Connecting with the Secretariat Webinar

April 17, 2025 | 1:30 pm – 3:00 pm ET

Welcome!

Thank you for joining us for today's webinar. The program will begin shortly.
You will not hear audio until we begin.

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Medical School Structure and Governance Variability: Identifying and Addressing Administrative Challenges

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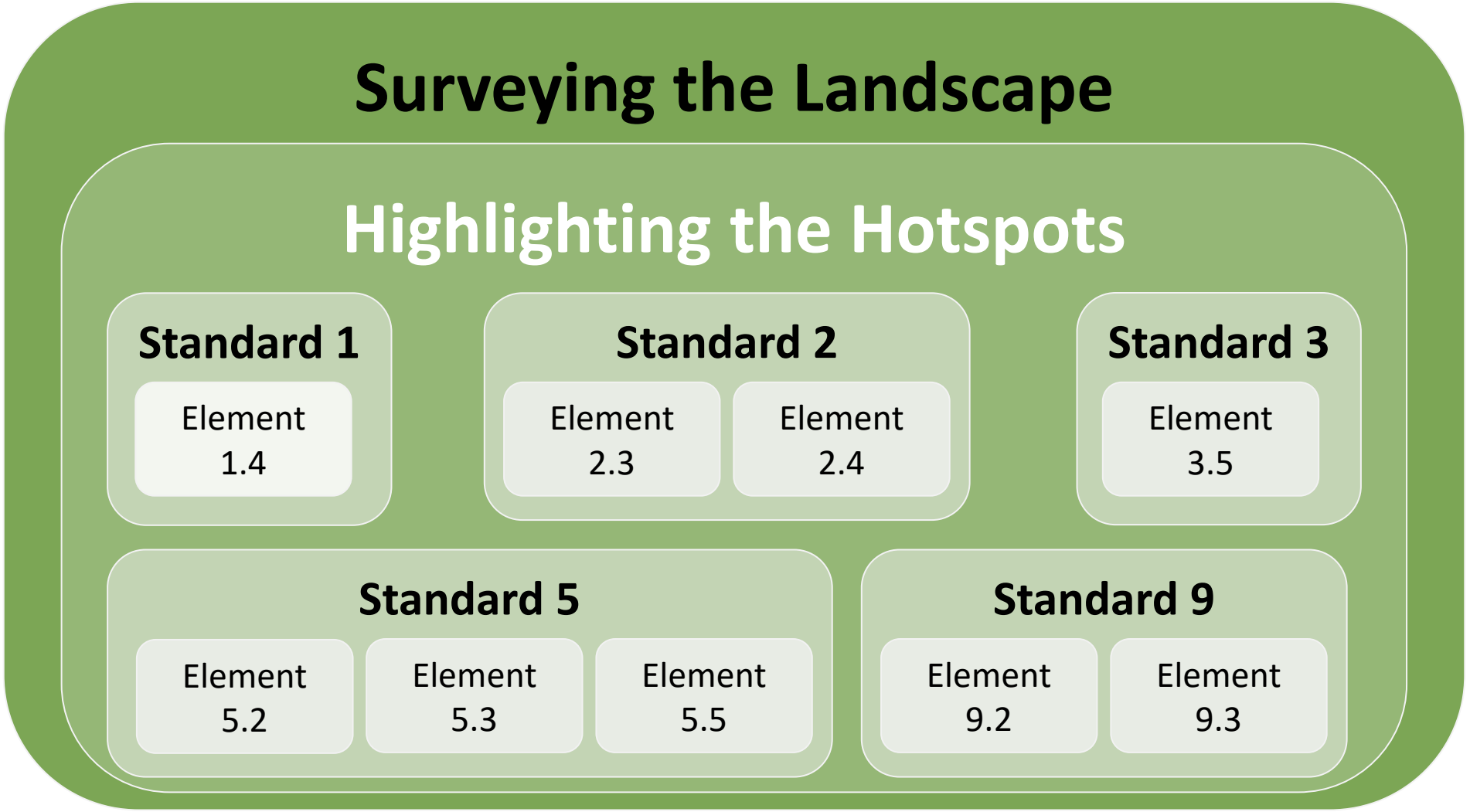
Roadmap



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Variability in Medical School Organizational Structure and Governance: The View from 10,000 Feet

- Over the past 20 years, the number of LCME-accredited medical education programs has increased by 28% (125 to 160).

