year MD educational program in a foreign country, with the diploma issued by the U.S. school.

Increasingly during the past decade, LCME Secretariat staff members have become involved in consultative activities with other countries interested in medical school accreditation. At the same time, U.S. licensing authorities have again become restless about the quality of foreign medical graduates, and calls for accreditation of foreign medical schools have returned to the discussion of the credentialing process for licensure in the United States. As early as October 2004, the LCME began learning of the increasing involvement of Secretariat staff in international accreditation issues. By 2005 the staff had begun collaborating with officials of the World Federation for Medical Education (WFME) to promote the development of international medical education accreditation standards. During that same year, the LCME learned about the creation of the Special Committee on the Evaluation of Undergraduate Medical Education, formed by the FSMB to address the lack of a quality assessment process for foreign medical schools whose graduates sought licensure in the United States. That committee eventually turned to the Foundation for the Advancement of International Medical Education and Research (FAIMER), an arm of the Educational Commission for Foreign Medical Graduates, to undertake a process for evaluating foreign schools. For its part, FAIMER brought LCME Secretariat staff into the discussions for developing such a framework.

In light of these activities, the LCME held a retreat on international accreditation issues in February 2010. The retreat led to further discussions between FAIMER and LCME staff and later that year to the creation of an internal policy document prepared by the LMCE staff on the role of the LCME in international accreditation. The document laid out a series of guiding principles delimiting the extent of LCME involvement in international accreditation, including the following:

- Provision of consultative assistance to national or regional accrediting organizations interested in enhancing accreditation or quality assurance systems
- Provision of consultative assistance to foreign medical schools seeking to meet local accreditation standards

- Participation in quality improvement reviews of international medical schools using local standards and procedures

The internal policy document also reiterated the long-standing LCME policy of not engaging or participating in—and not accrediting—any individual medical school located outside U.S. and Canadian political jurisdictions. In addition, it included a statement of LCME cooperation with other organizations such as FAIMER and the WFME in promulgating international quality assurance efforts in medical education. The policies are now posted on the LCME website.[241] As evidence of its commitment to international accreditation, the LCME applied for recognition from the WFME and was accorded a 10-year term of recognition in April 2014.

PART IV

External Relations

Chapter 16

Interactions With Other Credentialing Organizations

Long before the creation of the LCME, both the AAMC and the AMA maintained close connections with licensing authorities. Efforts of the AAMC and AMA to improve the quality of medical education during the 19th century had foundered, in no small part, from the lack of a mechanism that would oblige medical schools to meet the organizations' standards. That mechanism would prove to be the cooperation of licensure organizations.

The LCME and Licensure Organizations

Until the early 20th century, the responsibility for physician licensure rested exclusively with state-level regulatory authorities, sometimes including medical schools themselves. As Kenneth Ludmerer pointed out, state licensure activities in the period from 1870 to 1910 were largely ineffectual, and the rigor of their requirements varied substantially from state to state.[242] The 1890 establishment of a national organization for state licensing boards, the National Confederation of State Medical Examining and Licensing Boards (NCSMELB), started a process for strengthening state requirements and fostered the development of stricter criteria for medical school admissions and curricula. By 1900 the AAMC had established a committee with the NCSMELB to explore joint adoption of uniform medical education standards. In 1908 the NCSMELB joined with the AAMC in establishing equipment requirements that medical schools needed to provide a suitable education program.

When the AMA established its Council on Medical Education (CME) in 1904, the proposed enforcement mechanism for achieving the council's efforts to improve educational quality was to enlist the House of Delegates to inform state societies of CME standards and recommend that the state organizations promulgate adoption of those standards within their county medical societies.[243] In 1904 the AMA began disclosing results of state licensure examinations in the annual "state board number" published in *JAMA* every April. By 1905 the council acknowledged the impact of collaboration between the AAMC and national licensure organizations, when it recommended that the AMA adopt the four-year curriculum standard that had been agreed to by the AAMC and the American Confederation of Reciprocating State Medical Examining and Licensing Boards.[244] The publication of the Flexner Report, bolstered by public support of Henry Pritchett, president of the Carnegie Foundation, tightened the growing bond between licensing authorities and the AMA.[245]

Immediately after their formation, both the Federation of State Medical Boards (FSMB, established in 1912) and the National Board of Medical Examiners (NBME, established in 1915) worked in close collaboration with the AAMC and the AMA. The AAMC saw opportunity in working with the FSMB; the minutes of the 1913 AAMC meeting captured its sentiments quite candidly: "There can be no question that an affiliation of activities and purposes of action on the part of the federation and this Association will not only be mutually advantageous but productive of the greatest possible good to medical education to the medical profession and to the people."[246] The NBME relationship was not

as strong, but the AAMC nevertheless recognized its potential contributions; as the 1916 proceedings stated, "Recognizing the need and importance of a generally accepted standard for medical licensure, and appreciating the effort of the National Board of Medical Examiners to satisfy this need … therefore be it resolved by the Association of American Medical Colleges that the purposes of the National Board of Medical Examiners be approved and its objects encouraged."[247] The AMA approved a similar endorsement of the NBME that same year.

Immediately upon its formation, the NBME restricted eligibility to take its licensure examination to graduates of medical schools listed in Class A by the CME. The FSMB, meanwhile, had established its own Committee on the Standardization of Medical Colleges in 1916, thus establishing a third organization promulgating criteria for medical schools and their educational programs. The growing emphasis on uniform licensure laws, in conjunction with educational requirements established by the AAMC and the AMA, had a stultifying effect on medical education at medical schools during the next decade. Recognizing the growing rigidity of medical curricula and the duplication of criteria maintained by the various credentialing organizations, the FSMB eventually stepped back from its role and ceded authority for medical education to the AAMC. As noted on the FSMB centennial celebration website, "By 1929, the conversation between the medical education and licensing communities shifted to avoiding 'duplication' of effort in overseeing medical education and avoiding overly detailed and inelastic state requirements that hampered curricular changes. The Federation agreed and in 1929 its membership called for revisions to their medical practice acts that 'conform[ed] as far as possible with the principles' of the AAMC."[248]

Licensure issues first appeared on the LCME agenda in the early 1950s. The minutes of the 1953 meeting of the LCME included an item on the topic. The AMA Council on Medical Education and Hospitals (CMEH) had begun discussing the possibility of establishing closer relationships with the FSMB the previous year. Meanwhile, the AAMC Executive Council appointed the Committee on Licensure in December 1952. The LCME members agreed that a three-way liaison committee representing these organizations would be desirable, and the first meeting of that group was planned for May 1953. The effort apparently foundered, however, as there was no further mention of the group in the minutes of later LCME meetings. While the AAMC, AMA, and LCME would continue to maintain cordial relations and regular communications with the FSMB, there were no further efforts within the LCME to formalize any relationship with the FSMB.

The interlocking relationship between the LCME and licensure organizations provided a suitable mechanism for ensuring educational quality for U.S. and Canadian medical schools, but it did not address the challenge of educational quality for graduates of foreign medical schools who sought licensure in the United States. As noted in the previous chapter, for much of their respective histories, the AMA had favored the publication of lists of acceptable foreign medical schools and the AAMC generally showed little or no interest in offering membership to such schools. In 1932 the AAMC adopted a resolution expressing concern about the quality of foreign medical graduates and recommending that the organizations responsible for licensure conduct a prompt and thorough investigation of the problem.[249]

The LCME provided a vehicle for the two organizations to discuss the problem of foreign medical schools, leading to broader discussions of the topic in 1954 with the NBME and FSMB and culminating in the 1956 creation of the Evaluation Service for Foreign Medical Graduates (renamed shortly after as the Educational Commission for Foreign Medical Graduates, or ECFMG.). As it had with the FSMB and NBME, the LCME maintained a cordial but distant relationship with the ECFMG, ceding to it the authority for validating the credentials of foreign medical graduates who intended to practice in the United States. In recent years, the LCME has shared its expertise with officials from the ECFMG and other organizations interested in developing a formal accreditation system for non-U.S. and non-Canadian medical schools.

The LCME and the Medical Education Continuum

Long before the creation of the LCME, its sponsoring organizations were intimately involved in the evaluation of medical education programs beyond the MD level. By 1905 the CME had already recommended in its ideal standard for medical education that a year as an intern in a hospital be adopted to round out the education of the physician. In 1912 the council acknowledged that clinical education and the internship year represented the next great challenge for its efforts to improve educational quality.[250] It began collecting reports from hospitals the following year for the purpose of developing a classification similar to its system for classifying medical schools. In 1914 the CME recommended that the internship year be made a requirement for medical students, and it began conducting inspections of postgraduate medical schools (institutions offering medical education beyond the MD level) that same year. The newly created AMA Committee on Graduate Medical Instruction, headed by Horace D. Arnold, proposed a series of requirements for graduate medical schools in 1915.[251] Two years later the AMA published its first list of approved hospitals.

The AAMC evinced interest in the internship period as early as 1909; in his address to the membership that year, President Eli Long called for the addition of a hospital year. He pointed out, "In the progress of events students are coming to feel more and more the necessity of supplementing their college course by hospital training.… [I]t would be better if the near future could see relations of schools and hospitals so adjusted that every graduate could be assured of a hospital position. To go a step further, it would be desirable to have the college course invariably include an additional hospital year, so that the latter might be given definiteness under college supervision."[252]

The subject received little further discussion within the AAMC in succeeding years, and the AMA CME continued to take the lead on promoting educational quality for programs beyond the MD degree. By 1924, however, postgraduate medical education had resurfaced as a topic of discussion at the AAMC in response to a perceived shortage of interns. Three papers addressed different dimensions of the subject at the 1924 annual meeting of the AAMC: "The Fifth Year Requirement: A Retrospect,"[253] "The Intern Problem,"[254] and "The Case of the Postgraduate Medical School."[255] In the discussion of the second of these papers, AAMC Secretary-Treasurer Fred Zapffe noted that the membership was unwilling to support a fifth internship year as part of the MD curriculum unless its constituents had some way of controlling the teaching during that year. Nevertheless, in 1925 the AAMC constitution was revised to provide membership to "any graduate school in medicine, a part of a university, any graduate division

of a university offering medical instruction, or any school offering courses in medicine to general practitioners but not leading to any degree."[256]

By 1927 the AAMC Executive Council obtained agreement from the membership to appoint a committee to define the scope of graduate and postgraduate study. That committee presented its report to the membership in 1928, and the AAMC then established the Committee on Intern Training to examine the quality of intern education. By this time the AMA had for the most part ceded interest in medical school education to the AAMC, and in 1928 the AMA proposed to undertake a comprehensive survey of all U.S. hospitals. At the AAMC, the Committee on Intern Training in 1930 expressed a desire "to formulate a list [of hospitals providing intern training] that will grow from year to year and increase in value, on which only those hospitals shall be mentioned whose staffs are doing sound and constructive teaching."[257] The proposal languished, however, and the minutes of AAMC meetings during the early part of the 1930s are noteworthy for the paucity of discussion of graduate medical education.

