

FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL

Accreditation and the Liaison Committee on Medical Education

Standards for Accreditation of Medical Education Programs
Leading to the M.D. Degree

Explanatory Annotations For Selected Accreditation Standards

LCME

LIAISON COMMITTEE ON MEDICAL EDUCATION

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INTRODUCTION

The Liaison Committee on Medical Education (LCME) was formed in 1942 by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association for the purpose of accrediting medical education programs leading to the M.D. degree in the United States and Canada. In the 1970s, a linkage was formed with the Committee on Accreditation of Canadian Medical Colleges (CACMS) to jointly accredit M.D. programs in Canada.

Over the years, there has been substantial change in medical education across the United States and Canada. In response to advances in science and medicine, medical schools have expanded their programs and partnerships in research and clinical care, and broadened the educational experiences of students through the addition of new pedagogical approaches and sites of training. The LCME believes that educational programs leading to the M.D. degree are best conducted in these enriched environments.

The historic and unique responsibility of a medical school is the selection and education of medical students, culminating in the award of the M.D. degree. To do this, a school must provide resources, including faculty and facilities, sufficient to support a curriculum offered in an intellectual environment that enables the program to meet the standards set forth in this document. The curriculum must be designed to instill in its graduates the knowledge, skills, and behaviors fundamental to the practice of medicine. In addition, the curriculum must instill lifelong habits of learning, dedication to service, and the values and attitudes consistent with a compassionate physician.

The extent of responsibility of a medical school for other educational programs depends on its resources and the educational resources of the community of the individual school. The LCME considers it important for the education of medical students that each school provide, or be affiliated with institutions that provide, programs in graduate medical education (residencies) and that the faculty of each school actively contributes to the development and transmission of new knowledge. The curriculum for the M.D. degree must be supplemented by a period of graduate medical education in order to prepare a physician for independent medical practice. Residents in graduate training programs are important resources for the clinical education of medical students. A medical school also must

contribute to the intellectual growth of its students and faculty through scholarly activity, including research in the biomedical sciences, the cultural and behavioral aspects of medicine, health services, health policy, preventive medicine and health maintenance, and the process of medical education itself.

Other educational programs conducted by medical schools or their affiliated institutions that contribute to an enriched environment for undergraduate medical education include postdoctoral fellowships, graduate education in the basic medical sciences, continuing education for physicians, and education in other health professions and allied health occupations. While graduate medical education is crucial for the teaching of clinical medicine, postdoctoral fellowships in biomedical sciences and in the clinical subspecialties contribute to the advancement of knowledge and to the development of future physician faculty members. Future faculty members and investigators in the basic medical sciences are developed through programs in graduate education leading to the Master of Science, Doctor of Philosophy, or Doctor of Science degrees. Many programs have emerged that offer additional opportunities for medical students to expand their options, including M.D./J.D., M.D./M.B.A., and M.D./M.P.H. programs. Medical schools provide leadership for programs of continuing education to maintain and increase the knowledge and skills of practicing physicians. Medical schools also participate in programs of education of other professionals in the health fields, in the education and training of allied health personnel, and in other programs of the general university.

In addition to conducting or participating in educational programs other than those leading to the M.D. degree, medical school clinical faculty members, where consistent with their academic responsibilities and professional training, commonly provide professional services to patients. These may include direct patient care in and out of the hospital, and indirect care, such as providing special tests or procedures. This activity not only contributes to the maintenance and enhancement of the skills of clinicians, but it is also of fundamental importance in the development of those skills in the physician-in-training; clinical education involves the student in gradually increasing responsibility for the care of patients under supervision. The foregoing constitutes the necessary environment for medical students to learn the practice of medicine, and assists as well in meeting local, regional, and national needs for patient services.

PART ONE

ACCREDITATION AND
THE LIAISON COMMITTEE ON
MEDICAL EDUCATION

Part One

ACCREDITATION AND THE LIAISON COMMITTEE ON MEDICAL EDUCATION

Purpose and Responsibility

The process of accreditation is designed to determine and to certify the achievement and the maintenance of minimum standards of education throughout the geographic area defined by the scope of responsibility of the accrediting agency. In the United States and Canada, accreditation is voluntary and is conducted by non-governmental bodies at the request of institutions or programs desiring accreditation.

The scope of responsibility of the Liaison Committee on Medical Education (LCME) is to accredit programs of medical education leading to the M.D. degree in the United States and territories and, in cooperation with the Committee on Accreditation of Canadian Medical Schools (CACMS), in Canada. The LCME is recognized as the accrediting body for these programs by the medical schools and their parent universities. It also is recognized for this purpose by the United States Secretary of Education, by the United States Congress in various health-related laws, and by U.S. state, provincial (Canada), and territorial licensure boards.

The primary responsibility of the LCME is to attest to the educational quality of accredited programs, directly serving the interests of the general public and of the students enrolled. The interests of the general public are served in a variety of ways. Historically, licensing bodies of the United States and Canada have accepted the M.D. degree from a program accredited by the LCME as a prerequisite for licensure. The list of accredited programs published annually by the LCME provides information that may be used when individuals select a personal physician or when premedical students select a medical school. The process of evaluation

and accreditation by the LCME assists institutions in determining effective allocation of their efforts and resources. The LCME further serves the public interest by encouraging institutions with accredited programs leading to the M.D. degree to support, to the extent of their available resources, other educational programs, including graduate and continuing physician education, allied health education, graduate education in the biomedical sciences, public health, research, and other related disciplines.

The scope of responsibility of the LCME is limited to evaluation and accreditation of the medical school's program leading to the M.D. degree in institutions licensed, incorporated, or chartered in the U.S. or Canada. In doing so, the LCME focuses on one set of activities in the matrix of multiple activities in a medical school or an academic health center, but it also considers the impact of these other activities on the quality of the program leading to the M.D. degree. Other educational programs conducted by a school or an academic health center are accredited by appropriate programmatic accrediting bodies and by regional accrediting associations that accredit entire institutions.

The LCME considers for accreditation only complete programs of medical education leading to the M.D. degree. The LCME evaluates new basic and clinical science components in branch locations of schools conducting complete accredited programs when the program of basic or clinical science is a component of the complete program of the institution granting the M.D. degree. The basic and clinical science components of a developing medical school are evaluated for accreditation when the degree-granting institution is committed to establishing a complete program and the procedures leading to initial provisional accreditation have been completed.

