HOD ACTION: Council on Medical Education Report 5 adopted and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-A-11

Subject: Maintaining Educational Quality in the Context of Emerging Models of Medical School Organization and Governance

Presented by: Baretta R. Casey, MD, MPH, Chair

Referred to: Reference Committee C
(Robert J. Havlik, MD, Chair)

Policy D-295.323 (AMA Policy Database), "Creation of Domestic For-profit Medical Schools," was adopted as follows by the House of Delegates:

> That our American Medical Association (AMA), in collaboration with the Association of American Medical Colleges (AAMC), the Liaison Committee on Medical Education (LCME), and the Commission on Osteopathic College Accreditation (COCA), will study new and emerging models of medical school organization and governance, including for-profit models and how medical school accreditation standards can protect the quality and integrity of the education, with a report back to the House of Delegates at the 2011 Annual Meeting.

BACKGROUND TO THE ISSUE

In his 1910 study, Abraham Flexner described his expectations for quality in medical education. Among these was the linkage of the medical school with the university. The medical sciences should, according to Flexner, be taught with the same rigor as university sciences and the university endowment should contribute to medical school funding.[1]

While Flexner and others espoused the model of a medical school as an integral component of a university, there were other organizational models in place at that time. For example, the then Medical University of the State of South Carolina was an example of an "independent" medical school[1] without organizational ties to a "parent" university. In the century following the Flexner report, new models of medical school organization and governance have emerged. This report will: 1) summarize various organizational models currently in place in US MD- and DO-granting medical schools; 2) describe issues related to educational quality potentially raised by these models; and 3) discuss the activities and standards of accrediting bodies that act to ensure educational quality regardless of the institutional model of organization and governance.

MEDICAL SCHOOL ORGANIZATIONAL AND GOVERNANCE MODELS

This section provides an overview of some models of organization and governance in current MD- and/or DO-granting medical schools that differ from the Flexnerian model of a medical school as an integral and co-located part of a university. Unless indicated, the following data are derived from MD-granting medical schools.

Independent Academic Medical Centers

In this model, the medical school is part of an institution that may offer other health professions programs but is not an integral part of a comprehensive university. There may also be medical schools that are part of university systems but have a separate governance structure. That is, the medical school campus has a president or chancellor who reports to the chief executive officer of the system. (An example of this is the three medical schools that are part of the University of Texas System). In 2010, there were 27 fully-accredited medical schools and two developing medical schools within this category.[2] As mentioned previously, some of these institutions have been in existence for a long period. The Medical University of South Carolina was founded in 1823 and Jefferson Medical College was founded in 1824.

Distributed Educational System

In a distributed educational system, a medical school has a regional campus located at a distance from the "main" campus which offers at least one year of the curriculum. A distributed campus may offer the preclinical portion of the curriculum, the clerkship years, or both. This model emerged with the expansion of medical education that occurred in the 1970s, and the number of medical schools with one or more distributed campuses has continued to grow. In 2010, approximately one-third of MD-granting medical schools had at least one distributed campus.[2] With the current phase of medical school expansion, the use of distributed campuses is increasing. Of the 130 schools responding to the 2009-2010 LCME Annual Medical School Questionnaire-Part II, 11 schools were planning to create a new distributed campus where none had existed before, 2 were planning to expand an existing campus to offer more years of the curriculum, and 20 were planning to increase the number of students at an existing campus.

Partnerships Between Colleges/Universities and Health Systems

In Flexner's model, the medical school or its parent university would own a teaching hospital or would affiliate with local hospitals to provide clinical training. In the partnership model, the medical school is a result of an equal partnership between a college/university and a health system. This relationship is often reflected in the name of the institution, for example, Hofstra North Shore-LIJ School of Medicine at Hofstra University, Oakland University William Beaumont School of Medicine, and Virginia Tech Carilion School of Medicine. This is a relatively new model; the three examples are schools recently-accredited by the LCME.