The CMEH continued its program of evaluating graduate medical education programs. In 1937 the council announced its plans to examine both the graduate and continuing phases of medical education, to include "the systematic courses offered in schools, hospital residencies, and other types of apprenticeship, continuation courses for those in practice and the educational programs of medical societies."[258] That same year, the Advisory Board for Medical Specialties announced plans for a study of graduate medical education. With growing interest in the continuum of medical education by several organizations, the AAMC expressed support for the National Council on Medical Education, Licensure, and Hospitals in 1938. The proposal was also supported by the CMEH, but the House of Delegates vetoed CMEH participation when the AMA met in 1939. The function of this new organization was clearly expressed by Willard Rappleye in his presentation to the AAMC in 1938:

> It is becoming increasingly apparent to those familiar with the situation there is need of coordination of the various phases of medical education and better definition of the responsibility of the various agencies, national and state agencies, universities, hospitals and professional bodies dealing with isolated and overlapping portions of the whole program, if medicine in this country is to meet fully its obligations. The logical conclusion from the present more or less unrelated and frequently overlapping efforts is to create some type of national coordinating body representative of the major interests involved in medical education and service in order that they may more effectively meet the new conditions and demands likely to be made upon us.[259]

Besides endorsing the creation of the proposed National Council on Medical Education, the AAMC through its Committee on Educational Policies also approved a recommendation to establish essential educational requirements for a satisfactory hospital internship and to prepare a list of those hospitals meeting such requirements. In February 1939 the AAMC Executive Council established the Committee on Internships to carry out this charge. These actions brought the AAMC into direct competition with the AMA and its long-standing history of quality assessment for graduate medical education.

When the LCME was established in 1942, the agenda of its first meeting included discussion of "the internship" in relationship to wartime pressures to shorten the training period. During that discussion, AAMC Secretary Zapffe informed members of the CMEH that the AAMC could not supply its list of hospitals approved for internships because New York had withdrawn its list; in response, Herman Weiskotten of the CMEH stated that the AAMC list "would be a definite advantage to the Council in its internship approval program." Minutes from the October 1947 meeting of the LCME suggested that the two organizations had developed a comfortable working relationship about approval of hospital programs, as the two groups agreed that the AAMC Committee on Internships should work closely with the inspection staff of the CMEH in connection with the approval of hospitals that provided internships.

Possible expansion of the LCME's scope of activities was further advanced in 1969 when the LCME first discussed a proposal to create the Commission on Medical Education, separate from but based on the organization of the LCME, which would undertake accreditation of graduate medical education, continuing medical education, and allied health programs.

By the early 1950s, the AAMC focus on graduate medical education had shifted mainly toward placement programs for interns, while the AMA continued its program of hospital inspections. Minutes of LCME meetings during the period revealed little discussion regarding graduate medical education programs. The topic reappeared in 1954. The AAMC decided that year to discontinue its list "Confidential Ranking of Internships as to Educational Standing," which had been intended to provide more detailed information about such programs than was available in the AMA-approved list. That same year, the CMEH established the standing Committee on Internships to review their quality. These activities appeared as items on the LCME agenda, with no action being taken.

Minutes of the July 1956 meeting of the LCME included a report on the formation of a CMEH ad hoc Committee on Postgraduate Medical Education (i.e., continuing medical education), "to study the field and determine what part the Council should play in the future of this field."[260] The AAMC's Executive Council had expressed an interest in the work of this committee, but it had decided that it would not take an active part and would withhold any further action of its own committee until the ad hoc committee's results were known. The issue of continuing medical education was then dormant as an LCME topic until the October 1960 meeting, when the members were informed about discussions taking place within the sponsoring organizations about potential development of a national organization for continuing education. The CMEH began a formal program for accreditation of continuing education programs in 1967.

For the next several years, LCME agendas reflected little discussion of issues related to later stages of the educational continuum. When the LCME engaged in detailed discussion of its core functions and purposes in March 1967, it raised the possibility of a broader scope of LCME activity, including accreditation of programs in other health professions and of graduate medical education. No decisions were made at this time. Possible expansion of the LCME's scope of activities was further advanced in 1969 when the LCME first discussed a proposal to create the Commission on Medical Education,

separate from but based on the organization of the LCME, which would undertake accreditation of graduate medical education, continuing medical education, and allied health programs. As the discussion of the proposed commission continued at ensuing meetings, it was reconceptualized as part of the LCME itself; in the 1971 AAMC proceedings, President John A.D. Cooper informed the membership that one of the organization's activities for the upcoming year would be "incorporating the accreditation of graduate medical education into an expanded LCME."[261] That notion did not get traction with other organizations, however, and in 1972 the LCME's sponsors, along with the American Hospital Association, American Board of Medical Specialties, and Council of Medical Specialty Societies, announced an agreement to establish a Liaison Committee on Graduate Medical Education (LCGME). The new LCGME would function in a parallel manner with the LCME, and policy issues for both organizations would be overseen by the Coordinating Council on Medical Education (CCME). The LCGME and CCME were composed of representatives from the five involved organizations and also included a public member and a representative from the federal government.

The LCME's relationship with the CCME posed a challenge when the former underwent its review for recognition by the U.S. Department of Education in 1972, but in light of the increasing autonomy that the LCME had achieved in relation to its primary sponsoring organizations, it was able to allay government concerns about its relationship with the CCME. The CCME, for its part, was much more engaged with establishment of the fledgling LCGME than with oversight of the LCME, and in later years it served mainly as a policy development platform for issues such as physician manpower and the financing of graduate medical education. The influence of the CCME on accreditation matters proved to be modest, and in 1980 it was reorganized as the Council on Medical Affairs, with no role in the oversight of accreditation. The LCGME was reconstituted in 1981 as the Accreditation Council for Graduate Medical Education (ACGME), and remained entirely distinct from the LCME in its operations and philosophy from its inception.

Maintaining Lines of Communication

As this chapter noted, the LCME generally maintained an arm's length relationship with other organizations involved in medical education and physician credentialing. In some cases, the LCME served as an important catalyst for discussion leading to the creation of other groups such as the ECFMG and ACGME. For other organizations such as the FSMB and NBME, the actions of those organizations complemented and strengthened the effectiveness of medical school accreditation, without requiring close collaboration with the accreditation side. Nevertheless, the LCME has made a sincere effort to maintain communication and awareness of other credentialing organizations in recent years.

The impetus for reestablishing close LCME contact with the other organizations can be attributed in large measure to the turnover in the Secretariat in 2000, bringing fresh ideas to the group. Frank Simon, the new AMA secretary to the LCME, had supported the AMA's graduate medical education efforts in the year preceding his assumption of the role of LCME secretary. Unlike previous and later LCME secretaries, who had been medical school deans or key figures in the leadership of the LCME's sponsoring organizations, AAMC Secretary David Stevens came from the outside as a high-ranking

official in the U.S. Department of Veterans Affairs. Although he also served for a time as the vice dean for academic affairs at the Case Western Reserve University School of Medicine, he was dedicated to health care quality improvement for most of his career. In that latter capacity, he developed a close working relationship with the executive director of the ACGME, David Leach. Thus, the new Secretariat leadership had already established close ties with other credentialing organizations. Discussions with the leaders of other groups took place during the summer of 2000 and led to the creation of a "broadband group" that agreed to meet at least once a year to review plans and possibilities for their respective organizations. The original group (which later self-identified as the "bull's-eye group" since the organizations often provided ready targets for frustrated constituents) consisted of the administrative leaders of the LCME, NBME, ACGME, Accreditation Council for Continuing Medical Education (ACCME), ECFMG, and FSMB. While its composition changed slightly over time, this informal network maintained communication for well over a decade before disbanding.

Chapter 17

The LCME and Federal Government Agencies

The AMA and the AAMC have had extensive interactions with various federal agencies during their respective histories, and each organization has evinced a distinct attitude toward the federal government. The AMA, as the organization representing the medical profession, has consistently been wary of the regulatory functions of government and potential intrusion into what it considers the free market for health care. The AAMC, on the other hand, representing medical schools and associated organizations, has looked to the various federal agencies as potential supporters of academic medicine missions. These distinctive positions posed some challenges for the LCME in its early years, but as accreditation became its primary focus, the LCME was principally concerned with successful navigation of the recognition process developed by the U.S. Department of Education.

The LCME and the U.S. Department of Education

As Harold Orlans pointed out in his detailed review of the history of higher education accreditation, the main activity of the federal government regarding accreditation until the late 1960s was simply the publication of a directory of institutions that were accredited by some agency (usually state universities or state departments of education, but some private groups as well).[262] Thus, the U.S. Office of Education had no particular interest in or oversight of the approval activities of the AMA or the membership requirements of the AAMC before the formation of the LCME.

Federal recognition of accrediting agencies began officially in 1952 with legislative approval of Public Law 550, the Veterans' Readjustment Assistance Act. That law required the U.S. commissioner of education to publish a list of nationally recognized accreditation agencies and associations determined to be a reliable authority as to the training offered by an educational institution. The first list of recognized accreditors published by the Office of Education in 1952 had actually been developed by the neophyte National Commission on Accrediting,[263] and included the Council on Medical Education and Hospitals of the AMA, not the LCME. The AAMC was not included on the list, and the minutes of the February 1953 LCME meeting indicated that AAMC officials had met with Office of Education staff seeking inclusion on the list. Subsequent issues of the Office of Education list identified the LCME, not its sponsors, as the nationally recognized agency for accreditation of MD-granting programs.

The next direct engagement of the LCME with the Office of Education took place in 1963. As Orlans noted, legislation adopted that year provided federal assistance for new educational institutions (including medical schools), provided that the government could determine that the institutions had a reasonable assurance of obtaining accreditation.[264] Thus, in November 1963, the Office of Education requested that the LCME provide such "letters of reasonable assurance" for new medical schools that showed promise of meeting LCME standards. This prodded the LCME to develop a three-tiered approach for classifying new schools; the schools were either (1) sufficiently well developed to merit an on-site evaluation, (2) lacking evidence to indicate readiness for an on-site evaluation, or (3) unsatisfactory. The LCME agreed to provide letters of reasonable assurance only for new schools determined to fall within the first of these categories.

Passage of the Higher Education Act in 1965 by the federal government gave the Office of Education greater responsibility and authority for the oversight of accrediting organizations. This legislation also established the requirement that accreditors undergo recurrent review by the Office of Education for renewal of their federal recognition. The reach of the Office of Education was further expanded by the passage of the 1965 National Vocational Student Loan Insurance Act. As Orlans asserted, "The acts presented OE [Office of Education] with a whole range of new programs and new types of institutions eligible for support."[265] The increased demands on the Office of Education ultimately led it to establish the Advisory Committee on Accreditation and Institutional Eligibility to facilitate its efforts. The new system of federal recognition also opened the door for public comment, creating a challenge for the LCME when it underwent the more rigorous recognition process for the first time in 1972.

As the LCME was preparing documentation for recognition by the Office of Education, it was informed in 1971 that the Women's Equity Action League provided public comment challenging the LCME's authority based on the LCME's failure to address perceived sexual discrimination in medical school admissions (in an era when women represented approximately 10% of all enrolled medical students). Orlans briefly discussed the Women's Equity Action League's criticism in his study of accreditation, pointing out that the league's claim prompted the advisory committee for the Office of Education to implement three recommendations: (1) an investigation of the LCME to determine the accuracy of the charge, (2) a statement from the office to all accrediting agencies expressing its concern about the impact of discrimination on educational quality, and (3) revision of recognition criteria to require accreditors to take positive steps to eliminate discrimination.[266] The LCME responded to the charge by providing information regarding the increasing percentages of women applying to medical schools and also emphasizing that it maintained, and enforced, an accreditation standard prohibiting discrimination on the basis of sex, creed, race, or national origin. With this response, the LCME was able to allay Office of Education concerns sufficiently to be granted recognition for a term of four years, although it was required to provide a follow-up report that included information about the enrollment of women and minorities in U.S. medical schools.