Composition of the LCME

The 17 members of the LCME are medical educators and administrators, practicing physicians, public representatives, and medical students. The Association of American Medical Colleges and the Council on Medical Education of the American Medical Association each appoint six professional members and one voting student member. The LCME itself appoints two voting public members, and a voting member is appointed by the CACMS. Members of LCME accreditation survey teams are invited to serve on the basis of interest in, and

knowledge of, current medical education. Members of the LCME and its survey teams, excluding full and part-time staff, serve the LCME without compensation, except for limited compensation to non-staff survey team secretaries. The LCME usually meets for two days quarterly. Site visits customarily require three to four days. The LCME may meet as needed to deal with special problems.

Process of Accreditation

The process of accreditation entails an institutional self-assessment, preparation of a database cataloging the program of medical education, and a site visit by a team of knowledgeable professionals selected by the LCME Secretariat. Generally, this process is repeated at seven-year intervals; limited accreditation surveys may be conducted to address identified areas of concern.

Sponsors of accredited programs of medical education leading to the M.D. degree are not charged for accreditation surveys, and the expenses of site visit teams are reimbursed by the LCME. For programs in the process of development but not yet awarded initial provisional accreditation, the LCME charges a fee for administration of the survey and requires reimbursement of the site visit expenses. Expenses for consultation visits to schools contemplating application for accreditation also will be reimbursed by the schools.

About the Standards

The accreditation status of programs leading to the M.D. degree is determined solely by the Liaison Committee on Medical Education. To be accredited, programs must meet the national standards set forth in this document, as judged by the LCME. These standards sometimes are stated in a fashion that is not susceptible to quantification because the nature of the evaluation is qualitative in character and can be accomplished only by the exercise of professional judgement by qualified persons. The LCME has begun to provide explanatory "annotations" to assist schools and surveyors in interpreting standards (see Part 3, p. 21).

In this document, the words "must" and "should" have been chosen with care. Use of the word "must" indicates that the LCME considers meeting the standard to be absolutely necessary if the program is to be accredited. Use of the word "should" indicates that the LCME considers an attribute to be highly desirable and makes a judgement as to whether or not its absence may

compromise substantial compliance with all of the requirements for accreditation.

The LCME develops its standards for accreditation through a process of study and debate, including public hearings. To ensure wide input, participants include the public; students; medical school faculty members; practicing physicians; and administrators of medical schools, hospitals, and universities. The LCME's Subcommittee on Standards is charged with the ongoing development and evaluation of standards. Substantive changes in standards must be approved by the Executive Council of the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association, and in Canada by the Association of Canadian Medical Colleges and the Council on Medical Education of the Canadian Medical Association.

Types of Accreditation and Actions Subject to Appeal

The types of accreditation awarded by the LCME are full or provisional. Established programs are eligible for full accreditation for a seven year term. Developing programs are eligible for provisional accreditation, usually for one year subject to renewal. In the year that the charter class of a provisionally accredited program is scheduled to graduate, the developing program becomes eligible for full accreditation.

Provisional Accreditation - The LCME responds to requests for information and assistance from sponsors of new programs of medical education leading to the M.D. degree by providing printed materials, consultation meetings, and consultation site visits. For evaluation for initial provisional accreditation, the school must submit documentation, including a medical education database, to demonstrate that its proposed program can be expected to meet the standards for accreditation at the time the stated number of first-year students will be admitted. After review and acceptance of the documents, the LCME makes a determination of the readiness for the scheduling of a survey team visit. Based on the completed pre-survey database questionnaire and the report of the survey team, the LCME determines whether or not to award initial provisional accreditation. Initial accreditation determinations cannot be applied retroactively.

Once provisionally accredited, a school's M.D. program is reevaluated annually for continued

provisional accreditation in similar fashion until the year of graduation of the charter class. A full survey is conducted at that time; in preparation, the school must conduct an institutional self-study and prepare a complete database. Based on consideration of the database, self-study, and findings of the survey, the LCME decides whether or not to award full accreditation.

Full Accreditation - The standard term of accreditation is seven years. Toward the end of the term, programs that have been fully accredited are required to submit a database and to conduct an institutional self-study in advance of a site visit by a survey team. The LCME determines the accreditation of the program after consideration of the database, the self-study, and the report of the survey team. During the term of accreditation, the LCME may require one or more progress reports, or may conduct short-duration interim re-visits to assess areas of special concern.

Actions Subject to Appeal - Actions subject to appeal are denial of provisional or full accreditation, probation, and withdrawal of accreditation. The LCME assigns probation for a specified period of time during which it expects the deficiencies of the program to be corrected. There are explicit procedures for appeal, described in the LCME's *Rules of Procedure*.

When the LCME has placed a program on probation or denied or withdrawn accreditation, the program must notify all students enrolled, those newly accepted for enrollment, and those seeking enrollment, of the resulting change in accreditation status.

Monitoring of Accredited Programs

Provisionally accredited programs submit an updated database and are surveyed by a site visit team each year until eligible for full accreditation.

Fully accredited programs, in the interval between surveys, may be required to have an interim site visit or submit reports about progress addressing problems identified during the previous survey, or in response to the LCME's annual program review by questionnaire. Detailed financial and educational questionnaires are sent annually to each school under the auspices of the LCME. Aggregate data derived from this questionnaire are analyzed by the staff of the AMA and the AAMC and are published in the annual education issue of the *Journal of the*

American Medical Association. The AAMC publication, *Directory of American Medical Education*, as well as the LCME Web site (www.lcme.org), list the accredited programs in the United States and Canada.

The LCME Executive Committee annually reviews descriptive data comparing each school with all other schools, evaluates each school's longitudinal data over a period of several consecutive years, and reports items requiring action to the LCME.

The Secretariat

Further information about accreditation can be obtained from the LCME Secretary at either the American Medical Association, 515 North State Street, Chicago, Illinois, 60610, or at the Association of American Medical Colleges, 2450 N Street, N.W., Washington, D.C., 20037. Information on accreditation in Canada may be obtained from the Secretary of the Committee on Accreditation of Canadian Medical Schools at the Association of Canadian Medical Colleges, 774 Echo Drive, Ottawa, Ontario, Canada, K1S 5P2.