- Where do medical education programs “reside?”
  - University
  - Academic health system
  - Joint university/academic health system
  - Free-standing, degree-granting institution
  - Corporation/corporate foundation

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Variability in Medical School Organizational Structure and Governance: The View from 10,000 Feet

- The organizational and governance structures of the medical schools that administer these programs, like those of their longer-established peers, reflect major changes in the health care macroenvironment over this period and corresponding changes in the microenvironment (i.e., relationships among the medical school, its sponsoring organizations, and its clinical affiliates).
  - Health system consolidations and competitive business models
  - Continued increase in the number of regional campuses
  - Continues increases in the numbers of MD-granting, DO-granting, and other health professional programs (and their class sizes)
  - Collective impact of intra-institutional, governmental, market, and technological forces on medical education and its necessary resource
- These changes, in turn, have resulted in recalibration/reallocation of the roles/responsibilities of the medical school dean in mission areas that impact the medical education program.
- These changes are associated with specific functional challenges related to LCME accreditation expectations.

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Element 1.4 (Affiliation Agreements)

In the relationship between a medical school and its clinical affiliates, the educational program for all medical students remains under the control of the medical school's faculty, as specified in written affiliation agreements that define the responsibilities of each party related to the medical education program. Written agreements are necessary with clinical affiliates that are used regularly for required clinical experiences; such agreements may also be warranted with other clinical facilities that have a significant role in the clinical education program. Such agreements provide for, at a minimum the following:

- The assurance of medical student and faculty access to appropriate resources for medical student education
- The primacy of the medical education program's authority over academic affairs and the education/assessment of medical students
- The role of the medical school in the appointment and assignment of faculty members with responsibility for medical student teaching
- Specification of the responsibility for treatment and follow-up when a medical student is exposed to an infectious or environmental hazard or other occupational injury
- The shared responsibility of the clinical affiliate and the medical school for creating and maintaining an appropriate learning environment

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Element 1.4 (Affiliation Agreements)

Challenges:

- The category of hospital/health system partner (i.e., a hospital/health system is under one organizational structure with the medical school, or is a primary affiliate, or is one of many affiliates) can affect the primacy of the medical education program.
- Increasing affiliates (due to increases in class size or regional campus formation), some at a distance from the medical school, adds complexities to managing the clinical education system and ensuring the expectations of the element are met.
- The fluid health care environment where hospitals/health systems may merge, re-form into new structures, or disaffiliate with a medical school/form new partnerships makes ensuring up-to-date affiliation agreements are in place more difficult.

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Element 1.4: Suggestions on how to Meet the Challenge

- A dispersed set of affiliates could benefit from having administrative staff (e.g., an assistant/associate dean) with the specified role of managing the relationships. Staff working on developing and managing agreements should be familiar with the requirements of the element.
- Regularly monitor affiliation agreements with current affiliates. Make sure they are up to date, re-signed at regular intervals if not evergreen, and that agreements with new affiliates are completed in a timely manner.
- Make sure that language of the agreements includes all required components (e.g., the AAMC "Clinical Training Agreement" (CTA)/page 1 is a useful template). Affiliation agreement language should be clear and specific related to the components of the element.
  Note, the CTA also can be utilized for ambulatory group practices so that the primacy of the educational program is maintained.

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Element 2.3 (Access and Authority of the Dean)

The dean of a medical school has sufficient access to the university president or other institutional official charged with final responsibility for the medical school and to other institutional officials in order to fulfill decanal responsibilities; there is a clear definition of the dean's authority and responsibility for the medical education program.

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Element 2.3 (Access and Authority of the Dean)

Challenges:

- If the dean's position description does not include responsibility for the clinical mission, there may not be a formal access point to the clinical enterprise.
- The complexity of health systems and the dispersion of clinical affiliates may make it difficult for the dean to be involved in decision-making by these partners in areas that affect the medical school, even if the dean has a formal health system role.
- A major health system or university administrative role may make it difficult for the dean to also function as the medical school chief academic officer (CAO). In that case, the individual serving as CAO may not be "at the table" to ensure medical school input when decision-making by clinical partners could affect the needs of the medical school and its educational program.

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Element 2.3: Suggestions on how to Meet the Challenge

- Specify the authority of the dean for the medical education program in the dean's formal position description (i.e., in the bylaws). This applies even if the dean is not the formal CAO.