When the LCME was due for renewal of its Office of Education recognition in 1976, it was challenged again, this time by another government agency, the U.S. Federal Trade Commission (FTC). The proceedings of the 1977 AAMC meeting captured the issue quite clearly:

> The LCME's status [as a nationally recognized accrediting agency] had been challenged before this Advisory Committee [of the Office of Education] by the FTC, on the grounds that the involvement of the American Medical Association constituted a conflict of interest and compromised the autonomy of the LCME. The FTC argued that the AMA, as a trade association, represented the economic interests of physicians and therefore had a vested interest in restricting the development and growth of new and existing schools of medicine.[267]

The staff analysis conducted by the Office of Education's Division of Eligibility and Agency Evaluation did not find merit in the FTC argument, but the findings did suggest some ambiguity in the extent of the LCME's autonomy and its relationship with its sponsoring organizations. Those perceptions were summarized in the letter from Commissioner of Education Ernest L. Boyer to LCME Secretary J.R. Schofield:

> The Division of Eligibility and Agency Evaluation and the Advisory Committee on Accreditation and Institutional Eligibility have indicated their concern about the lack of independence of the Liaison Committee pertaining to its administration and financing. Another major issue raised by the Division and the Advisory Committee relates to the procedures of the Liaison Committee which require the review of certain of its accreditation decisions by the Executive Council of the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association before the decisions are final. These procedures which are employed by the Liaison Committee place certain decisions within the responsibility of bodies that are not directly involved in the evaluation process and, hence, are not fully accountable for the decisions rendered.[268]

The accreditation decisions requiring AMA and AAMC approval involved the placement of medical schools on probation or consideration for withdrawal of accreditation. On the basis of these findings and other concerns noted in the staff analysis of the LCME, the Office of Education extended the term of the LCME's recognition for a two-year period, with a report on its deficiencies to be provided after one year of that term.

After reviewing this decision with Office of Education staff, the LCME secretaries prepared a memorandum to the LCME membership summarizing the issues and possible responses. The Secretariat characterized the underlying issues as follows:

> For most of its 42 years, the LCME has exercised functional independence with regard to its operation but the USOE now requires evidence of structural autonomy as well. If it is decided that USOE requirements are to be met, the LCME requests that its sponsoring associations, the AMA and AAMC, modify their by-laws or other rules of procedure so as to permit the LCME to develop the requisite autonomy required by the USOE for recognition.[269]

The memo identified several options for the sponsoring organizations, including acceptance of all the recognition requirements, acceptance of some but not all requirements, a request for reconsideration by the Office of Education, legal action, or withdrawal from the recognition process and removal from the official list of recognized agencies. The sponsors ultimately opted for the first of these options, relinquishing their role in all aspects of LCME decision making except for final approval of new or revised accreditation standards; the sponsors also retained the authority to appoint professional and student members of the LCME. The FTC would challenge the LCME again late in the 1980s, when it conducted an investigation of the LCME policy prohibiting medical schools from accepting students from non-LCME-accredited schools for core clinical clerkships; the LCME was able to allay this FTC concern without changing its policies or standards.

Ensuing petitions for renewal of federal recognition by the LCME were largely uneventful. One notable event took place when the LCME sought renewal in 1997. To avert potential problems in addressing

the Department of Education's requirements that accrediting agencies demonstrate separation and independence from any sponsoring or supporting organizations, the LCME Secretariat opted to seek recognition as an exclusively programmatic accreditor (not subject to the separate and independent stipulations of the federal regulations). This action affected a small number of medical schools that had until then obtained institutional accreditation from the LCME, and thus those schools were required to obtain regional accreditation to maintain that status and ensure ongoing student access to Title IV federal funding programs.

As noted in Chapter 15, in 1992 the federal government came to grips with the appropriate use of its student loan programs for U.S. citizens who attended medical schools outside the political jurisdiction of the country. To address that problem, amendments to the Higher Education Act authorized the creation of the National Committee on Foreign Medical Education and Accreditation (NCFMEA) under the auspices of the Department of Education. The purpose of the NCFMEA was to determine the comparability of accreditation standards in foreign countries with those of the LCME; U.S. citizens attending medical schools in countries determined to have comparable standards would be eligible for Title IV funding. The federal government had made an effort in the late 1970s to address this problem. The surgeon general had invited the LCME to participate in a process for establishing the comparability of foreign medical school accreditation in 1979, which the LCME declined; that effort by the government did not gain traction, however, and the issue remained dormant until 1992. The LCME was not invited to participate in the activities of the NCFMEA, although the latter's membership has occasionally included former members of the LCME.

Other Federal Influences

While the main interactions between the LCME and the federal government have involved the Department of Education and its predecessor, there were also occasional exchanges with other agencies, particularly those associated with national defense, health care, and research. The LCME itself did not interact with the U.S. Department of War during World War II or the Korean War, but it did provide the locus for discussions about how to deal with wartime issues and policies of the department. The key issue around which those discussions crystallized was the need for physician manpower during both wars and its impact on medical education.

To ensure adequate physician availability to meet the health care needs of the military, medical schools in the early 1940s were under pressure to accelerate completion of their educational programs, and most did so by shortening the curriculum. Although it is not entirely clear that these wartime concerns precipitated the decision of the AMA and the AAMC to meet and establish a liaison committee, there is no doubt that they contributed to that decision, and much of the discussion at the 1942 meeting centered on the war problems. In his opening remarks at that meeting, Loren Chandler, dean of Stanford's medical school, acknowledged the mutual benefit obtainable through cooperation of the two organizations, to "keep our medical schools and our graduates coming along on a high standard and help to meet the problems that we will be faced with during this war emergency." Much of the remaining discussion during that meeting focused on such problems, including protection of medical students from the Selective Service Act, the inclusion of tropical and military medicine as medical

school subjects, the accelerated curricula of the medical schools, and financial support (particularly scholarships) for medical schools.

The only war-related issue discussed at the first meeting of the LCME was the accelerated curriculum, particularly the difficulties in relation to licensure requirements in many states that established four years of medical education as a minimum. There was also a concern about provision of an accelerated curriculum by medical schools on probation. At the second meeting of the LCME, wartime issues served as the first topic for discussion. The minutes of that meeting stated that "the status of premedical education, medical education and the hospital internship in the military program was the first subject considered which included a discussion of the Specialized Training Program of the Army and the Navy, the relationship of the Council and the College Association to these war programs and the success of the accelerated program of the medical schools."[270] No action resulted from this discussion.

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Minutes of many LCME meetings from the period have not been preserved, so it is impossible to document the extent to which war-related topics were discussed during the remainder of the World War II period. Minutes from October 1945 did not include any war-related topics. The issue did resurface in April 1948, when the LCME met to discuss federal aid to medical education and "pending war manpower legislation as it might affect medical personnel." Concerns about Korean War preparations continued as a discussion item, again without action, through the November 1952 LCME meeting. Subsequent U.S. military engagements would not prompt LCME consideration.

Apart from war-related issues, LCME interactions with the federal government involved health care (mainly hospitals and internships) and the funding of medical schools. As it did with military matters, the LCME provided a vehicle for discussion of these topics, with any needed actions taken by the sponsoring organizations. Activities of the U.S. Veterans Administration served as a point of discussion during the early 1950s, in relation to both the suitability of veterans' hospitals for intern education and to the appropriateness of GI Bill support for the training of interns and residents. LCME representatives were not positively disposed to either of these issues.

Federal funding of medical schools was a major topic that originally served as a wedge between the two sponsoring organizations, with the AMA opposed and the AAMC favoring such support; that issue helped to fuel the rancor that surfaced at the February 1950 meeting of the LCME (described in Chapter 3). The development of a private organization to support medical education (the National Fund for Medical Education), and lack of rapid action on federal legislation to provide support for medical schools, ameliorated the concerns that had grown around this issue.

A related topic that arose in the mid-1950s was the development of federal support for biomedical research. The minutes of the June 1954 meeting indicated that the LCME was not comfortable with a federal presence in this arena, noting that "[t]here was considerable discussion of the dangers and implications of medical schools accepting Federal aid …" and concern that schools would be responsible for supporting investigators should federal funding be withdrawn. Such concerns were apparently not too serious, however, as the minutes from the next meeting indicated that representatives of the sponsoring organizations had met with the Public Health Service about the issue, and no further discussion took place. By the summer of 1956, LCME concerns about federal support for biomedical science investigators had completely evaporated, as the minutes of the June 1956 meeting summarized the new Senior Research Fellowship Program offered by the National Institutes of Health (NIH); no objections to the program were raised, and the subject was simply noted as an external event taking place. By 1960 the LCME had become fully supportive of federal aid to medical schools, including legislation that would authorize $250 million for construction of facilities for medical, dental, and public health education and research. The LCME also recommended in February 1960 that its sponsors seek a change in NIH policies to provide full reimbursement for the costs of research when providing medical school grants.

In later years the LCME focus shifted largely away from discussion of topics related to government activities and much more toward its internal processes and standards. While pending federal legislation or agency action would prompt an occasional response or discussion from the LCME, such incidents were relatively sparse once the profession and the medical schools accommodated, and often embraced, a federal role in the support of medical education.

Chapter 18

Accreditation Umbrella Organizations: NCA, COPA, CORPA, CHEA, ASPA

In addition to the accountability framework established by the federal government for accrediting agencies, those agencies also have a long history of working with private organizations that serve a similar function. The value of the private umbrella organizations to the accrediting agencies themselves has been a hot topic in the accreditation community. On the positive side, the umbrella organizations have offered stature to accreditors, especially those who may not have been eligible for federal recognition; they also provide a potentially valuable venue for discussion of issues faced by accreditation in general. On the other hand, the motivations of some of the private organizations have been questioned, especially those organizations which were established by the leaders of universities and colleges (see discussion in the Introduction). For accrediting agencies recognized by the U.S. Department of Education, there is also an additional administrative burden involved in recognition by a private organization.

The NCA and Its Successors

Umbrella organizations for specialized accreditation are a relatively recent phenomenon in higher education, with the first private organization of that type established in 1949. The creation of the National Commission on Accrediting (NCA) was a direct response to the proliferation of specialized accrediting agencies in the aftermath of World War II. Frank Dickey, former NCA executive director, acknowledged as much in a paper delivered at the 1973 meeting of the Northwest Association of Secondary and Higher Schools:

> Immediately following World War II a rash of activity developed in the accreditation field. Institutions of higher education found themselves beset with many new and sometimes questionable organizations seeking to accredit specialized programs on their campuses. The administrative officers of these institutions concluded that something had to be done; otherwise, their institutions would be pulled and tugged in a hundred different directions by these accrediting organizations with their varied and different standards and procedures. Consequently, the National Commission on Accrediting was established in 1949 to seek ways to deal with these problems.[271]

The first evidence of the LCME's awareness of the NCA appeared in the minutes from its February 1951 meeting, although the sponsoring organizations had some previous contact with the commission. Those minutes noted that the Council on Medical Education and Hospitals (CMEH) had not heard from the NCA since the previous LCME meeting and that Dean Smiley of the AAMC was scheduled to meet with the NCA that same month. When Smiley met with NCA officials, "all he intended to do [was] to tell them what [was] involved in accreditation." The LCME's sponsors were, at the outset, positively disposed to working with the NCA. The minutes of the February 1952 LCME meeting stated that the CMEH "was of the opinion that an attempt should be made to maintain reasonably friendly relations with the National Commission on Accrediting," and the AAMC Executive Council had voted similar action.