PART TWO

STANDARDS FOR ACCREDITATION OF
MEDICAL EDUCATION PROGRAMS
LEADING TO THE M.D. DEGREE

Part Two

**STANDARDS FOR
ACCREDITATION OF MEDICAL
EDUCATION PROGRAMS
LEADING TO THE M.D.
DEGREE**

Objectives

An essential objective of a program of medical education leading to the M.D. degree in the United States and Canada must be the meeting of standards for accreditation by the LCME, so that its graduates will be prepared to enter and complete graduate medical education, to qualify for licensure, to provide competent medical care, and to have the educational background necessary for continued learning. A medical school may establish additional objectives for its educational program, consistent with its program resources. A medical school must define its educational objectives and make them known to faculty, residents, and students. While recognizing the existence and appropriateness of diverse institutional missions and educational objectives, the LCME subscribes to the proposition that local circumstances do not justify accreditation of a substandard program of medical education leading to the M.D. degree.

Accreditation is awarded on the basis of judgement that there is an appropriate balance between the size of the enrollment in each class and the total resources of the program, including the faculty, physical facilities and the budget. If there is to be substantial change in the size of the enrollment of students or the resources of the institution, the LCME must be notified of the proposed change so that it may reevaluate the program's accreditation status.

Governance

Accreditation will be conferred only on those programs that are legally authorized under applicable law to provide a program of education beyond secondary education. A medical school

should be a component of a university that has other graduate and other professional degree programs. The program of medical education leading to the M.D. degree must be conducted in an environment that fosters the intellectual challenge and spirit of inquiry as characterized by the community of scholars that constitutes a university.

A medical school should be part of a not-for-profit university or chartered as a not-for-profit institution by the government of the jurisdiction in which it operates. If not part of a university, an independent school must have a governing board composed of persons who have no personal or pecuniary interest or other conflict of interest in the operation of the school, its associated hospitals, or any related enterprises. Terms of governing board members should be overlapping and sufficiently long to permit the members during their tenure to gain an understanding of the programs of the medical school in order to develop policy in the interests of the school and of the public. Additionally, if not a component of a regionally accredited institution, a U.S. medical school must achieve institutional accreditation (or pre-accreditation as a first step to achieving full accreditation) from the appropriate regional association for accreditation of colleges and universities, both as an aid in achieving its total institutional goals and to comply with the conditions and scope of the LCME's program accreditation designated by the U.S. Department of Education.

Administration

General

Administrative officers and members of a medical school faculty must be appointed by, or on the authority of, the governing board of the medical school or its parent university. The chief official of the medical school, who usually holds the title "dean", must have ready access to the university president or other university official charged with final responsibility for the school, and to other university officials as are necessary to fulfill the responsibilities of the dean's office.

The dean must be qualified by education and experience to provide leadership in medical education, in scholarly activity and research, and in care of patients. The dean should have the assistance of such associate or assistant deans and staff as are necessary for administration of admissions, student affairs, academic affairs, graduate education, continuing education, hospital relationships, research, business and planning, and fund raising.

The manner in which the medical school is

organized, including the responsibilities and privileges of administrative officers, faculty, students, and committees must be promulgated in medical school or university bylaws. A committee structure is the usual mechanism for involving faculty and others in decisions concerning admissions, promotions, curriculum, library and research, etc. The names, membership, and functions of such committees are not prescribed by these standards, but rather are subject to local determination and needs.

Some universities with programs in the health fields in addition to medicine have an office of vice-president for health affairs or a similarly designated office. If such an office exists, there must be clear understanding of the authority and responsibility of the vice president for health affairs, of the dean of the medical school, of the faculty, and of the directors of the other components of the medical center and university.

In determining the appropriate organization, emphasis should be placed on the importance of the collegiality of the medical school faculty responsible for undergraduate medical education and for the continuum of medical education. Consideration should be given to the commitments of faculty members who have multiple academic responsibilities in several educational programs of a complex university, so as to assure each educational program adequate faculty resources. A decision must be made concerning the provision of a single faculty or of combined faculties to serve the needs of each of several health-related or other academic programs of the university, and concerning the advisability of joint faculty appointments.

Geographically Separated Programs

If components of the program are conducted at sites geographically separated from the main campus of the medical school, the chief academic officer of the medical school must be responsible for the conduct and maintenance of quality of the educational experience offered at these sites and for identification of the faculty at all sites. The principal academic officer of each geographically separated site must be administratively responsible to the chief academic officer of the medical school conducting the accredited program. The faculty in each discipline, in all sites, must be functionally integrated by administrative mechanisms that ensure comparable quality in the educational experiences and consistency in student evaluation at the geographically separated segments of the program.

A large number of program sites or a significant distance between sites may require extra academic

and administrative controls in order to maintain the quality of the entire program.

Educational Program for the M.D. Degree

Duration

The program of education in the art and science of medicine leading to the M.D. degree must include at least 130 weeks of instruction, preferably scheduled over a minimum of four calendar years.

Design and Management

The program's faculty is responsible for the design, implementation, and evaluation of the curriculum. There must be integrated institutional responsibility for the design and management of a coherent and coordinated curriculum. The chief academic officer must have sufficient resources and authority provided by the institution to fulfill this responsibility. The curriculum of the program leading to the M.D. degree must be designed to provide a general professional education, recognizing that this alone is insufficient to prepare a graduate for independent, unsupervised practice. Medical schools must evaluate educational program effectiveness by documenting the achievement of their students and graduates in verifiable and internally consistent ways that show the extent to which institutional and program purposes are met.

The committee responsible for curriculum should give careful attention to the impact on students of the amount of work required. The committee should monitor the content provided in each discipline in order that objectives for education of a physician are achieved without attempting to present the complete, detailed, systematic body of knowledge in that discipline. The objectives, content, and methods of pedagogy utilized for each segment of the curriculum, as well as for the entire curriculum, should be subjected to periodic evaluation. Redundancies and deficiencies in the curriculum identified by the evaluations should be corrected.

In the assessment of program quality by multiple measures, schools should consider student evaluations of their courses and teachers, as well as other indicators such as data on student performance, academic progress and program completion rates, acceptance into residency programs, postgraduate performance, licensure of graduates, and emerging measures that may prove to be valid. The results of such evaluations should be used to determine how well schools are fulfilling their objectives and to assess

the need for program improvement. Schools also should evaluate the performance of their students and graduates in the framework of national norms of accomplishment. Review and necessary revision of the curriculum is an ongoing faculty responsibility.