For-profit Medical Schools

The standards used by the American Medical Association Council on Medical Education in its 1906 review of medical schools included the following:

> The extent to which the medical school was conducted for the profit of the faculty.[3]

Concern about for-profit medical education persists to this day. Currently there is one for-profit DO-granting medical school which has attained accreditation by the Commission on Osteopathic College Accreditation (COCA). There is one for-profit institution that plans to grant the MD degree. It has applied for, but not yet been reviewed for, LCME accreditation.

ISSUES RELATED TO EDUCATIONAL QUALITY

There are some issues related to educational program quality that emerge from one or more of these models. The issues also may apply to medical schools of the "Flexnerian" (university-based) type.

Assuring Consistent Educational Quality at All Locations

A distributed medical education system adds complexity to assuring that all medical students have a quality medical education. This includes the need for students to be taught according to the same educational program and course/clerkship objectives, be exposed to similar educational resources (such as lectures, discussions, online programs) to help them achieve those objectives, and be evaluated consistently to determine if they have achieved the specified objectives. To bring this level of consistency at program sites that must be many miles apart requires a variety of strategies.

Effective Communication

There needs to be communication among educational sites at a variety of levels, including the educational program leadership, the course/clerkship leadership, and the individual faculty. Faculty at the sites should have information about their responsibilities as teachers and evaluators and be prepared for these roles.

Evaluation and Follow-up

Evaluation of student performance and satisfaction needs to be reviewed for each educational program site to determine if there are sites that require specific attention. These areas of concern then need to be effectively addressed by the central medical school administration and curriculum governance structure.

Effective Governance

There should be ways to link faculty at the distributed sites into the medical school governance process, such as the admissions committee and the curriculum committee. This allows the site faculty to have input into educational decision-making and makes it less likely that they will act autonomously to teach outside the educational program objectives and to set divergent standards.

Maintaining Medical Education as a Priority Mission

All medical schools have multiple missions. The relative importance of the educational mission may be influenced by the priorities of organizational leaders and the cultures of institutional partners. Explicit medical school policies and procedures, including faculty reward systems, can help keep education as a priority.

Maintaining Faculty Control of the Educational Program and Related Decisions

When income is a priority, there may be incentives to utilize instructional methods that allow a large class size to admit a large number of students so as to maximize tuition revenue, and to focus faculty time on revenue-generating activities rather than on scholarship. Faculty governance structures that assure faculty control of the curriculum and the admissions process may mitigate this concern.

Assuring Sufficient Resources for Medical Education

Flexner stated that "medical education is expensive to teach."[1] This is as true today as 100 years ago. Resources include adequate and appropriate space for the educational program, sufficient faculty with the desired expertise, and appropriate clinical resources. Medical schools and their institutional partners should assure that funding is available to provide such resources instead of being channeled into other areas, such as to investors, or to other medical school missions.

THE ROLE OF ACCREDITING BODIES

Accreditation Standards for MD- and DO-granting Schools

Among other accreditation standards of the LCME and the COCA, there are standards that address the following areas:

- The requirement of an explicit statement of medical school mission;
- An institutional commitment to scholarship;
- The requirement to develop and implement educational program objectives and to evaluate the attainment of the objectives at the level of the individual student and the educational program;
- Cooperation between the medical school and the affiliated sites in planning and implementing instruction;
  (Note: The LCME also requires that there be comparable educational experiences and equivalent methods of assessment at all sites within a given discipline.)
- The requirement for explicit and effective conflict of interest policies for board members, administrators, and faculty members;
- The requirement that the medical school chief academic officer (the dean or the dean's designate) has the responsibility for fiscal management and sufficient resources to fulfill his or her responsibilities for the educational program;
- Appropriate and sufficient faculty, facilities, and learning resources; and
- Explicit admissions policies and practices.
  (Note: The LCME also states that admission is the responsibility of the faculty and must not be influenced by political or financial factors.)[4,5]