The NCA's interest in the LCME was clearly deeper than simply gaining an understanding of accreditation, however. The minutes of the June 1951 LCME meeting summarized communications that had been sent by the NCA to both the AAMC and the AMA, requesting that the councils of the two sponsors impose a moratorium on accrediting programs for the balance of the 1951–1952 academic year or "until such time as the Commission is able to meet with the accrediting groups." In its efforts to stifle the proliferation of accreditors, the NCA decided that the specialized accreditation activities of the LCME's sponsors should be circumscribed or eliminated. In a letter to NCA members dated November 7, 1952, NCA Executive Secretary Fred Pinkham indicated that the AAMC and AMA were among a group of accrediting organizations "with special problems" that required additional time for a final NCA determination of their appropriate function. Harold Orlans stated that the NCA considered the AAMC to be an association concerned with the improvement of medical education and not accrediting, while the AMA's accrediting activities needed to be worked out with the NCA before transfer of its accrediting functions to the regional accrediting agencies.[272]

When NCA plans were shared with the LCME at the November 1952 meeting, the members roundly rejected them. According to those minutes:

> Dr. Weiskotten stated that he did not believe that American medicine would be willing to surrender its position with regard to the accreditation of medical schools, neither would the Council [on Medical Education and Hospitals] be willing to surrender its cooperative relationships with the Association of American Medical Colleges and neither did he think that medical educators, in general, would be willing to accept such a program as that proposed by the National Commission on Accrediting.[273]

The LCME agreed to prepare a joint document pointing out problems with the NCA proposal to be accompanied by a letter on LCME stationery conveying the LCME's concerns to the dean of each medical school, along with a request that the information then be passed on to the university president. This rebuttal document, dated December 22, 1952, made the following points:

1. Accreditation procedures used for medical schools had evolved and been perfected over a period of 40 years, and the high standards in medical education were due in no small part to the accreditation system.
2. For the past decade, accreditation activities for medical schools had been conducted jointly by the AMA and the AAMC by way of the LCME, with parallel standards, shared procedures, a single report, and wherever possible parallel action by both sponsors (although each organization reserved the right to make an accreditation decision independently).
3. To meet their obligation to the public, medical schools are obliged to promote and ensure high standards for medical education.
4. Most states require candidates for licensure to be graduates of medical schools approved by the AMA, the AAMC, or both.
5. Ten of the 81 medical schools operating (at the time) are not part of a university and are thus outside the jurisdiction of regional accrediting organizations.
6. Medical schools are frequently geographically separate from the parent university and operate in a different manner.

7. The complex organization of medical schools and their missions cannot be adequately evaluated by individuals who are not familiar with medical schools and medical education.
8. Because medical school graduates practice anywhere in the country, it would be inappropriate to apply varying criteria of regional accrediting organizations to an educational program that is functionally national in scope.
9. The standards of a medical school are of special interest and concern to the public and should not be diluted by being averaged with the findings regarding other parts of a university.[274]

The strong response from the LCME prevailed over the desires of the NCA to, in Orlans' words, "subdue the medical profession." Orlans noted, "In January 1953, representatives of the AMA and the AAMC told the commission that they would continue to accredit medical schools as they had done for decades. If the institution wished, they would provide a copy of their accrediting report to the regional association; they would be glad to help the regionals and, if possible, participate in their team visits."[275] The LCME subsequently made a sincere effort to enhance its cooperation with the regional accrediting associations, and rather than diluting or harnessing the influence of the LCME, NCA efforts had the opposite effect of strengthening the organization as an accrediting agency.

In the aftermath of the NCA encounter, the LCME did engage in serious discussions with the Middle States Association of Colleges and Secondary Schools in 1953 about possible avenues for collaboration, but with limited success. Other regional accreditors, specifically the Southern Association of Colleges and Secondary Schools and the North Central Association, proposed collaborative activities with the LCME in 1954; the LCME demurred on the former, but agreed with the latter to include a "generalist" (most likely a university president) on some medical school accreditation teams. The LCME also agreed to provide information about its activities for the annual questionnaire compiled by the NCA. Cooperation with the regional accreditors quickly began to wane, however. At its June 1955 meeting, the LCME engaged in extended discussion of joint evaluations with regional organizations and decided to be much more circumspect in such activities because of concerns about misinterpretation of reports of such evaluations by the regional associations. When the LCME met in October 1955, it considered a recommendation from the AAMC Executive Council, which "expressed concern with regard to the increasing complexity of the relationships of the Liaison Survey Team in conducting joint evaluations with regional accrediting agencies." The LCME adopted the Executive Council recommendation that stipulated the LCME would conduct visits and share information when the timing of the visit coincided with that of the regional accreditor. For visits that did not coincide in time, the LCME would share information with the regional about the last LCME survey, but only if so requested by the university involved. The LCME also agreed to authorize regional association representatives to participate as observers when requested, with expenses for such participation borne by the regional association.

The NCA appeared again on the LCME's radar screen in 1956. At the June meeting that year, the LCME was informed about criteria for accrediting agencies being proposed by the NCA; action was deferred because the AAMC Executive Council had not seen the criteria. There was no further mention of this

issue in the minutes of subsequent LCME meetings nor in the annual proceedings of the AAMC from later that year. Subsequent interactions with the NCA were rarely recorded in LCME minutes. In February 1958, the LCME agreed to participate in a proposed national study of accreditation conducted by the NCA; the June 1958 minutes indicated that the proposal was not well received by the councils of the sponsoring organizations, however, and no action subsequently materialized. In June 1966 the LCME responded to NCA concerns about some discrepancies with NCA policies and procedures.

Minutes of the April 1972 LCME meeting noted that the LCME had received recognition by the NCA for a five-year term; it is unclear, however, when the LCME began the process of undergoing NCA recognition. At that same meeting, LCME members were informed of the pending merger of the NCA with the Federation of Regional Accrediting Commissions of Higher Education, a group formed by the accrediting arms of each regional accrediting agency in 1964.[276] That merger occurred officially in 1975, with the new organization operating as the Council on Postsecondary Accreditation (COPA). In contrast to the understandable resentment exhibited by the LCME toward the NCA in the NCA's early years, COPA was readily embraced. The LCME had an opportunity to review and comment on draft COPA bylaws in 1974, agreed to join the organization in January 1976, and was recognized by COPA shortly after. The relationship with COPA was in general quite positive, although there were occasional issues. The minutes from the June 1981 meeting indicated some frustration on the LCME's part with the value COPA was providing relative to the dues it required for membership. In 1989 the LCME had to change its appeal procedure for adverse actions, adding a mechanism for external review of such decisions, to maintain its recognition from COPA.

In contrast to the understandable resentment exhibited by the LCME toward the NCA in the NCA's early years, COPA was readily embraced.

Unfortunately, COPA underwent serious internal problems in the early 1990s, and in 1993 the regional accreditors withdrew from membership in the organization, effectively bringing about COPA's demise. COPA was rapidly succeeded by another private umbrella organization, the Commission on Recognition of Postsecondary Accreditation (CORPA). The LCME became a dues-paying member of CORPA in February 1994. CORPA was unable to sustain itself, however, and by 1996 had given way to yet another umbrella organization developed by university presidents, the Council for Higher Education Accreditation (CHEA). The LCME was wary of this latest organization, due in no small part to the perception that university presidents were using it to dampen the influence of specialized accreditors. The LCME opted not to become a member or undergo the CHEA recognition process; it decided that the federal recognition process was sufficient to maintain its credibility as an accountable accrediting agency.

At the same time that COPA disbanded, another organization arose to address the needs of the specialized accreditation community. The Association of Specialized and Professional Accreditors (ASPA) began operation in the summer of 1993, with the goal of providing services and advocacy for specialized accreditation organizations. When the LCME joined CORPA in 1994, it also paid the

initial dues for membership in ASPA and has maintained that membership ever since. Unlike NCA, COPA, and CHEA, ASPA has never provided a recognition function as one of its services, and thus the LCME has never been asked to undergo a recognition process as a condition of ASPA membership. However, the LCME Secretariat staff has maintained a visible presence in ASPA activities over the years, frequently attending national meetings of the organization.

Conclusion

This ends the history of medical school accreditation in the United States (and Canada). By the time this publication becomes public, another year or two will have passed, and the LCME will continue its long tradition of evaluating medical schools and the educational programs they offer, each time prodding the institutions to become better at what they do. Readers may draw their own conclusions about the lessons to be learned from this history, but some appear to be fairly obvious to the author:

- Whatever its flaws, accreditation is ingrained in the functioning of medical schools, and the LCME's authority flows from its acceptance by those schools and not by recognition from outside organizations.
- Despite the substantial differences over time in their relative size, influence, and cultures, the AMA and the AAMC have been unwavering in their support for the LCME.
- Accreditation standards are labile, reflect the prevailing conditions and philosophy of the times in which they are adopted, and collectively fluctuate in alternating cycles of broad generality and narrow specificity.
- Accreditation procedures and processes have proven much less amenable to major change and present a compelling opportunity to enhance the LCME's reputation and stature going forward, within the broader accreditation community as well as among the medical schools the LCME accredits.
- The workload of the LCME has increased progressively over time, as accreditation processes, procedures, and relationships have grown increasingly varied and complex.

The interpretations listed above are by no means intended to be comprehensive, and readers will undoubtedly be able to add to or modify this list. However the events recorded here are interpreted, it is the author's hope that understanding of the origins and evolution of medical school accreditation will foster a sound commitment to the preservation of what has worked well and a desire to effect meaningful change that will justify the medical education community's continued and enthusiastic support of the LCME.

Appendix A

Key Dates in the History of Medical School Accreditation

1847: Founding of the American Medical Association (AMA)

1876: Creation of the Provisional Association of American Medical Colleges, renamed the following year as the American Medical College Association

1883: Publication of the first issue of the *Journal of the American Medical Association* (*JAMA*)

1890: Establishment of the National Confederation of State Medical Examining and Licensing Boards; Reestablishment of the American Medical College Association as the Association of American Medical Colleges (AAMC)

1904: Formation of the AMA's Council on Medical Education; AAMC begins program of medical school visitations

1906: AMA Council on Medical Education begins inspections of medical schools

1907: Council on Medical Education produces its first classification of medical schools

1910: AMA adopts *Essentials of an Acceptable Medical School*; Flexner Report published

1912: Creation of the Federation of State Medical Boards

1915: Founding of the National Board of Medical Examiners

1932: Council on Medical Education discontinues use of ABC classification system in its list of approved medical schools

1934: AMA Council on Medical Education begins last comprehensive program of medical school inspections

1942: Formation of the LCME

1943: Founding of the Association of Canadian Medical Colleges (ACMC), now known as the Association of Faculties of Medicine of Canada

1949: Establishment of the National Commission on Accrediting

1951: Last major revision of *Essentials of an Acceptable Medical School*; AAMC Executive Council invited to participate in the review

1952: U.S. Office of Education creates a list of recognized accrediting organizations; LCME adopts its own letterhead for official communications

1956: Creation of the Evaluation Service for Foreign Medical Graduates, precursor of the Educational Commission for Foreign Medical Graduates

1957: LCME adopts *Functions and Structure of a Modern Medical School* as its statement of accreditation standards; agrees to alternate responsibility for setting meeting agendas between the two sponsors, setting the stage for a dual secretariat; endorses the use of a jointly sponsored LCME annual questionnaire for collecting data on medical education

1961: LCME debates relative merits of having a full-time paid secretary versus having each sponsor designate a secretary to manage LCME activities