Content

The medical faculty is responsible for devising a curriculum that permits students to learn the fundamental principles of medicine, to acquire skills of critical judgement based on evidence and experience, and to develop an ability to use principles and skills wisely in solving problems of health and disease. In addition, the curriculum must be designed so that students acquire an understanding of the scientific concepts underlying medicine. In designing the curriculum, the faculty must introduce current advances in the basic and clinical sciences, including therapy and technology, changes in the understanding of disease, and the effect of social needs and demands on medical care.

The curriculum cannot be all-encompassing. However, it must include the sciences basic to medicine, a variety of clinical disciplines, and ethical, behavioral, and socioeconomic subjects pertinent to medicine. There should be presentation of material on medical ethics and human values. The faculty should foster in students the ability to learn through self-directed, independent study throughout their professional lives.

The curriculum must include the contemporary content of those expanded disciplines that have been traditionally titled anatomy, biochemistry, physiology, microbiology and immunology, pathology, pharmacology and therapeutics, and preventive medicine. Instruction within these basic sciences should include laboratory or other practical exercises which facilitate the ability to make accurate quantitative observations of biomedical phenomena and critical analyses of data. When graduate students and postdoctoral fellows in the biomedical sciences serve as teachers or teaching assistants, they must be familiar with the educational objectives of the course and be prepared for their roles in teaching and evaluation.

All schools must provide broad-based clinical education programs that equip students with the knowledge, skills, attitudes, and behaviors necessary for further training in the practice of medicine. Instruction and experience in patient care must be provided in both ambulatory and hospital settings. All schools must offer a core curriculum in primary care, utilizing the disciplines or multidisciplinary approaches involved in the delivery of such care.

Clinical education programs involving patients should include disciplines such as family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery. Schools that do not require clinical experience in one or another of these disciplines must ensure that their students possess the knowledge and clinical abilities to enter any field of graduate medical education. Clinical instruction should cover all organ systems, and must include the important aspects of preventive, acute, chronic, continuing, rehabilitative, and end-of-life care.

The faculty must participate in a process that defines the objectives of clinical education and establishes quantified criteria for the types of patients (real or simulated), the level of student responsibility, and the appropriate clinical settings necessary to accomplish these purposes. A system for monitoring the achievement of clinical educational goals must be developed, based on these criteria, and students must be evaluated in this framework. If the level or diversity of student interactions with patients does not meet the school-based criteria, specific mechanisms must be in place to adjust the criteria or to alter the educational program. Either may be done only within appropriate, documented means that ensure continued educational quality.

The curriculum must provide grounding in the body of knowledge represented in the disciplines that support the fundamental clinical subjects, for example, diagnostic imaging and clinical pathology. Students must have opportunities to gain knowledge in those content areas that incorporate several disciplines in providing medical care, for example, emergency medicine and the care of the elderly and disabled. In addition, students should have the opportunity to participate in research and other scholarly activities of the faculty.

The committee responsible for curriculum must require close faculty supervision of the learning experience of each student at the appropriate level of graded clinical responsibility. Supervision must be provided throughout required clerkships by members of the school's faculty. The required clerkships should be conducted in a teaching hospital or ambulatory care facility where residents in accredited programs of graduate medical education, under faculty guidance, may participate in teaching the students. Residents must be fully informed about the educational objectives of the clerkships and be prepared for their roles as teachers and evaluators of medical students. In an ambulatory care setting, if faculty supervision is present, resident participation may not be required.

The faculty committee responsible for curriculum should develop, and the chief academic officer should enforce, the same rigorous standards for the content of each year of the program leading to the M.D. degree. The final year should complement and supplement the curriculum so that each student will acquire appropriate competence in general medical care regardless of subsequent career specialty.

The curriculum should include elective courses designed to supplement the required courses and to provide opportunities for students to pursue individual academic interests. Faculty advisors must guide students in the choice of elective courses. If students are permitted to take electives at other institutions, there should be a system centralized in the dean's office to screen the students' proposed extramural programs prior to approval and to ensure the return of a performance appraisal by the host program. Another system, devised and implemented by the dean, should verify the credentials of students from other schools wishing to take courses or clerkships at the school, approve assignments, maintain a complete roster of visiting students, and provide evaluations to the parent schools.

All instruction should stress the need for students to be concerned with the total medical needs of their patients and the effect on their health of social and cultural circumstances. The curriculum should prepare students for their role in addressing the medical consequences of common societal problems, for example, providing instruction in the diagnosis, prevention, appropriate reporting and treatment of violence and abuse. A medical school must assure that its students learn and exhibit scrupulous ethical principles in caring for patients, and in relating to patients' families and to others involved in the care of patients. The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient.

In view of the increasing pace of discovery of new knowledge and technology in medicine, the LCME encourages experimentation that will increase the efficiency and effectiveness of medical education. Experiments should have carefully defined goals and plans for implementation, including methods of evaluating the results. Planning for educational innovation should consider the incremental resources that will be required,

including demands on library facilities and operation, information management needs and computer hardware and software.

The LCME must be notified of plans for major modification of the curriculum, so that the term of accreditation of the program can be reconsidered if judged necessary.

Evaluation of Student Achievement; Due Process

The medical school faculty must establish principles and methods for the evaluation of student achievement, and make decisions regarding promotion and graduation. The evaluation of student achievement must employ a variety of measures of knowledge, competence and performance, systematically and sequentially applied throughout medical school. There should be specific attention to the development of problem-solving and clinical reasoning abilities. Each provisionally accredited program must utilize methods for determining the quality of its program and the level of achievement of its students compared to national norms.

The faculty of each discipline should set the standards of achievement by students in the study of that discipline. Narrative descriptions of student performance and of non-cognitive achievements should be recorded to supplement grade reports in all required clinical clerkships and in all courses where student-faculty interaction permits this form of assessment. The faculty committee should review the frequency of examinations and their scheduling, particularly when the students are enrolled in several subjects simultaneously. The LCME urges schools to develop a system of evaluation that fosters self-initiated learning by students, and disapproves of the use of frequent tests which condition students to memorize details for short-term retention only. Institutions must develop a system of assessment which assures that students have acquired and can demonstrate on direct observation the core clinical skills, behaviors, and attitudes needed in subsequent medical training. Communication skills are integral to the education and effective function of physicians. There must be specific instruction and evaluation of these skills as they relate to physician responsibilities, including communication with patients, families, colleagues and other health professionals.

There must be comparable educational experiences and equivalent methods of evaluation across all alternative instructional sites within a given discipline. If geographically separated campuses are operated, a single standard for promotion and graduation of students should be applied.