- Ensure that the position description of the dean includes the responsibility for interacting with key organizational leaders outside of the medical school, regardless of the specific missions for which the dean is responsible. Work with sponsoring organization/health system leadership to build these linkages.

- If the dean is not the CAO, ensure that the dean is kept up-to-date with educational program issues touching on external partners and is prepared to advocate for educational program needs with the leadership of external stakeholders.

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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 effectively the missions of the medical school.

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Element 2.4 (Sufficiency of Administrative Staff)

- Financial and other pressures from external sources (e.g., the sponsoring organization/health system/legislative actions) may affect the medical school administration (e.g., administrators filling multiple roles, significant turnover in dean's staff and department chairs, longstanding administrative vacancies) or create other issues affecting the educational program (e.g., problems ensuring protected time for course/clerkship directors).
- A mis-match between how the school is organized (e.g., the presence of a dispersed educational system) and the administrative positions in the dean's office can lead to poor functional coordination.
- Unclear definitions of administrator roles/responsibilities could lead to inefficiencies/poor communication among administrators and with students/gaps in student support. This can result in students being unaware of who is available to address their concerns.

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Element 2.4: Suggestions on how to Meet the Challenge

- Develop clear descriptions of the roles/responsibilities of administrators. Clear definitions will help identify any functional gaps.
- Ensure that the time commitment for administrative positions is reasonable, and that the workload is feasible.
- Ensure that information about the roles/responsibilities of dean's staff is available to students.

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Element 3.5 (Learning Environment/Professionalism)

A medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, develop and conduct appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.

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Element 3.5 (Learning Environment/Professionalism)

Challenges:

- How the dean (and supporting cast of decanal staff, department chairs, and clerkship directors) ensure that professional behaviors of all the members of the educational environment – both “owned” by the school and not owned by the school - comport with the expectations of the educational program
- How the school evaluates the learning environment in all settings
- How the dean ensures that a positive environment exists in all the educational settings, particularly those that the dean does not directly control, and how the dean influences the learning environment in those settings that are not under the dean’s direct control

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Element 3.5: Suggestions on how to Meet the Challenge

- The LCME expects that the program has defined the professional behaviors AND has made these known to the students, faculty, and residents (refer to DCI Table 3.5-1).
- The LCME expects that the program has specified, published, disseminated how to report lapses observed in any member of the educational environment.
- The LCME expects the program to have policy/procedure on the processing of reports: how, where, who.
- The LCME expects that it is clearly stated in policy and made known to all members of the environment that retaliation will not be tolerated.
- The LCME expects that there is a central location for tracking the reports.
- The LCME expects that the program has mechanisms for monitoring the learning environment, such as student feedback mechanisms, reporting mechanisms for negative observations, reviews of the data.
- The LCME expects that the program can demonstrate effectiveness of the monitoring and reporting process.
- Suggestion: Provide feedback to the community on problems and actions taken

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Element 5.2 (Dean's Authority/Resources)

The dean of a medical school has sufficient resources and budgetary authority to fulfill the dean's responsibility for the quality and sustainability of the medical education program.

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Element 5.2 (Dean's Authority/Resources)

The challenge is for the dean (or CAO) to have the authority and relationships (with university and clinical affiliates) to set the budget necessary to support the program and/or negotiate for resources (faculty time/facilities/funding) with affiliates.

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Element 5.2: Suggestions on how to Meet the Challenge

- The LCME expects that the school can describe the way(s) the dean/CAO works with the sponsoring organization(s) (e.g. university, health system, boards) to have input into budgeting for the school.

- The LCME expects the school to be able to describe the authority of the dean/CAO to access funds within the budget as needed to support the program.

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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.

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Element 5.3 (Pressures for Self-Financing)

The nature of the challenge is to balance pressures (university, health system, legislature) to increase revenues (tuition, clinical income, research funding) and class size against the reality of existing resources (facilities, faculty, clinical sites, faculty time) to maintain the quality of the educational program and avoid a heavy burden of debt on students.

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Element 5.3: Suggestions on how to Meet the Challenge

- The LCME expects that the school determines the availability of resources to support a class size.
- The LCME expects that the dean has the ability/authority to work with affiliates to ensure resources to support a class size.
- The LCME expects that a proposed increase in class size can be supported by available resources, or a plan (with funding and/or additional resources) to support the increase.
- The LCME expects that school leadership is involved in the conversation to set tuition.
- The LCME expects that tuition does not place an excessive debt load on the students.