1962: LCME creates its first standing committee, the Committee on Accreditation Procedures; approves *Guide for Medical School Visitation* to help schools prepare for accreditation surveys

1964: ACMC Executive Secretary authorized to observe LCME meetings

1965: First two-day meeting of the LCME

1966: LCME sponsors begin using the title of "LCME secretary" as designation for their respective chief professional staff supporting LCME activities

1969: LCME discontinues use of confidential probation as an accreditation action; establishes system for annual rotation of LCME chairs and secretaries between sponsoring organizations

1970: Federal member and public member appointed to LCME

1971: Women's Equity Action League challenges LCME recognition from U.S. Office of Education

1972: Founding of the World Federation for Medical Education; creation of the Liaison Committee for Graduate Medical Education, precursor of the Accreditation Council for Graduate Medical Education; progress reports begin to appear as a regular item on the agenda of LCME meetings

1973: Final sponsor approval for major revision of *Functions and Structure of a Modern Medical School,* retitled as *Functions and Structure of a Medical School*

1975: National Commission on Accrediting merges with Federation of Regional Accrediting Commissions of Higher Education, creating the Council on Postsecondary Accreditation

1976: LCME adopts *Guidelines to Functions and Structure of a Medical School* to expound on its accreditation requirements and expectations; Federal Trade Commission challenges LCME recognition from U.S. Office of Education

1977: LCME publishes first *Guide for Writing a Survey Report*; appointment of medical students as members of the LCME

1979: Establishment of the Committee on Accreditation of Canadian Medical Schools (CACMS); LCME adopts *Rules of Procedure* as its formal policy document

1980: LCME approves *Role of Students on LCME Accreditation Surveys* to help medical students prepare for an LCME accreditation survey

1985: Third major revision of *Functions and Structure of a Medical School*

1986: Carol Aschenbrener appointed as first female professional member of LCME

1987: LCME adopts fixed seven-year term for accreditation of medical schools

1990: Adoption of the United States Medical Licensure Examination as the single pathway for licensure of U.S. physicians

1991: Appointment of federal member discontinued

1992: LCME celebrates 50th anniversary

1995: U.S. Department of Education establishes National Committee on Foreign Medical Education and Accreditation, for purpose of determining comparability of accreditation standards in foreign countries with LCME standards (comparability required for U.S. citizens to receive federal financial aid to attend foreign medical schools)

2002: *Functions and Structure of a Medical School* undergoes major reorganization and employs a list format for standards along with a prose version; medical education database and survey report guide are redesigned to align with individual standards

2008: LCME adopts "warning" accreditation action for medical education programs at risk of being placed on probation

2010: LCME begins to appoint field secretaries to supplement its full-time professional staff

2012: LCME sponsors approve LCME Advisory Council to oversee activities of LCME

2013: LCME and CACMS agree to a memorandum of understanding articulating roles and responsibilities of the two organizations in regard to Canadian medical education accreditation

2014: *Functions and Structure of a Medical School* undergoes second major reorganization, resulting in identification of 12 standards encompassing 95 elements

Appendix B

LCME Members 1942–2020

Note: Dates of service have been taken from LCME minutes whenever possible; dates recorded in LCME minutes vary at times from years of service reported in proceedings of annual meetings of the AMA and the AAMC.

Professional Members of the LCME

Council on Medical Education Appointees		**AAMC Executive Council Appointees**	
Name	Years	Name	Years
Fitz, Reginald	1942–1943	Bachmeyer, Arthur C.	1942–1951
Heyd, Charles Gordon	1942–1947	MacEwen, Ewen M.	1942–1946
Weiskotten, Herman G.	1942–1957	Zapffe, Fred C.	1942–1947
Johnson, Victor	1943–1958	Hinsey, Joseph C.	1947–1955
Anderson, Donald G.	1947–1953	Smiley, Dean F.*	1948–1957
Deitrick, John E.	1948–1949	Berry, George Packer	1950–1952
Manlove, Francis R.	1950–1953	Dorst, Stanley	1951–1955
Stone, Harvey B.	1950–1951	Darley, Ward	1952–1964
Murphy, Franklin	1952–1953	Moore, Robert	1953–1957
Turner, Edward L.	1953–1959	Lippard, Vernon	1953–1956
Faulkner, James M.	1954–1960	Diehl, Harold	1955–1956
Wiggins, Walter S.	1954–1966	Youmans, John	1956–1958
Shepherd, Glen R.	1956–1960	Coggeshall, Lowell T.	1956–1959
McKittrick, Leland S.	1957–1963	Scott, Gordon H.	1957
Wescoe, Clarke	1957–1967	Mitchell, John McK.	1958–1960
Stone, Charles	1958–1959	Young, Richard	1958–1966
Bowers, John Z.	1960–1962	Hunter, Thomas	1959–1961
Nunemaker, John C.	1960	Sheehan, John	1959
Caughey, John	1960	Aagard, George	1960–1962
Hussey, Hugh	1960, 1963	Marsh, Homer	1960
Youmans, John	1960–1962	Anderson, Donald G.	1961–1963
Allan, Warde B.	1961–1964	Deitrick, John E.	1962–1964
Caldwell, Guy A.	1961	Wolf, George A.	1963–1966
English, Harlan	1962–1965	Wilson, Vernon E.	1963–1965
Willard, William R.	1962–1970	Cross, Richard	1964–1965
Manegold, Richard F.	1963–1965	Howard, Robert H.	1966–1970

continued

Council on Medical Education Appointees		AAMC Executive Council Appointees	
Name	Years	Name	Years
Sodeman, William	1965,1968–1973	Parks, John	1967–1968
Sawyer, Kenneth C.	1965–1970	Glaser, Robert J.	1968–1969
Breese, Melvin W.	1965	Crispell, Kenneth R.	1969–1974
Robinson, E. Bryce	1967–1973	DuVal, Merlin K.**	1969–1971
Cannon, Bland W.	1969–1974	Hamilton, T. Stewart	1969–1975
Wilson, Vernon E.	1968–1970	Kinney, Thomas D.	1969–1976
Land, Francis L.	1970–1973	Tupper, C. John	1970–1976
White, Joseph M.	1970–1976	Suter, Emanuel	1971–1972
Chapman, Earle M.	1971–1972	Knobil, Ernst	1971–1974
Bostick, Warren L.	1972–1978	Cazort, Ralph J.	1972–1976
Culver, Perry J.	1973–1980	Beering, Steven C.	1974–1980
Wildgen, J. Jerome	1973–1974	Estabrook, Ronald W.	1974–1980
Bucher, Robert M.	1974–1975	Kemph, John P.	1975–1981
Corcoran, Patrick J.V.	1974–1980	Andrews, Edward C.	1976–1980
Burgher, Louis W.	1975–1979	Fordham, Christopher C.	1976–1979
Kellow, William F.	1975–1981	Ross, Richard S.	1976–1979
Zarafonetis, Chris J.D.	1976	Gronvall, John A.	1980–1982
Stone, Robert S.	1977–1982	Schwarz, Roy M.	1980–1983
O'Doherty, Desmond	1979–1984	Van Citters, Robert L.	1981–1983
Alexander, Eben	1980–1983	Clemente, Carmine	1981–1986
Connar, Richard G.	1981–1986	Buchanan, J. Robert	1982–1983
Potchen, E. James	1981–1986	Deal, William B.	1982–1987
Thoma, George E.	1982–1987	Reynolds, Richard C.	1983–1987
Chapman, John E.	1983–1988	Dunn, Marvin R.	1984
Jenkins, M.T.	1985–1990	Mann, Marion	1984–1985
Albers, John E.	1986–1991	Luginbuhl, William H.	1985–1990
Jacott, William E.	1987–1990	Aschenbrener, Carol A.***	1986–1991
Reals, William J.	1987–1992	Cohen, David H.	1987–1990
Riddick, Frank A.	1988–1992	O'Brien, Richard L.	1988–1993
Weston, W. Donald	1989–1994	Greer, David S.	1988–1993
Dockery, J. Lee	1990–1992	Berns, Kenneth L.	1989–1992
Stephenson, Hugh E.	1991–1996	Foreman, Spencer	1989–1992
Nixon, Sam A.	1992–1994	Daly, Walter	1990–1995
Sherman, Charles D.	1992–1993	Gonnella, Joseph S.	1992–1997
Golden, William E.	1992–1997	Moy, Richard H.	1992–1997
Moyers, Richard H.	1993–1998	Cassell, Gail H.	1993–1997
Lukemeyer, George T.	1994–1997	Neaves, William B.	1994–1999
Daugherty, Robert M.	1995–2000	Wallace, Andrew G.	1994–1996
Gary, Nancy E.	1995	Nutter, Donald O.	1996–2002

continued

Council on Medical Education Appointees		AAMC Executive Council Appointees	
Name	Years	Name	Years
Nelson, Nancy E.	1995–2002	Keimowitz, Robert I.	1996–1999
Patchin, Rebecca	1996–2003	Wilson, Emery A.	1997–2004
Simon, Frank A.****	1997–1999	Hallock, James A.	1997–2000
Thompson, James N.	1997–2002	Kline, Susan A.	1997–2004
Rohack, J. James	1999–2001	Hutton, John J.	2000–2003
Talley, Robert C.	1999–2006	Korf, Bruce R.	2000–2006
Franks, Ronald D.	2000–2007	Hundert, Edward M.	2000–2002
Wilson, H. David	2001–2004	Ballard, Bruce L.	2002–2007
Enarson, Cam	2002–2008	Kirch, Darrell G.	2002–2006
Sirio, Carl A.	2002–2008	Gabbe, Steven G.	2003–2009
Reichgott, Michael J.	2003–2009	Lawley, Thomas J.	2004–2010
Allen, Richard	2004–2009	Lichter, Allen S.	2004–2007
Nasca, Thomas J.	2006–2007	Koeppen, Bruce M.	2006–2012
Nora, Lois M.	2007–2012	Parisi, Valerie M.	2006–2012
Swee, David E.	2008–2014	Colenda, Christopher C.	2007–2013
Drees, Betty M.	2008–2011	Dent, Georgette A.	2007–2013
Gold, Jeffrey P.	2008–2014	Rappley, Marsha D.	2009–2015
Andrews, Mitchell DeWayne	2009–2012	Woolliscroft, James O.	2010–2013
Ross, Arthur J.	2009–2015	Wilkerson, LuAnn	2011–2017
Roth, Paul B.	2011–2017	Flotte, Terence R.	2012–2015
Fogarty, John P.	2011–2017	Hadley, Roger M.	2012–2018
Butler, Patricia	2012–2015	Lindemann, Janet C.	2012–2018
Lambert, David R.	2014–2020	Mitchell, Stephen Ray	2013–2019
Schindler, Barbara A.	2014–2020	Mouton, Charles P.	2013–2019
Newton, Warren*****	2015–2018	Woodward, LouAnn	2013–2019
Simons, Ken	2015–2018	Rock, John A.	2015–2018
Ganzel, Toni	2016–2019	Wynne, Joshua	2017–2020
Christner, Jennifer	2017–2020		
Mejicano, George	2017–2020		

*Voting member, 1948–1949; ex officio subsequently
**Served as a federal participant in 1972
***Became LCME secretary in 2004
****Became LCME secretary in 2000
*****Originally a student participant on the LCME (1983–1984)