The medical school must publicize to all faculty members and students its standards and procedures for the evaluation, advancement, and graduation of its students and for disciplinary action. There should be a fair and relatively formal process for the faculty or administration to follow when taking any action that adversely affects the status of a student. The process should include timely notice of the impending action, disclosure of the evidence on which the action would be based, and an opportunity for the student to respond. A student's records must be available for review by the student, and the student must have the right and be given the opportunity to challenge the accuracy of the record. Student records must be confidential and should be made available only to members of the faculty and administration with a need to know, unless released by the student, or as otherwise governed by laws concerning confidentiality.

Academic Counseling and Career Guidance

The chief academic officer and the directors of all courses and clerkships must design and implement a system of evaluation of the work of each student during progression through each course or clerkship. Each student should be evaluated early enough during a unit of study to allow time for remediation. Academic advising is an inherent responsibility of the teaching faculty. The system of academic advising for students must integrate the efforts of faculty members, course directors, and student affairs officers with the school's counseling and tutorial resources. The faculty and the chief academic officer must establish a system to assist students in selecting a future medical career and in developing a strategy for application to residency programs. This system should not permit disruption of a student's curriculum in general medical education by external pressures to make premature application to residency programs. Letters of reference or other credentials should not be provided until the fall of the student's senior year.

Medical Students

Admissions

Generally, students preparing to study medicine should be encouraged to acquire a liberal education in addition to completing any required course in science. It is recognized that some students will choose to study a specific field in depth, according to their personal interests and abilities.

Each medical school should restrict its premedical course requirements to those subjects it considers essential to provide the student with the academic preparation necessary for the satisfactory completion of the medical school curriculum. Ordinarily, three or more years of undergraduate education are necessary to complete the requirements for entrance into medical school; however, special programs may allow this to be reduced.

The faculty of each school should develop criteria and procedures for the selection of students, which should be published and available to potential applicants and to their collegiate advisors. To further the accomplishment of its purposes, each medical school should have policies and practices addressing the gender, racial, cultural, and economic diversity of its students. Medical schools must strive to select students who possess the intelligence, integrity, and personal and emotional characteristics that are perceived necessary for them to become effective physicians.

While physical disability should not preclude a student from consideration for admission, each school should develop and publish technical standards for the admission of handicapped applicants, in accordance with legal requirements.

The selection of students for the study of medicine is the responsibility of the medical school faculty through a duly constituted committee. Persons or groups external to the medical school may assist in the evaluation of applicants, but the final responsibility must not be delegated outside the medical faculty. There must not be any political or financial influence on the selection of students. All factors utilized in the selection process must be made public.

A medical school's publications, advertising, and student recruitment should present a balanced and accurate representation of the mission and objectives of the educational program. The catalog or equivalent informational materials must describe all courses offered by the school, a complete description of the requirements for the M.D. degree and all associated degrees, the most recent academic calendar for each of the curricular options available, a description of the admissions process, and the enumeration of criteria used in the selection of students.

There must be no discrimination on the basis of sex, age, race, creed or national origin. Compliance with both written and implied public policy must be assured. The student body should be drawn from a wide spectrum of economic backgrounds. Advanced standing may be granted to students for work done prior to admission.

Geographically Separated Campuses - If geographically separated campuses are operated, the selection and assignment of all medical students is the ultimate responsibility of the degree granting school. Within reasonable limits, students should have the opportunity to move between the component programs of the school.

Recognizing that quality and quantity of educational opportunities may vary between components, it is recommended that transfer students with advanced standing be assigned for at least half their first academic year to that component of the school which offers the most complete program and broadest variety of resources and experiences.

Students assigned to a branch campus should receive the same privileges and access to student services as students on the main campus.

Transfer and Visiting Students - Differences in curricula across schools require that decisions about the transfer of students between schools be based on an assurance that the courses previously taken are compatible with the program to be entered. Accepted transfer students must have demonstrated achievements in premedical education and medical school that are comparable to those of students in the class they join. There must be sufficient institutional resources to accommodate the transfer of students. Transfer students may be accepted into the middle years of the curriculum, but must not be accepted into the final year of the program except under rare circumstances.

Students visiting from other schools for clinical clerkships and electives must possess qualifications equivalent to the students they will join in these experiences. There must be sufficient institutional resources to accommodate such students without significantly diminishing the resources available to students already enrolled. Visiting students must be registered by the school for the period in which they are visiting, so as to ensure that they satisfy the school's requirements for health records, immunizations, health insurance, and liability protection.

Consideration of Class Size - The number of students to be admitted is determined by the resources of the school and the number of qualified applicants. To achieve and maintain accreditation, each medical school must demonstrate that it has access to a pool of applicants sufficiently large and possessing national level qualifications to fill its first year class. The critical resources include finances, the size of the faculty, the variety of academic fields

represented, the library, the number and size of classrooms and student laboratories and the adequacy of equipment, and office and laboratory space for the faculty. There should be available a spectrum of clinical resources sufficiently under the control of the faculty to ensure breadth and quality of bedside and ambulatory clinical teaching.

When determining the size of the medical student body, the school should consider the need to share resources to educate graduate students or other students within the university; the size and variety of programs of graduate medical education, both as a responsibility and as a supplement to the teaching program; and responsibilities for continuing education, patient care, and research.

Financial Aid; Tuition and Fee Refund Policy

A medical school must provide students with effective counseling about financial aid. To the extent possible, a school should develop its own resources for providing financial aid to students, thereby reducing their dependence upon external sources.

Institutions must make available clear, fair, and equitable policies for the refund of tuition, fees and other allowable payments in accordance with applicable state and federal laws.

Amenities for Students

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. The medical school should have an appropriate security system for its personnel and all properties.

Personal Counseling; Student Health Services

A school must have an effective system of personal counseling for students. The faculty and administrators should determine whether personal counsel is to be provided by an officer of administration, by assignment of faculty members or others for this purpose, or both. There should be a program to promote the mental well-being of students and facilitate adjustment to the physical and emotional demands of medical school. Confidential counseling by mental health professionals must be available to students.

There must be a system for preventive and therapeutic health services to students, to make health insurance available to all students and their dependents, and to make disability insurance available to students. Medical schools should follow

Centers for Disease Control and Prevention (or the Laboratory Center for Disease Control, in Canada) and/or relevant state (or provincial, in Canada) guidelines in determining which immunizations are appropriate for medical students. Schools must develop policies dealing with students' exposure to infectious and environmental hazards. The policies must include: (1) education of students about methods of prevention; (2) the procedures for care and treatment after exposure, including definition of financial responsibility; (3) and the effects of infectious and/or environmental disease or disability on student education activities.