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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 that have adequate numbers and types of patients (e.g., acuity, case mix, age, gender).

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Element 5.5 (Resources for Clinical Instruction)

Challenges:

- Dean has variable levels of control depending on the governance structure
- Potential presence of trainees (MD/DO/NP/PA) from other schools
- Potential future changes in ownership of the training site

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Element 5.5: Suggestions on how to Meet the Challenge

1. Every clinical teaching site provides adequate numbers and types of patients to meet the school's Learning Objectives and Required Clinical Experiences in each clerkship.
    - Work with the site to identify the total number of "learners" that can be effectively trained - from your school and other schools
    - Monitor RCE completion within each site and clerkship
    - Survey students regarding ability to meet RCEs and clerkship LOs

2. Monitor potential changes in the healthcare system/site that will affect patient numbers/mix or the status of the the affiliation in the near future.
    - Communication between the school and clinical partner
    - Develop plans in anticipation of changes that affect student access to patients

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Element 9.2 (Faculty Appointments)

A medical school ensures that supervision of medical student learning experiences is provided throughout required clerkships by members of the school's faculty.

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Element 9.2 (Faculty Appointments)

Challenges:

- Utilizing clinicians to teach/assess medical students who may not be employed by the medical school
- Obtaining the appropriate documentation (CV, letters) for the school's faculty appointment/promotions committee
- Tracking status of physician preceptors (new vs departing faculty members)
- Identifying other health professionals who are interacting with students and ensuring their supervision by faculty

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Element 9.2: Suggestions on how to Meet the Challenge

- Identify someone at the clinical training site who serves as point person for identifying potential faculty and keeping the school informed of faculty departures
- Provide administrative support to convert CVs into proper format, obtain letters of recommendation and other appropriate documents, and turn them in on time
- Develop a system to monitor and track faculty appointment status at clinical sites

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Element 9.3 (Clinical Supervision of Medical Students)

A medical school ensures that medical students in clinical learning situations involving patient care are appropriately supervised at all times in order to ensure patient and student safety, that the level of responsibility delegated to the student is appropriate to the student's level of training, and that the activities supervised are within the scope of practice of the supervising health professional.

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Element 9.3 (Clinical Supervision of Medical Students)

Challenges:

- Creating a clinical supervision policy that can be applied to multiple clinical sites
- Disseminating policy/training faculty across different health systems and structures
- Monitoring compliance

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Element 9.3: Suggestions on how to Meet the Challenges

1. The curriculum committee develops a clinical supervision policy that clearly delineates:
   - levels of supervision that are congruent with the level of trainee
   - levels of responsibility that are congruent with level of trainee
   - expectations for supervision of non-faculty health professionals who are interacting with students
2. Train all faculty at the sites on the policy
3. Train students on the policy
4. Log training of faculty and students
5. Provide mechanism(s) for students to report concerns regarding clinical supervision without fear of retaliation
6. Monitor compliance with supervision policy by surveying students/process for follow-up if issues arise

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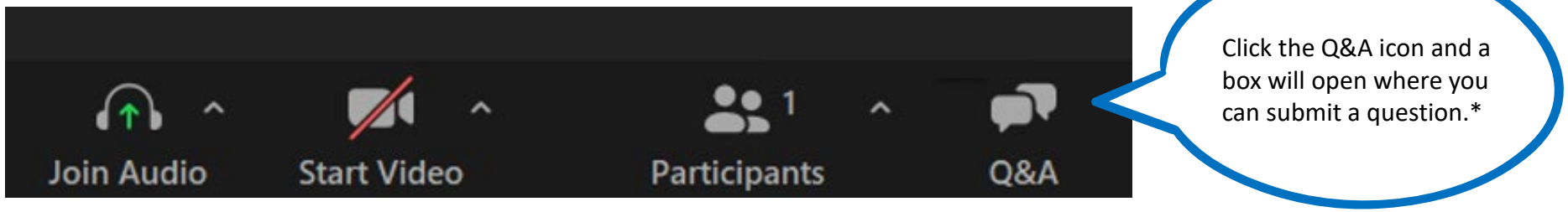
Ready for Questions!