Public Members of the LCME

Name	Years
Stark, Nathan	1973–1974
Innskeep, Harriett	1973–1978
Ortega, Arturo	1975–1980
Innis, Pauline	1979–1983
O'Connor, Sandra Day	1981–1982
Waltz, Jon R.	1982–1983
McCree, Wade H.	1984–1985
Babbitt, Harriet	1985–1990
Throdahl, Monte	1986–1991
Ryan, John W.	1989–1994
Miller, Elaine King	1994–1997
Washington, Walter	1994–1995
Blumenstein, Sarah W.	1996–2002
Western, Harvey J.	1997–2000
Cowen, Robert E.	2001–2004
Davis, Dick C. E.	2003–2006
Spaulding, Susan	2005–2011
Winograd, Peter	2007–2013
Golodner, Linda F.	2011–2017
Fink, Joseph L.	2013–2019
DeVaney, Sharon	2017–2020

ACMC/CACMS Members of the LCME*

Name	Years
Firstbrook, John	1973–1975
Holmes, Brian	1975–1977
McLeod, L.E.	1977–1981
Vandewater, S.L.	1982–1988
MacDiarmid, William D.	1989–1991
Hurteau, Gilles	1991–1992
Wilson, Douglas R.	1992–1996
Popkin, David R.	1996–2001
Woollard, Robert F.	2001–2008
Fuks, Abraham	2008–2014
Miller, D. Douglas	2014–2015
Casiro, Oscar	2015–2019

*The ACMC representative began as an observer in 1973 and was given voting privileges for Canadian, but not U.S., medical schools in 1977; by 1980, the LCME extended full voting privileges for the Canadian representative (now from CACMS, not the ACMC)

Student Members of the LCME

Council on Medical Education Appointees		AAMC Executive Council Appointees	
Name	Years	Name	Years
Isonaka-Kurzner, Sharon	1979–1980	Kaplan, Lee Michael	1979–1980
Lynn-Brown, Serena	1980–1982	Gates, Geoffrey	1980–1981
Kramer, Karolyn	1982–1984	Brinton, Daniel	1981–1982
Willner, Catherine L.	1984–1986	Furcolow, John	1982–1983
Simkin, Deborah	1986–1987	Newton, Warren*	1983–1984
Apte, Dipali	1987–1989	Hasley, Peggy B.	1984–1985
Gross, Rick D.	1989–1990	McCarthy, John F.	1985–1986
Lane, David A.	1990–1991	Cook, Ian	1986–1987
Belton, Janet	1991–1992	Donnell, David	1987–1988
Anderson, Donald J.	1992–1993	Ptak, Thomas	1988–1989
Grady, Brian P.	1993–1994	Schwartzberg, Ross E.	1989–1990
Shipman, Scott A.	1994–1995	Erickson, Sonya S.	1990–1991
Vogel, Sarah	1995–1996	Morris, Jonathan A.	1991–1992
Basile, Laura	1996–1997	Mangrum, J. Michael	1992–1993
Katz, Gary	1997–1998	Dykes, Daryll C.	1993–1994
Acierno, Stephanie	1998–1999	Ulanski II, Lawrence J.	1994–1995
Schneider, Jason	1999–2000	Dillon, Kristen	1995–1996
Miller, Aaron M.	2000–2001	Teal, Laura J.	1996–1997
de la Garza, Adam	2001–2002	Chin, Peter	1997–1998
Kile, Christina M.	2002–2003	Wise, Laura	1998–1999
McCarthy, Jenifer	2003–2004	Walker, Shaka	1999–2000
Gibson, Margaret	2004–2005	Awad, Michael M.	2000–2001
Zimmerman, Hannah	2005–2006	Brett-Major, David	2001–2002
Brislen, Heather	2006–2007	Lin, Erin McKean	2002–2003
Zammit, Christopher	2007–2008	Park, Sylvia	2003–2004
Greenzang, Cathleen	2008–2009	Wiatrek, Rebecca L.	2004–2005
Tackett, Sean	2009–2010	Sanchez, George A.	2005–2006
Cleary, MaryEllen	2010–2011	Berns, Stephen	2006–2007
Shaller, Melinda	2011–2012	Kaufman, Margit	2007–2008
Heinen, Shady	2012–2013	Simpson, Khara	2008–2009
McShane, Michael	2013–2014	Sivakumar, Walavan	2009–2010
DeVolder, Jake	2014–2015	Abram, Elizabeth	2010–2011
Quinton, Jacob	2015–2016	Whitgob, Emily	2011–2012
Nelson, Matthew	2016–2017	Ostapenko, Laura	2012–2013

continued

Council on Medical Education Appointees		AAMC Executive Council Appointees	
Name	Years	Name	Years
Singh, Raj	2017–2018	Petri, Camille	2013–2014
		Schnedl, Bradley	2014–2015
		Fornari, Marci	2015–2016
		Maurer, Katie	2016–2017
		Piccoli, Cara	2017–2018

*Appointed as regular LCME member by AMA in 2015–2016

Federal Participants of the LCME

Name	Years
Zapp, John S.	1970–1972
Duval, Merlin K.	1972
Stone, Robert S.	1973–1976
Mather, John H.	1976–1977
Knouss, Robert F.	1978–1979
Moritsugu, Kenneth	1980–1983
Masica, Daniel	1984–1986
Robinson, William	1986
Weaver, Donald	1987–1990
Gaston, Marilyn	1990

Appendix C

Biographical Sketches of LCME Secretaries

From 1942 through the mid-1960s, there was no formal role or title for staff from the LCME's sponsoring organizations who provided secretarial functions for the organization. Those functions were typically provided by the chairs and/or secretaries of each sponsoring council. The title of "LCME secretary" first came into public discourse in 1966, and the sketches below are for the individuals who served in that capacity from 1966 onward.

LCME Secretaries Appointed by the American Medical Association

Ruhe, C.H. William, 1967–1968. William Ruhe obtained his medical degree from the University of Pittsburgh School of Medicine in 1940. He joined the school's faculty after completing his internship at West Penn Hospital, achieving the rank of associate professor of physiology and pharmacology. In 1960 he joined the American Medical Association (AMA) as the assistant secretary to the Council on Medical Education, and he provided staff support to the LCME beginning in 1964. Although he only served for one year as the LCME secretary from the council, he continued to provide staff support to the organization, attending LCME meetings through June 1976. At that time he was appointed as the AMA group vice president for medical education and later as the senior vice president for medical education and scientific affairs. He retired from the organization in 1982. Apart from his LCME service, Dr. Ruhe was also prominent in the development of a system for the accreditation of continuing medical education and the establishment of family practice as a medical specialty. He passed away on April 30, 2007.

Nicholson, Hayden C., 1968–1970. Hayden Coler Nicholson was a graduate of the University of Michigan and served on the faculty at that institution from 1931 through 1946. He held a term as the executive secretary of the National Research Council before accepting the deanship at the University of Arkansas School of Medicine in 1950. In 1954 he was appointed as the first provost of medical affairs and continued in the dual role of provost and dean until 1955. While at Arkansas, Dr. Nicholson worked closely with the university president to secure funding for the medical center complex in Little Rock. After leaving the university, he became the executive director of the Hospital Council of Greater New York. In 1962 he was appointed as the dean of the University of Miami School of Medicine, and in 1967 he was awarded the additional title of vice president for medical affairs. In 1968 he took the position of director for the Department of Medical Education at the AMA. Dr. Nicholson passed away in December 1995.

Leymaster, Glen R., 1970–1972. Glen Leymaster received his medical degree from the Harvard Medical School in 1942. He began his academic career at Johns Hopkins in 1944 after finishing his residency at Boston City Hospital and remained on the faculty there until 1948. He then joined the faculty at the University of Utah School of Medicine, eventually becoming the chair of the Department of Preventive Medicine. He was appointed as the associate secretary to the Council on Medical Education in 1960 and continued in that role through 1963. From 1964 to 1970 he served as president and dean of the

Women's Medical College of Pennsylvania and rejoined the AMA as the director of undergraduate education from 1970 through 1975. He attended his final LCME meeting in June of 1975. He passed away on July 2, 1997.

Peterson, Edward S., 1972–1987. Like his predecessor Glen Leymaster, Edward Schmidt Peterson was a Harvard-educated physician, receiving his medical degree in 1945. After brief stints in military service and in private practice, he began his academic career at the Northwestern University Medical School in 1954 as its director of clinics, ultimately rising to the position of associate dean there. He joined the AMA in 1972, first as assistant director and later as director of undergraduate medical education. He retired in 1988 and has the distinction of being the longest-tenured AMA secretary to the LCME. Dr. Peterson had a deep interest in medical history and the history of the American West, publishing over 30 articles on those topics during his career. He passed away on June 3, 2013.

Jonas, Harry S., 1987–2000. Harry Jonas received his MD degree from the Washington University School of Medicine in 1952, specializing in obstetrics and gynecology. Before joining the AMA as assistant vice president for medical education, he had served for nine years as the dean of the University of Missouri–Kansas City School of Medicine. During his term as LCME co-secretary he also served as the secretary to the Council on Medical Education. Dr. Jonas has been an outspoken, nationally recognized leader in his medical specialty during the course of his career. He is a past president of the American College of Obstetricians and Gynecologists and served five terms on the regional screening panel for the President's Commission on White House Fellowships. He has also served on the boards of Physicians for Reproductive Choice and Health and the Health Care Foundation of Greater Kansas City. After concluding his service with the LCME, Dr. Jonas was one of three founding members of a medical education and accreditation consulting group, DJW Associates.

Simon, Frank A., 2000–2006. Frank Simon obtained his MD degree from the New York University School of Medicine. After completing residency training in pediatrics at the Johns Hopkins Hospital, he joined the faculty at the University of Texas (UT) Medical School at Houston in 1973. At UT Houston he served variously as the clerkship director for pediatrics, program director for the residency program in pediatrics, and ultimately as the associate dean for educational programs. In 1989 he accepted a position as vice dean at the University of Medicine and Dentistry of New Jersey–Robert Wood Johnson Medical School. He joined the AMA as the director of graduate medical education in 1999 and later assumed the role of director of the Division of Undergraduate Medical Education Policy and Standards. During his tenure with the LCME, Dr. Simon was deeply involved in working with the World Federation for Medical Education in the development of criteria and processes for the international recognition of accrediting agencies. After his departure from the AMA, Dr. Simon took on a consulting role with the Educational Commission on Foreign Medical Graduates and later joined the George Washington University School of Medicine and Health Sciences as senior advisor to the vice president for health affairs. He maintains a position as an associate of the Medical School Advisory Group LLC, a medical education and accreditation consulting organization. Dr. Simon is also a member of the board of trustees for the American University of the Caribbean School of Medicine.

Barzansky, Barbara, 2007–Present. Barbara Barzansky has the dual distinctions of being the first non-MD to serve as an LCME secretary and the longest-serving member of the LCME professional staff. She received her doctorate in cell biology and anatomy from the University of California, Irvine, and conducted postdoctoral studies at the University of Wisconsin before joining the faculty at the Medical University of South Carolina. She then obtained a master's degree in Health Professions Education at the University of Illinois–Chicago, becoming a faculty member at that institution in what is now the Department of Medical Education. She attended her first LCME meeting as an AMA staff member in 1988 and has served continuously since then, culminating in her appointment as LCME co-secretary in 2007. In her staff role at the AMA, she has been responsible for the publication of "Medical Schools in the United States," a summary of the state of undergraduate medical education included in the annual medical education issue of the *Journal of the American Medical Association.* She has also served as principal staff to the AMA Council on Medical Education. Her résumé includes well over 75 publications and book chapters on topics of medical education.