The Learning Environment

Each medical school or its parent university should define the standards of conduct in the teacher-learner relationship. Schools should develop and widely promulgate written procedures that allow medical students to report violations of these standards—such as incidents of harassment or abuse—without fear of retaliation. The procedures also should specify mechanisms for the prompt handling of such complaints, and for the educational methods aimed at preventing student mistreatment.

Resources for the Educational Program

Finances

The substantial cost of conducting an accredited educational program leading to the M.D. degree should be supported from diverse sources, including income from tuition, endowments, earnings by the faculty, parent university, annual gifts, grants from organizations and individuals, and appropriations by government. Undue pressure for institutional self-financing must not compromise the educational mission of the medical school. Dependence upon tuition must not cause schools to seek enrollment of more students than their total resources can accommodate.

General Facilities

A medical school must have, or be assured use of, buildings and equipment that are quantitatively and qualitatively adequate to provide an environment conducive to high productivity of faculty and students. Geographic separation between facilities may be dysfunctional. The facilities must include faculty offices and research laboratories, student classrooms and laboratories, amenities for students, offices for

administrative and support staff, and a library. Access to an auditorium sufficiently large to accommodate the student body is desirable. The school should be equipped to conduct biomedical research and must provide facilities for humane care of animals when animals are used in teaching and research.

Faculty

Members of the faculty must have the capability and continued commitment to be effective teachers. Effective teaching requires knowledge of the discipline and an understanding of curricular design and pedagogy. The administration and the faculty should understand and employ methods to assess student performance that show the extent to which stated educational objectives are achieved.

Persons appointed to a faculty position must have demonstrated achievements within their disciplines commensurate with their faculty rank. The recruitment and development of a medical school's faculty should take into account its mission, the diversity of its student body, and the populations that it serves. It is expected that faculty members will have a commitment to continuing scholarly productivity, thereby contributing to the educational environment of the medical school.

In each of the major disciplines basic to medicine and in the clinical sciences, a critical mass of faculty members must be appointed who possess, in addition to a comprehensive knowledge of their major disciplines, expertise in one or more subdivisions or specialties within each of these disciplines. In the clinical sciences, the number and kind of specialists appointed should relate to the amount of patient care activities required to conduct meaningful clinical teaching at the undergraduate level, as well as for graduate and continuing medical education.

Physicians practicing in the community can make a significant contribution to the educational program of the medical school, subject to individual expertise, commitment to medical education, and availability. Practicing physicians appointed to the faculty, either on a part-time basis or as volunteers, should be effective teachers, serve as role models for students, and provide insight into contemporary methods of providing patient care. The quality of an educational program is enhanced by the participation of volunteer faculty in faculty governance, especially in defining educational goals and objectives.

There must be clear policies for the appointment, renewal of appointment, promotion, granting of tenure and dismissal of members of the faculty. The appointment process must involve the

faculty, the appropriate departmental heads, and the dean. Each appointee should receive a clear definition of the terms of appointment, responsibilities, line of communication, privileges and benefits, and policy on practice earnings. Faculty members should receive regularly scheduled feedback on their academic performance and their progress towards promotion. Opportunities for professional development should be provided to enhance faculty members' skills and leadership abilities in teaching and research.

The education of both medical students and graduate physicians requires an academic environment that provides close interaction between faculty members, so that those skilled in teaching and research in the basic sciences can maintain awareness of the relevance of their disciplines to clinical problems. Such an environment is equally important for clinicians, for from the sciences basic to medicine comes new knowledge which can be applied to clinical problems. A medical school should endeavor to provide a setting in which all faculty members work closely together in teaching, research, and health care delivery, to disseminate existing knowledge and to generate new knowledge of importance to the health and welfare of mankind.

Graduate medical education and graduate education in the biomedical and behavioral sciences are important parts of the academic environment of a medical school. There should be regular institutional review of the graduate programs in which medical school faculty participate, addressing the quality of education, the research and scholarship of the faculty, and the progress and achievement of the trainees.

The dean and a committee of the faculty should determine medical school policies. This committee typically consists of the heads of major departments, but may be organized in any manner that brings reasonable and appropriate faculty influence into the governance and policymaking processes of the school. The full faculty should meet often enough to provide an opportunity for all to discuss, establish, and otherwise become acquainted with medical school policies and practices.

A medical school should have policies which deal with circumstances in which the private interests of its faculty or staff may conflict with their official responsibilities.

Library

The medical school must have a well-maintained and catalogued library, sufficient in size and breadth

to support the educational programs offered by the institution. The library should receive the leading biomedical and clinical periodicals, the current numbers of which should be readily accessible. The library and any other learning resources should be equipped to allow students to learn new methods of retrieving and managing information, as well as to use self-instructional materials. A professional library staff should supervise the library and provide instruction in its use.

If the library serving the medical school is part of a medical center or university library system, the professional library staff must be responsive to the needs of the medical school, its teaching hospitals, the faculty, resident staff, and students who may require extended access to the journal and reference book collections. The librarian should be familiar with the methods for maintaining relationships between the library and national library systems and resources, and with the current technology available to provide services in non-print materials. If the faculty and students served by the library are dispersed, the utilization of departmental and branch libraries should be facilitated by the librarian and by the administration and faculty of the school.

The library should also be a community resource in support of continuing medical education.

Clinical Teaching Facilities

The medical school must have adequate resources to provide clinical instruction to its medical students. A hospital or other clinical facility that serves as a base for the education of both medical students and residents must have adequate instructional facilities and information resources for the medical staff, residents, and students.

There must be written affiliation agreements between the medical school and its clinical affiliates that define the responsibilities of each party. In all relationships between medical schools and clinical affiliates, the academic programs for medical student education must remain under the control of the school's faculty. Department heads and faculty must have authority consistent with their responsibility for the instruction of medical students. The LCME should be advised of anticipated changes in affiliation status of a program's teaching hospitals.