The LCME also has an accreditation standard that states:

> A medical education program should be, or be part of, a not-for-profit institution legally authorized under applicable law to provide medical education leading to the MD degree (standard IS-2).[4]

The LCME defines the use of the word "should" in its standards as follows:

> Use of the word "should" indicates that compliance with the standard is expected in the absence of extraordinary and justifiable circumstances that preclude full compliance.[4]

Other Activities of the LCME

The role of accrediting bodies is to assure that medical education programs meet defined standards. The emerging models of medical school organization and governance stimulated the LCME to consider this issue. An internal LCME task force developed, and the LCME approved, a "white

paper" titled "Accreditation Issues Arising from New Models of Medical School Organization and Governance," which is attached. This discussion paper articulated a set of principles related to medical school organization and governance that are relevant for all medical schools. This discussion paper was posted on the LCME Web site in June 2010.

SUMMARY AND RECOMMENDATIONS

The emergence of a for-profit medical school has given rise to significant pro and con debate within the osteopathic medical community[6,7] and calls for change in MD-granting medical schools to make education less costly and more efficient for individuals and institutions.[8] However, not only for-profit educational programs pose challenges. The expansion of medical education has led to the emergence of new organizational and governance models that have the potential for positive innovation but also could present issues related to program quality. Accreditation standards need to be reviewed to assure that they are sufficiently comprehensive to address the implications for quality of all the models. This imperative has led to action by accrediting bodies. For example, the LCME has begun a process with its stakeholders to: 1) identify the core values that should underlie medical schools as organizations; 2) review accreditation standards and policies to assure that these values are reflected; and 3) revise, if necessary, standards and the data collected to support evaluation of compliance with standards.

AMA policy supports "continued efforts to review and define standards for medical education at all levels" and the "continued participation in the evaluation and accreditation of medical education…" (Policy H-295.995, [#34], "Recommendations for Future Directions for Medical Education.")

In this context, the Council on Medical Education recommends that the following recommendations be adopted and that the remainder of this report be filed:

1) That our American Medical Association (AMA) encourage the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance. (Directive to Take Action)

2) That our AMA rescind HOD Policy D-295.323, "Creation of Domestic For-profit Medical Schools." (Rescind HOD Policy)

Fiscal Note: Less than $500.

ATTACHMENT
Liaison Committee on Medical Education "White Paper," 2010
Available on the LCME Web site (www.lcme.org)

ACCREDITATION ISSUES ARISING FROM NEW MODELS OF MEDICAL SCHOOL ORGANIZATION AND GOVERNANCE

The policies, procedures, and standards of the Liaison Committee on Medical Education (LCME) have, in a large part, been grounded in the context of what might be considered a "traditional" model of medical school organization and governance. This model, which crystallized in the first half of the twentieth century, has the following characteristics.

A single non-profit university or health science center includes a medical school that sponsors one complete medical education program. A variation is that the university or health science center may be part of a larger, state-based university system that includes other medical schools (such as the University of California or University of Texas systems). In the traditional medical school model, there is a chief academic officer responsible for the medical education program, which is delivered at a single site that includes a "main campus" and affiliated teaching hospitals.

Divergence from this model began to occur during the 1970s, when some medical schools developed distributed campuses located at a distance from the "main" campus. These campuses typically offered portions of the educational program that could be identical to or different from the curriculum offered at the "main" campus.

This document aims to explore the implications for accreditation of new models of medical school organization and governance that diverge even further from the traditional (see ATTACHMENT). Some of these models already exist in the United States or Canada. Other models are hypothetical but, potentially, feasible.

The models were used as a stimulus to consider what is required for the organization and governance of an educational program to be in compliance with accreditation standards. In general, standards require the following:

- A governance structure free from financial and other conflicts of interest.
- An administrative structure under the control of the medical school's chief academic officer.
- An educational program under the control of the medical school's faculty.
- A system to assure access to appropriate and sufficient resources to conduct the educational program according to the objectives developed by the faculty.