How to ask a question in Zoom:

Hover your mouse over the bottom of the screen to bring up the toolbar.



*Only speakers will see the questions submitted. Participants will not see other participants' questions.

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Announcements

Two new documents were posted to the LCME website on April 11, 2025:

Document Type	Document	Effective Academic Year	Publication Date (click to download)
Guidelines & Procedures	Checklist of Requirements for Completing the Independent Student Analysis (ISA) for Full Accreditation	2026-27	April 2025
Data Collection Instrument (DCI)	DCI for Full Accreditation Surveys	2026-27	April 2025

lcme.org/publications

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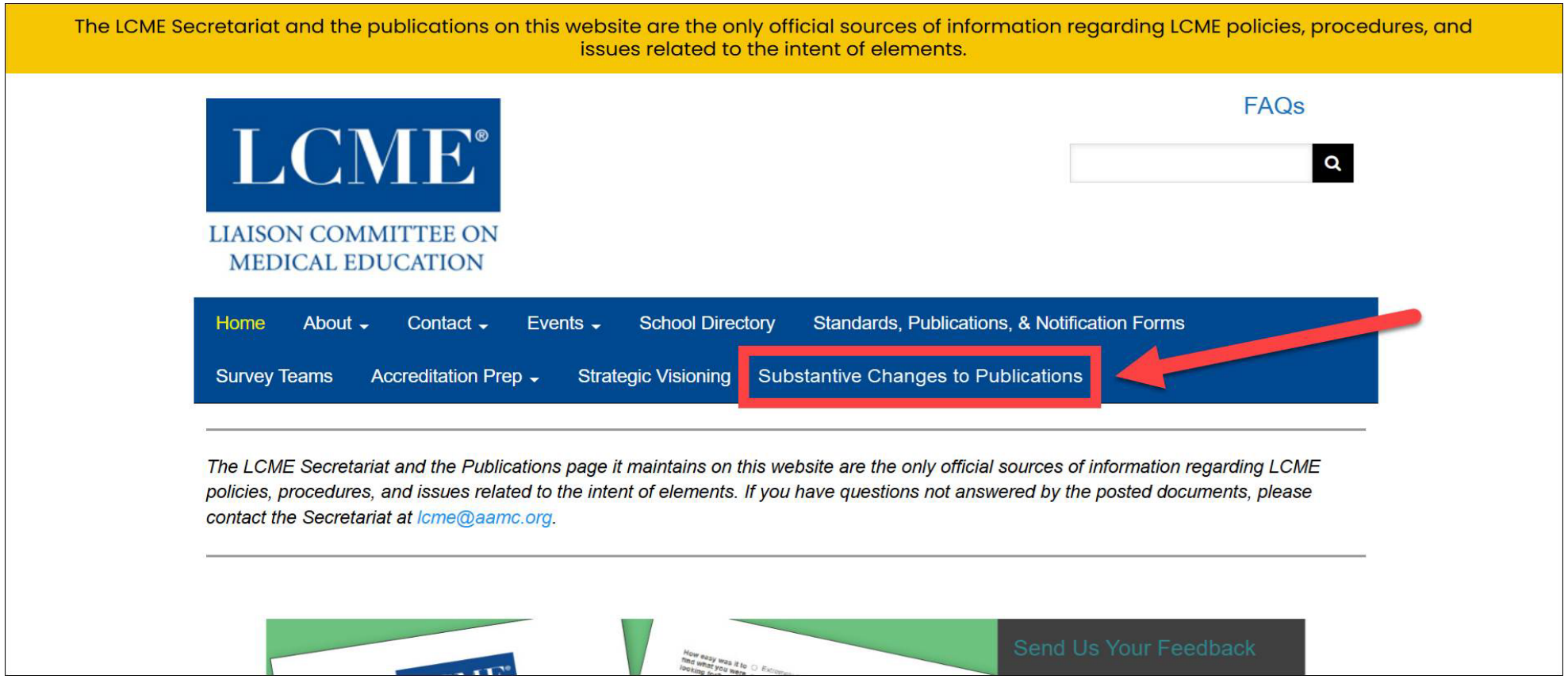
Substantive Changes to Publications



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Next Webinar: Thursday, June 5, 2025

Longstanding Pre-clerkship Educational Program Challenges and Emerging Clerkship Educational Program Challenges

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