PART THREE

EXPLANATORY ANNOTATIONS
FOR SELECTED ACCREDITATION STANDARDS

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EXPLANATORY ANNOTATIONS FOR SELECTED ACCREDITATION STANDARDS

The LCME is engaged in a process of reviewing the validity, reliability, and clarity of its accreditation standards. One of the outcomes of this review process is the development of explanatory annotations to clarify the operational meaning of selected accreditation standards. The first set of such annotations is provided below. These annotations are designed to help schools and surveyors understand more clearly the intent of the standard, as well as to indicate ways in which compliance with the standard is assessed. Although some of the annotations use the words "must" or "should" they ought not to be taken as standards on their own.

Additional annotations will be forthcoming as the process for reviewing standards progresses.

<p>EDUCATIONAL OBJECTIVES (page 11)</p> <p>A medical school must define its educational objectives and make them known to faculty, residents, and students.</p>	<ol style="list-style-type: none">1. Educational objectives are statements of the items of knowledge, skills, behaviors, and attitudes that students are expected to exhibit as evidence of their achievement. They are not statements of mission or broad institutional purpose, such as education, research, health care, or community service. Educational objectives state what students are expected to learn, not what is to be taught.2. Student achievement of these objectives must be documented by specific and measurable outcomes (e.g., USMLE results, measures of basic science grounding in the clinical years, performance of graduates in residency training, performance on licensing examinations, etc.).3. National norms should be used for comparison whenever available.
<p>INSTITUTIONAL ACCREDITATION (page 11)</p> <p>Additionally, if not a component of a regionally accredited institution, a U.S. medical school must achieve institutional accreditation (or pre-accreditation as a first step to achieving full accreditation) from the appropriate regional association for accreditation of colleges and universities, both as an aid in achieving its total institutional goals and to comply with the conditions and scope of the LCME's program accreditation designated by the U.S. Dept. of Education.</p>	<ol style="list-style-type: none">1. The LCME is recognized by the U.S. Department of Education as an accrediting agency for educational programs, specifically for the accreditation of medical education programs leading to the M.D. degree. Because the LCME is not recognized as an institutional accrediting agency, it lacks standing to accredit stand-alone medical schools as institutions of higher education.2. Institutional accreditation is granted by regional accrediting agencies, and is required to qualify for federal financial assistance programs authorized under Title IV of the Higher Education Act.

**CURRICULUM DESIGN AND
MANAGEMENT (page 12)**

There must be integrated institutional responsibility for the design and management of a coherent and coordinated curriculum.

1. **Integrated institutional responsibility:** The standard implies that an institutional body, (commonly a curriculum committee) will design, manage, and evaluate the educational program. An effective central curriculum authority will exhibit:
 - a. Faculty, student, and administrative participation.
 - b. Expertise in curricular design, pedagogy, and evaluation methods.
 - c. Empowerment, through bylaws or decanal mandate, to work in the best interests of the institution without regard for parochial or political influences, or departmental pressures.
2. **Coherent and coordinated curriculum:** The program as a whole will be designed to achieve the school's overall educational objectives. Evidence of coherence and coordination includes:
 - a. Methods of pedagogy and student evaluation that are appropriate for the achievement of the school's educational objectives.
 - b. Logical sequencing of the various segments of the curriculum.
 - c. Content that is coordinated and integrated within and across the academic periods of study (horizontal and vertical integration).
3. **Curriculum management:** Management signifies leading, directing, coordinating, controlling, planning, evaluating, and reporting. Evidence of effective curriculum management includes:
 - a. Evaluation of program effectiveness by outcomes analysis, using national norms of accomplishment as a frame of reference.
 - b. Monitoring of content and workload in each discipline, including the identification of omissions and unwanted redundancies.
 - c. Review of the stated objectives of courses and clerkships, as well as methods of pedagogy and student evaluation, to assure congruence with institutional educational objectives.
4. Minutes of the curriculum committee and reports to the faculty governance and deans should document that such activities take place and should show the committee's findings.

RESOURCES AND AUTHORITY OF THE CHIEF ACADEMIC OFFICER (page 12)

The chief academic officer must have sufficient resources and authority provided by the institution to fulfill this responsibility [for the design and management of a coherent and coordinated curriculum].

1. The dean often serves as the chief academic officer, with ultimate individual responsibility for the design and management of the educational program. He or she may, however, delegate operational responsibility for curriculum management and implementation to a vice dean or associate dean.
2. The kinds of resources needed by the chief academic officer to assure appropriate design and management of the educational program include:
 - a. Adequate numbers of teachers who have the time and training necessary to achieve the program's objectives.
 - b. Appropriate teaching space for the methods of pedagogy employed in the educational program.
 - c. Appropriate educational infrastructure (computers, audiovisual aids, laboratories, etc.).
 - d. Educational support services, such as examination grading, classroom scheduling, and faculty training in methods of teaching and evaluation.
 - e. Support and services for the efforts of the curriculum management body and for any interdisciplinary teaching efforts that are not supported at a departmental level.
3. The chief academic officer must have explicit authority to ensure the implementation and management of the educational program, and to facilitate change when modifications to the curriculum are determined to be necessary.

DEMONSTRATION OF ETHICAL PRINCIPLES (page 14)

A medical school must assure that its students learn and exhibit scrupulous ethical principles in caring for patients, and in relating to patients' families and others involved in the care of patients.

1. A school should assure that students receive instruction in medical ethics, human values, and communication skills before engaging in patient care activities. As students take on increasingly more active roles in patient care during their progression through the curriculum, adherence to ethical principles should be observed and evaluated, and reinforced through formal instructional efforts.
2. In student-patient interactions there should be a means for identifying possible breaches of ethics in patient care, either through faculty/resident observation of the encounter, patient reporting, or some other appropriate method.
3. "Scrupulous ethical principles" imply characteristics like honesty, integrity, maintenance of confidentiality, and respect for patients, patients' families, other students, and other health professionals. The school's educational objectives may identify additional dimensions of ethical behavior to be exhibited in patient care settings.

EVALUATION OF STUDENT ACHIEVEMENT
(page 14)

The evaluation of student achievement must employ a variety of measures of knowledge, competence, and performance, systematically and sequentially applied throughout medical school. There should be specific attention to the development of problem-solving and clinical reasoning abilities.

1. The system for evaluating student achievement should include methods of assessment that indicate the extent to which students have achieved institutional educational objectives across the domains of knowledge, skills, behaviors, and values/attitudes.
2. Evaluations of student performance should measure not only cognitive learning, but also performance of the core clinical skills, behaviors, and attitudes needed in subsequent medical training and practice, and the ability to use data appropriately for solving problems commonly encountered in medical practice.