Core Principles

After review of the potential models, the LCME developed a set of core principles that are grounded in the LCME accreditation standards. Regardless of the model of organization/governance a medical school chooses to adopt, it must be able to demonstrate adherence to these principles and to the applicable standards.

1. Medical education is explicitly recognized as a key mission by the institutional sponsor(s) and members of the medical education community. The priority of education is codified and represented in medical school bylaws or other formal statements of organization and purpose, governing principles, planning activities, and institutional policies and procedures.

2. There are clear and appropriate policies for management of financial, educational, and other conflicts of interest in medical school governance and operations, and there is credible evidence that the policies are implemented and followed.

3. Regardless of the structure of the educational program or the locations where education is delivered, there are policies and practices that assure the medical school's chief academic officer has ultimate authority to assure educational program quality.

4. The design, implementation, delivery, evaluation and management of the educational program, as well as the selection of students, are the responsibility of and under the sole control of the medical school faculty. The faculty, in turn, are responsible to the chief academic officer of the medical school for their role in the educational program.

5. The institutional governing board has the responsibility for the appointment of medical school leadership and, either directly or by delegation to the chief academic officer, the appointment of medical school faculty.

6. The medical school has control of, or has guaranteed access to, appropriate and sufficient resources to support the delivery of the educational program and the other medical school missions.

Implications of the Core Principles

The following describe the LCME's interpretation of the implications of the core principles for medical education programs and how the principles relate to its accreditation standards. The principles should be considered in planning and implementing new models of institutional organization and governance. Regardless of the model(s) selected, medical schools and their institutional sponsors should be prepared to document compliance with relevant accreditation standards.

The full citations for the listed LCME accreditation standards are contained in Functions and Structure of a Medical school, which can be accessed through the LCME web site: www.lcme.org. Please note that the list of standards associated with each principle is meant to be illustrative, not exclusive.

1. Medical Education as a Priority Mission

The medical education program must be based in an institution legally authorized to grant the MD-degree. The LCME expects that medical education is explicitly included among the missions of the medical school and that institutional planning and decision-making at all levels reflect the priority of the educational mission. The educational mission cannot be compromised by other institutional missions or imperatives, such as the need for the medical school or its institutional sponsor to generate revenue from research, clinical care, or other activities.

Relevant Accreditation Standards: IS-1, IS-2, ER-3

Implications: A medical school that cannot demonstrate the priority of and explicit support for education in its formal policies and in its operations would not be in compliance with accreditation standards.

2. Avoidance of Conflict of Interest

There must be a clear description, codified in institutional by-laws or other formal policies, of how the educational program is governed. There must be formal policies that mitigate the possibility of

conflict of interest in institutional decision-making at all the levels and evidence that these policies are followed. Policies to avoid the impact of financial, educational, and other conflicts of interest should apply to individuals involved in institutional governance (members of the governing board) and to medical school administrators and faculty in their various roles.

Relevant Accreditation Standards: IS-4, IS-5, MS-7, FA-8

Implications: A medical school that cannot demonstrate that there are policies to eliminate or manage conflicts of interest at the specified levels and also that these policies are followed would not be in compliance with accreditation standards.

3. Authority of the Chief Academic Officer for the Educational Program

The role, authority, and responsibilities of the medical school's chief academic officer (CAO) must be clearly articulated and widely understood, and he/she should have ready access to university/institutional officials to facilitate the fulfillment of his/her responsibilities. The CAO of the medical school (i.e., the dean or the dean's designate) must be ultimately accountable for and must have corresponding authority over and access to resources to assure the quality of the educational program. The CAO must have authority for the educational program regardless of the sites where education occurs or the ways that the curriculum is organized and delivered.