LCME Secretaries Appointed by the Association of American Medical Colleges

Smythe, Cheves McC., 1966–1969. Cheves McCord Smythe was a 1947 graduate of the Harvard Medical School. His academic medicine career began when he joined the faculty at the Medical University of South Carolina in 1955; he was appointed as the dean there in 1963 and served in that role for three years. He accepted a position at the Association of American Medical Colleges (AAMC) in 1966 as an associate director in the Office of the Executive Director. In 1969 he was appointed as the first director of the Department of Academic Affairs at the AAMC. He left the AAMC in 1970 to accept the deanship at the newly created University of Texas Medical School at Houston, continuing as dean there until 1975. From 1982 through 1985 he served as the dean of the Aga Khan University of Health Sciences in Karachi, Pakistan. He returned to the University of Texas Medical School at Houston and was called on to serve as interim dean there from 1995 to 1996. He remains at that institution today, as dean emeritus with a faculty appointment in general internal medicine.

Wilson, Marjorie P., 1970–1973. Marjorie Price Wilson obtained her medical degree from the University of Pittsburgh School of Medicine in 1949 and completed residency training in pediatrics at the Children's Hospital of the University of Pittsburgh. She later completed a residency in clinical pathology and accepted a position at the Veterans Administration (VA) in medical education administration. She left the VA to accept a position as assistant director for program planning and evaluation at the National Institutes of Health and subsequently transferred to the role of associate director for the National Library of Medicine. She joined the AAMC in 1970 as the director for the Division of Program Liaison and Evaluation (subsequently renamed as the Department of Institutional Development). Dr. Wilson continued in that role through 1980. Apart from her role at the LCME, she provided the primary staff support for the AAMC Council of Deans and was instrumental in the creation of the Management Advancement Program to foster professional development for leaders of academic medicine. She was the lead author for the AAMC publication *Management and Leadership in Academic Medicine.* After her

departure from the AAMC, she moved on to the position of senior associate dean at the University of Maryland School of Medicine, where she was appointed vice dean in 1986. From 1988 through 1995 she served as the president of the Educational Commission for Foreign Medical Graduates. Dr. Wilson passed away in 1997.

Schofield, James R., 1973–1987. James Roy Schofield was awarded the MD degree from Baylor University College of Medicine in 1947. He remained at his alma mater after graduation as a member of the faculty in the Department of Anatomy. While at Baylor, he progressed to positions of greater responsibility, culminating in his appointment as dean of academic affairs from 1964 through 1970. In 1970 he joined the AAMC as the deputy director of the Department of Institutional Development in October 1971. In 1972 he assumed the title of director for the newly named Division of Accreditation within the Department of Institutional Development, and he held that position until his retirement in 1987. During his tenure at the AAMC, Dr. Schofield documented the proliferation and expansion of medical schools that occurred from the 1950s through the early 1980s in his book *New and Expanded Medical Schools, Mid-Century to the 1980s: An Analysis of Changes and Recommendations for Improving the Education of Physicians*. He passed away on May 20, 2007.

Kassebaum, Donald G., 1988–1999. Donald G. Kassebaum learned his craft of internal medicine and cardiology at the University of Oregon School of Medicine. After completing his residency training there, he took a position as senior research fellow in the cardiology division at the University of Utah School of Medicine. He returned to Oregon as a faculty member in 1962, and after the reorganization of the system as the Oregon Health Sciences University, he was appointed as the vice president and director for hospitals and clinics. He moved on to accept the position of executive dean of the University of Oklahoma College of Medicine in 1986. He joined the AAMC as the associate vice president in the Division of Institutional Planning and Development in the summer of 1988, at which time he began his tenure as LCME co-secretary. He was appointed as the vice president of the newly created Division of Educational Research and Assessment in 1991, continuing as an AAMC vice president and LCME co-secretary until his retirement in 1999. During his career, Dr. Kassebaum published 55 articles on cardiac physiology, medical education, and accreditation. He passed away on October 19, 2012.

Stevens, David P., 1999–2003. David P. Stevens received his MD degree from the Western Reserve University School of Medicine in 1966. He began his career in academic medicine at that institution after completing his residency training in gastroenterology at University Hospitals in Cleveland, and he eventually rose to the position of vice dean for academic affairs. In 1995 he shifted his career focus to health policy, becoming a Robert Wood Johnson Health Policy fellow at the Institute of Medicine. In that capacity, he served as health policy advisor to U.S. Senator Nancy Landon Kassebaum. In 1996 he became the chief of the Office of Academic Affiliations at the U.S. Department of Veterans Affairs, where he worked closely with Under Secretary Kenneth Kizer before joining the LCME in 1999. After leaving the LCME, he spent a year as the George W. Merck Senior Fellow at the Institute for Healthcare Improvement. From 2003 to 2007 he was vice president for health care improvement and the founding director of the AAMC's Institute for Improving Clinical Care. He was editor in chief for *Quality and Safety in Health Care*, served as a member of the advisory board for the *British Medical Journal*, and

chaired the National Advisory Committee of the Robert Wood Johnson Clinical Scholars Program. He is currently the editor emeritus of *Quality and Safety in Health Care,* a senior fellow at the Institute for Healthcare Improvement, and an adjunct professor in the Institute for Leadership and Improvement at the Dartmouth Institute for Health Policy and Clinical Practice. His résumé includes nearly 100 articles and book chapters on health care quality, health policy, and medical education.

Aschenbrener, Carol A., 2004–2007. Carol Aschenbrener received the MD degree from the University of North Carolina at Chapel Hill School of Medicine. After completing her residency in pathology at the University of Iowa, she stayed on at that institution for more than 20 years, eventually rising to the position of senior executive dean in the College of Medicine. She then moved on to accept the position of chancellor for the University of Nebraska Medical Center, serving in that role for four years. Before joining the AAMC in 2004 as vice president for the Division of Medical School Standards and Assessment, she achieved prominence in various academic medicine roles, including membership on the AMA Council on Medical Education, the LCME, the Accreditation Council for Graduate Medical Education, and the Accreditation Council for Continuing Medical Education. Dr. Aschenbrener also served on the Institute of Medicine's Task Force on Research in Women's Health and on the National Institutes of Health (NIH) Advisory Committee on Research in Women's Health. She also served as a chair of the National Board of Medical Examiners. She was a major contributor to the development of the Executive Leadership in Academic Medicine (ELAM) program and has maintained an active role as a career consultant for ELAM fellows. When the AAMC underwent a reorganization in 2007–2008, Dr. Aschenbrener was appointed as its executive vice president and chief strategy officer. In November of 2011 she was designated as the chief medical education officer at the AAMC and continued in that role until January 2015, when she returned to individual practice as an executive coach and consultant.

Hunt, D. Daniel, 2007–2016. Dan Hunt earned his MD degree from Cornell University Medical College in 1973. During his postgraduate training period in psychiatry at the Hospital of the University of Pennsylvania, he also earned an MBA from the Wharton School of Business. Before joining the LCME, he was probably best known for the 17 years he spent as the associate dean for academic affairs at the University of Washington School of Medicine. In that role, he oversaw the WWAMI program that provides medical education in five Western states (Washington, Wyoming, Alaska, Montana, and Idaho) and established his reputation as a strong advocate for diversity as the founding principal investigator for the Native American Center of Excellence and the Robert Wood Johnson Minority Medical Education Program. That commitment to the medically underserved surfaced again in 2004, when he accepted the position of founding vice dean for academic activities at the Northern Ontario Medical School. Dr. Hunt has served as past president of the International Health Medical Education consortium and has published over 50 peer-reviewed articles about medical education, international health, psychiatry, and accreditation. He was honored with the Distinguished Service Award from the AAMC Group on Regional Medical Campuses in 2015. He continues to serve the LCME on a part-time basis as an assistant LCME secretary.

Catanese, Veronica, 2016–Present. The newest LCME co-secretary, Veronica Catanese, received her MD degree from the New York University (NYU) School of Medicine. After completing residency training in internal medicine and a clinical fellowship in endocrinology, diabetes, and metabolism at the NYU Medical Center, she obtained a research fellowship at the Joslin Diabetes Center of Harvard Medical School. She then returned to NYU as a faculty member, eventually becoming its senior associate dean for education and student affairs, as well as the firm chief and director of resident research in the Department of Medicine. Dr. Catanese moved on to accept the positions of vice dean, dean for academic affairs, and principal business officer for the new Hofstra Northwell School of Medicine. There she led the school's successful initiative to obtain full LCME accreditation, while providing leadership in strategic planning, educational program development, and alignment with clinical partners. Dr. Catanese has a highly visible national profile in academic medicine, having served as president and foundation president of the American Federation for Medical Research and as editor in chief for the *Journal of Investigative Medicine*. She has also served as a member of the Institute of Medicine's Clinical Research Roundtable and as cochair of the training committee for the NIH Director's Clinical Research Roadmap working group.

Appendix D

Historical Origins of Selected LCME Standards and Elements

Many current accreditation standards and elements have undergone multiple revisions of both content and language. This appendix identifies the earliest known references to the content of some present LCME standards, citing the language of the current element and the exact language of the original standard, as written in either *Essentials of an Acceptable Medical College* or *Functions and Structure of a Medical School.* The reader should refer to Chapters 6–10 for a more detailed discussion of the origin and evolution of medical school accreditation standards.

Standard 1: Mission, Planning, Organization, and Integrity

Element 1.3 Mechanisms for Faculty Participation: A medical school ensures that there are effective mechanisms in place for direct faculty participation in decision-making related to the medical education program, including opportunities for faculty participation in discussions about, and the establishment of, policies and procedures for the program, as appropriate.

***Functions and Structure of a Modern Medical School,* 1957:** The faculty should be organized into suitable departments representing the major basic science and clinical fields. Each such department should have a voice, through appropriate committees of the faculty, in the administration of the academic affairs of the school. The entire faculty should meet one or more times annually to provide an opportunity for all faculty members to become acquainted with and to discuss medical school policies and practices.

Element 1.5 Bylaws: A medical school promulgates bylaws or similar policy documents that describe the responsibilities and privileges of its administrative officers, faculty, medical students, and committees.

***Functions and Structure of a Modern Medical School,* 1957:** The manner in which the medical school is expected to conduct its affairs, including the responsibilities and privileges of administrative officers, faculty, and students, should be clearly indicated in bylaws approved for the medical school itself or adequately presented in the bylaws of the parent university.

Standard 2: Leadership and Administration

Element 2.1 Administrative Officer and Faculty Appointments: The senior administrative staff and faculty of a medical school are appointed by, or on the authority of, the governing board of the institution.

***Functions and Structure of a Modern Medical School,* 1957:** Officers and faculty of the school should be appointed by the board of trustees.

Element 2.2 Dean's Qualifications: The dean of a medical school is qualified by education, training, and experience to provide leadership in medical education, scholarly activity, patient care, and other missions of the medical school.

***Essentials of an Acceptable Medical College,* 1910, number 7:** [An acceptable medical college has] Careful and intelligent supervision of the entire school by a dean or other executive officer who holds, and has sufficient authority to carry out, fair ideals of medical education as interpreted by modern demands.

Element 2.4 Sufficiency of Administrative Staff: A medical school has in place a sufficient number of associate or assistant deans, leaders of organizational units, and senior administrative staff who are able to commit the time necessary to accomplish the missions of the medical school.