COMPARABILITY OF EDUCATIONAL EXPERIENCES ACROSS ALTERNATIVE SITES OF INSTRUCTION
(page 14)

There must be comparable educational experiences and equivalent methods of evaluation across all alternative instructional sites within a given discipline.

1. Compliance with this standard requires that educational experiences given at alternative sites have the same educational objectives. Course duration or clerkship length must be identical. The instruments and criteria used for student evaluation, as well as policies for the determination of grades, will be the same at all alternative sites. The faculty who teach at various sites will be sufficiently knowledgeable in the subject matter to provide effective instruction, and will have a clear understanding of the objectives of the educational experience and the evaluation methods used to indicate achievement of those objectives. Opportunities to enhance teaching and evaluation skills should be available for faculty at all instructional sites.
2. While the types and frequency of problems or clinical conditions seen at alternate sites may vary, each course or clerkship must identify any core experiences needed to achieve its objectives, and assure that students receive sufficient exposure to such experiences by some appropriate means. Likewise, the proportion of time spent in inpatient and ambulatory settings may vary according to local circumstance, but in such cases the course or clerkship director must assure that limitations in learning environments do not impede the accomplishment of objectives.
3. To facilitate comparability of educational experiences and equivalency of evaluation methods, the course or clerkship director should orient all participants, both faculty and students, about the educational objectives and grading system used. This can be accomplished through regularly scheduled meetings between the director or the course or clerkship and the directors of the various sites that are used.
4. The course/clerkship leadership should review student evaluations of their experiences at alternative sites to identify any persistent variations in educational experiences or evaluation methods.

**QUALIFICATIONS OF THE
FACULTY AS TEACHERS**
(page 17)

Members of the faculty must have the capability and commitment to be effective teachers. Effective teaching requires knowledge of the discipline and an understanding of curricular design and pedagogy.

1. This standard implies that faculty members involved in teaching, course planning, and curricular evaluation will have or have ready access to expertise in teaching methods, curriculum development, program evaluation, and student evaluation. Such expertise may be supplied by an office of medical education or by faculty/staff members with backgrounds in educational sciences.
2. Formal faculty development programs or consultation with experts in the educational sciences should be available to faculty.
3. Faculty involved in the development and implementation of a course, clerkship, or larger curricular unit should be able to design the learning activities and corresponding evaluation methods in a manner consistent with stated educational objectives.
4. The planning of curricular units should include internal and external formal evaluations of those units, and incorporate the findings of such evaluations when contemplating revisions.
5. Among the lines of evidence indicating compliance with this standard are the following:
 - a. Documented participation of the faculty in professional development activities related specifically to teaching and evaluation.
 - b. Attendance at regional or national meetings on educational affairs.
 - c. Evidence of currency of knowledge in a faculty member's discipline (through CME participation, publications, presentations at meetings, etc.).

FACULTY KNOWLEDGE OF STUDENT EVALUATION METHODS
(page 17)

The administration and faculty should understand and employ methods to assess student performance that show the extent to which stated institutional objectives are achieved.

1. To meet the requirements of this standard the chief academic officer, curriculum leaders, and faculty should understand, or have access to individuals who are knowledgeable about, methods for measuring student performance. The school should provide opportunities for faculty members to develop their skills in such methods.
2. Those directly responsible for the evaluation of student performance should understand the uses and limitations of various test formats, the purposes and benefits of criterion-reference vs. norm-referenced grading, reliability and validity issues, formative vs. summative assessment, etc. Such understanding will promote the development of evaluation methods appropriate for the school's educational objectives and facilitate the interpretation of student performance in the context of national norms.

EDUCATIONAL RESOURCES AT CLINICAL TEACHING SITES
(page 18)

A hospital or other clinical facility that serves as a base for the education of medical students must have adequate instructional facilities and information resources for the medical staff, residents, and students.

1. Compliance with this standard requires that, in clinical facilities where medical students are taught, appropriate resources for teaching and learning be present or conveniently available. Among these resources are areas for individual study, for conferences, and for lectures.
2. Information resources, including current library holdings and access to other library systems, must be sufficient for educational purposes and either present in the facility or readily available in the immediate vicinity.
3. A sufficient number of computers or other forms of information technology are required for Internet access to the literature and to other educational software or resources.

AFFILIATION AGREEMENTS
(page 18)

There must be written affiliation agreements between the medical school and its clinical affiliates that define the responsibilities of each party.

1. The nature of the relationship between the medical school and its clinical affiliates is extremely important. Written affiliation agreements codify mutual expectations and responsibilities and avoid misunderstandings.
2. It is particularly important to have written agreements with affiliates whose facilities are used for core clerkships, to assure that demands for patient care do not conflict with the educational needs of the medical school. At a minimum, schools must have written agreements with those health care facilities where medical students take required clerkships on a regular basis.
3. Where circumstances warrant, schools may also need to enter into agreements with clinical facilities that provide financial support or serve as sites for graduate medical education, occasional use in required clerkships, or electives.

AFFILIATION AGREEMENTS (cont.)

4. Among the issues that ought to be addressed in affiliation agreements are the following:
 - a. An affirmation of commitment by the health care facility to the education of medical students.
 - b. Primacy of the medical school over academic affairs and the education and evaluation of students.
 - c. The role of the medical school in appointments/ assignments of faculty members responsible for teaching students.
 - d. The procedures and authorities to investigate and adjudicate complaints about unprofessional behavior, or to take disciplinary action.
 - e. The mechanics of notifying the school and students about the facility's requirements for patient safety.
 - f. Specification of the parties responsible for treatment and follow-up when students are accidentally exposed to environmental hazards or infectious diseases.

AUTHORITY OF THE MEDICAL SCHOOL FOR ACADEMIC PROGRAMS IN AFFILIATED CLINICAL SITES (page 18)

In all relationships between medical schools and clinical affiliates, the academic programs for medical student education must remain under the control of the school's faculty. Department heads and faculty must have authority consistent with their responsibility for the instruction of medical students.

1. In clinical facilities that provide an instructional setting for medical students, the structure and evaluation of clinical experiences must be determined by the medical school's faculty.
2. If department heads of the school are not also the clinical service chiefs at affiliated institutions, the affiliation agreement must confirm the authority of the department head to assure faculty and student access to appropriate clinical resources for medical student education.
3. The responsibility of the clinical facility for patient care should not diminish or preclude opportunities for medical students to undertake patient care duties under the appropriate supervision of medical school faculty and residents.