Relevant Accreditation Standards: IS-8, IS-9, ED-36, ED-39, ED-40

Implications: A medical school where the chief academic officer does not have authority for the educational program at all sites and appropriate resources for the educational program is not in compliance with accreditation standards.

4. Faculty Control of the Educational Program

Individuals formally designated as faculty of the medical school must be responsible for the educational program, including program planning, delivery, and evaluation. There must be mechanisms that allow the faculty to participate in institutional decision-making about the educational program and other medical school missions. The faculty, in turn, must be formally accountable to the medical school and, ultimately, to its chief academic officer for the quality of their work and the time that they spend related to the missions of the medical school. Faculty also must have responsibility for policies and practices related to admission to and progress through medical school.

Relevant Accreditation Standards: ED-34, MS-3, MS-4, FA-6, FA-12, FA-13, ER-10

Implications: A medical school that places limits on the responsibility of the faculty for the educational program is not in compliance with accreditation standards.

5. Authority for Faculty Appointment

The leadership of the medical school (the CAO and/or the departmental leadership) should have authority to recruit and promote faculty appropriate to the needs of the educational program and other medical school missions.

Relevant Accreditation Standards: IS-7, FA-3, FA-4, FA-7

Implications: A medical school that does not have policies and practices to assure faculty quality and accountability is not in compliance with accreditation standards.

6. Medical School Access to Sufficient Resources for the Educational Program
The medical school must have access to the resources needed to achieve its educational and other institutional missions. These resources include faculty of the appropriate numbers and disciplines, funding, facilities, information and library resources, clinical sites, and patients.

Relevant Accreditation Standards: FA-2, ER-2, ER-4, ER-6, ER-11

Implications: A medical school that lacks access to any of the necessary resources is not in compliance with accreditation standards.

ATTACHMENT

POTENTIAL NON-TRADITIONAL MODELS OF MEDICAL SCHOOL ORGANIZATION AND GOVERNANCE

These models are not intended to be mutually exclusive. It cannot be assumed that each model would be in compliance with all LCME accreditation standards.

Relationship Between the Medical School and its Institutional Sponsor(s)

a. A not-for profit medical school with not-for-profit sponsor(s)
   i. two or more universities
   ii. one or more universities and a hospital/health system
   iii. a hospital/health system

b. A not-for profit medical school with a for-profit sponsor
   i. the medical school is a not-for-profit foundation within a for-profit organization (for example, a health system)

c. For-profit medical school
   i. an independent medical school that is itself a for-profit entity
   ii. a for-profit medical school that is a component of a for-profit entity

Relationship Among Medical School Components

a. A medical school with two or more campuses where one or both does not offer the complete (four-year) educational program

b. A medical school with two or more campuses that each offer the complete (four-year) educational program (a single degree is granted)
   i. all campuses offer the same curriculum (e.g., Northern Ontario Medical School, University of British Columbia, emerging programs at Mercer/Texas A&M)
   ii. each campus offers a separate track (i.e., a distinct educational program)

c. Two or more complete and independent medical education programs within a single institution (e.g., university)
   i. both offer the MD degree
   ii. one offers the MD degree and one offers the DO degree

Relationships Among Medical Schools

a. Two U.S./Canadian medical schools affiliate to share faculty/students/resources

b. A U.S./Canadian medical school affiliates with an international medical school

Contractual Relationships Between a Medical School and Other Entities (Schools/Colleges, Health Systems, Commercial Enterprises)

a. Medical school/medical school department contracts with another educational unit (e.g., school or college that is not a medical school) to provide educational resources (e.g., faculty)
   i. within a different college in the same university, where faculty appointment is to the college/department
   ii. from another university

b. Medical school/medical school department contracts with a non-university-based health system/group practice outside the sponsoring university to provide educational resources (e.g., faculty)

c. Medical school/medical school department contracts with a for-profit entity to provide educational resources

REFERENCES

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