***Functions and Structure of a Modern Medical School,* 1957:** Because of the diverse and heavy responsibilities placed upon the dean or executive officer, assistance by suitably qualified persons should be provided. In many medical schools, for example, there is an assistant dean who devotes major attention to student affairs and another assistant for administering the postgraduate program. In the conduct of the fiscal affairs of the school, the dean should have the assistance of a capable business officer.

Standard 3: Academic and Learning Environments

Element 3.3 Diversity/Pipeline Programs and Partnerships: A medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.

***Functions and Structure of a Modern Medical School,* 1957:** The complexity of modern medicine can be best served by physicians who in composite represent a variety of backgrounds in education and experience.

Standard 4: Faculty Preparation, Productivity, Participation, and Policies

Element 4.1 Sufficiency of Faculty: A medical school has in place a sufficient cohort of faculty members with the qualifications and time required to deliver the medical curriculum and to meet the other needs and fulfill the other missions of the institution.

***Essentials of an Acceptable Medical College,* 1910, number 12:** [An acceptable medical college has] At least six expert, thoroughly trained instructions in the laboratory branches, salaried so they may devote their time to instruction and to that research without which they cannot well keep up with rapid progress being made in their subjects. These instructors should rank sufficiently high to have some voice in the conduct of the college. There should also be a sufficient number of assistants in each department to look after the less important details.

-Also-

***Essentials of an Acceptable Medical College,* 1910, number 14:** The members of the faculty, with a few allowable exceptions, should be graduates of institutions recognized as medical colleges and should have had a training in all departments of medicine. They should be appointed because of their ability as teachers and not because they happen to be on the attending staff of some hospital or for other like reasons.

Element 4.3 Faculty Appointment Policies: A medical school has clear policies and procedures in place for faculty appointment, promotion, granting of tenure, remediation, and dismissal that involve the faculty, the appropriate department heads, and the dean, and provides each faculty member with written information about his or her term of appointment, responsibilities, lines of communication, privileges and benefits, performance evaluation and remediation, terms of dismissal, and, if relevant, the policy on practice earnings.

***Essentials of an Acceptable Medical School,* 1933:** Nominations for faculty positions should originate in the faculty, usually being made by the dean in consultation with the department heads or a committee of the faculty. Reasonable security of tenure must be assured in order that the personnel of the faculty may have adequate stability.

Standard 5: Educational Resources and Infrastructure

Element 5.1 Adequacy of Financial Resources: The present and anticipated financial resources of a medical school are derived from diverse sources and are adequate to sustain a sound program of medical education and to accomplish other programmatic and institutional goals.

***Essentials of an Acceptable Medical College,* 1927:** Statistics show that modern medicine cannot be acceptably taught at a medical school depending solely on income from students' fees. No medical school should expect to secure admission to, or be retained in class C, therefore, which does not have a generous income from [the] state and in private endowment in addition to students' fees.

Element 5.3 Pressures for Self-Financing: A medical school admits only as many qualified applicants as its total resources can accommodate and does not permit financial or other influences to compromise the school's educational mission.

***Essentials of an Acceptable Medical School,* 1938:** The number of students to whom an adequate medical education can be given by a college is related approximately to the laboratory and hospital facilities available and to the size and qualifications of the teaching staff.

Element 5.4 Sufficiency of Buildings and Equipment: A medical school has, or is assured the use of, buildings and equipment sufficient to achieve its educational, clinical, and research missions.

***Essentials of an Acceptable Medical School,* 1933:** The school should own, or enjoy the use of, modern fireproof buildings sufficient in size to provide lecture rooms, class laboratories, small laboratories for

the members of the teaching staff and advanced students, administrative offices, and a medical library. Equipment should be adequate, both for student use and for research.

Element 5.5 Resources for Clinical Instruction: A medical school has, or is assured the use of, appropriate resources for the clinical instruction of its medical students in ambulatory and inpatient settings and has adequate numbers and types of patients (e.g., acuity, case mix, age, gender).

***Essentials of an Acceptable Medical College,* 1910, number15:** The college should own or entirely control a hospital in order that students may come into close contact with patients under the supervision of the attending staff. The hospital should have a sufficiently large number of patients to permit the student to see and study the common varieties of surgical and medical cases as well as a fair number in each of the so-called specialties.

-Also-

***Essentials of an Acceptable Medical College,* 1910, number 16:** The college should have easily accessible hospital facilities of not less than 200 patients which can be utilized for clinical teaching (for senior classes of 100 students or less), these patients to represent in fair proportion all departments of medicine.

-Also-

***Essentials of an Acceptable Medical College,* 1910, number 17:** The college should have additional hospital facilities for children's diseases, contagious diseases, and nervous and mental diseases.

-Also-

***Essentials of an Acceptable Medical College,* 1910, number 20:** [An acceptable medical college has] A dispensary, or out-patient department, under the control of the college, the attendance to be a daily average of 60 cases (for senior classes of 100 students or less), the patients to be carefully classified, good histories and records of the patients to be kept and the material to be well-used.

Element 5.11 Study/Lounge/Storage Space/Call Rooms: A medical school ensures that its medical students have, at each campus and affiliated clinical site, adequate study space, lounge areas, personal lockers or other secure storage facilities, and secure call rooms if students are required to participate in late night or overnight clinical learning experiences.

***Functions and Structure of a Medical School,* 1985:** A school should provide students with amenities that increase efficiency, such as study space, lounge areas, and food service, if not available in the immediate vicinity of the school. Personal lockers should be available to each student.

Standard 6: Competencies, Curricular Objectives, and Curricular Design

Element 6.1 Format/Dissemination of Medical Education Program Objectives and Learning Objectives: The faculty of a medical school define its medical education program objectives in outcome-based terms that allow the assessment of medical students' progress in developing the competencies that the profession and the public expect of a physician. The medical school makes these medical education program objectives known to all medical students, faculty, residents, and others with responsibility for medical student education and assessment. In addition, the medical school ensures that the learning objectives for each required learning experience (e.g., course, clerkship) are made known to all medical students and those faculty, residents, and others with teaching and assessment responsibilities in those required experiences.

***Functions and Structure of a Modern Medical School,* 1957:** A medical school should develop a clear definition of its total objectives, appropriate to the needs of the community it is designed to serve and the resources at its disposal. When objectives are clearly defined, they should be made familiar to faculty and students alike, so that efforts of all will be directed towards their achievement.

Element 6.2 Required Clinical Experiences: The faculty of a medical school define the types of patients and clinical conditions that medical students are required to encounter, the skills to be performed by medical students, the appropriate clinical settings for these experiences, and the expected levels of medical student responsibility.

***Essentials of an Acceptable Medical College,* 1927:** At least six maternity cases should be provided for each senior student, who should have actual charge of these cases under the supervision of the attending physician. A carefully prepared report of each case should be handed in by the student.

Element 6.3 Self-Directed and Lifelong Learning: The faculty of a medical school ensure that the medical curriculum includes self-directed learning experiences and time for independent study to allow medical students to develop the skills of lifelong learning. Self-directed learning involves medical students' self-assessment of learning needs; independent identification, analysis, and synthesis of relevant information; and appraisal of the credibility of information sources.

***Essentials of an Acceptable Medical School,* 1945:** The main purpose of the undergraduate curriculum should be to provide the student with a sound foundation in the fundamentals of medicine on which he can build in the future in general or special practice or in scientific investigation. He should have acquired such habits of mind and thought that in addition to profiting by his professional experience, he will continue to educate himself throughout his life.

Element 6.5 Elective Opportunities: The faculty of a medical school ensure that the medical curriculum includes elective opportunities that supplement required learning experiences and that permit medical students to gain exposure to and deepen their understanding of medical specialties reflecting their career interests and to pursue their individual academic interests.

***Functions and Structure of a Medical School,* 1973:** [Instruction] should foster and encourage the development of the specific and unique interests of each student by tailoring the program in accordance with the student's preparation, competence, and interests by providing elective time whenever it can be included in the curriculum for this purpose.

Element 6.8 Education Program Duration: A medical education program includes at least 130 weeks of instruction.

***Essentials of an Acceptable Medical College,* 1910, number 9:** [An acceptable medical college has] A fully graded course [of study] covering four years of at least 30 weeks, exclusive of holidays, and at least 30 hours per week of actual work; this course should be clearly set forth in a carefully prepared and printed schedule of lectures and classes.

Standard 8: Curricular Management, Evaluation, and Enhancement

Element 8.1 Curriculum Management: A medical school has in place an institutional body (e.g., a faculty committee) that oversees the medical education program as a whole and has responsibility for the overall design, management, integration, evaluation, and enhancement of a coherent and coordinated medical curriculum.

***Essentials of an Acceptable Medical School,* 1945:** The entire course [of instruction] should be designed as an integrated program of instruction with the objective of the education of the student in the science, art, and practice of medicine, including the understanding of health and its cultivation and the understanding of disease and its prevention and treatment … No rigid curriculum for accomplishing these objectives [of the curriculum] can be prescribed. On the contrary, continuous study of the curriculum by the faculty with the introduction of modifications and new methods and materials to take proper cognizance of advances in medical science and changing conditions of medical practice is essential in the conduct of an acceptable medical school.

Standard 9: Teaching, Supervision, Assessment, and Student and Patient Safety

Element 9.5 Narrative Assessment: A medical school ensures that a narrative description of a medical student's performance, including his or her non-cognitive achievement, is included as a component of the assessment in each required course and clerkship of the medical education program whenever teacher-student interaction permits this form of assessment.

***Functions and Structure of a Modern Medical School,* 1957:** Qualitative evaluations of each student by instructors should be included in the student records.

Standard 10: Medical Student Selection, Assignment, and Progress

Element 10.2 Final Authority of Admissions Committee: The final responsibility for accepting students to a medical school rests with a formally constituted admissions committee. The authority and composition

of the committee and the rules for its operation, including voting privileges and the definition of a quorum, are specified in bylaws or other medical school policies. Faculty members constitute the majority of voting members at all meetings. The selection of individual medical students for admission is not influenced by any political or other factors.

***Essentials of an Acceptable Medical College,* 1927:** The admission of students to the medical school must be in the hands of a responsible committee or examiner whose records shall always be open for inspection.

Standard 11: Medical Student Academic Support, Career Advising, and Educational Records

Element 11.1 Academic Advising: A medical school has an effective system of academic advising in place for medical students that integrates the efforts of faculty members, course and clerkship directors, and student affairs staff with its counseling and tutorial services and ensures that medical students can obtain academic counseling from individuals who have no role in making assessment or promotions decisions about them.

***Functions and Structure of a Medical School,* 1973:** It is very important that there be available an adequate system of student counseling. Such counseling is especially critical for those students who may require remedial work. Academic programs allowing students to progress at their own pace are desirable.

Standard 12: Medical Student Health Services, Personal Counseling, and Financial Aid Services

Element 12.1 Financial Aid/Debt Management Counseling/Student Educational Debt: A medical school provides its medical students with effective financial aid and debt management counseling and has mechanisms in place to minimize the impact of direct educational expenses (i.e., tuition, fees, books, supplies) on medical student indebtedness.

***Functions and Structure of a Medical School,* 1973:** Special attention must be paid to providing financial aid for students since it is desirable that economic hardship not hinder the acquisition of an education in medicine.

Element 12.4 Student Access to Health Care Services: A medical school provides its students with timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of their required educational experiences and has policies and procedures in place that permit students to be excused from these experiences to seek needed care.

***Functions and Structure of a Modern Medical School,* 1957:** There should be an active student health service providing for periodic medical examination and medical care for the student body. This is important not only in the maintenance of student health but also because of its inherent educational values.

Appendix E

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