SURVEY REPORT GUIDE

FOR FULL AND LIMITED LCME & CACMS SURVEY VISITS
CONDUCTED IN THE 2012-2013 ACADEMIC YEAR

LIAISON COMMITTEE ON MEDICAL EDUCATION

**COMMITTEE ON THE ACCREDITATION OF
CANADIAN MEDICAL SCHOOLS**

www.lcme.org

Survey Report Guide 2012-13

Liaison Committee on Medical Education
Committee on the Accreditation of Canadian Medical Schools

For additional information, contact:

LCME Secretariat
Association of American Medical Colleges
2450 N Street N.W.
Washington, DC 20037
Telephone: 202-828-0596   Fax: 202-828-1125

LCME Secretariat
American Medical Association
515 North State Street
Chicago, IL 60654
Telephone: 312-464-4933   Fax: 312-464-5830

Secretariat
Committee on Accreditation of Canadian Medical Schools
Association of Faculties of Medicine of Canada
265 Carling Avenue, Suite 800
Ottawa, Ontario, Canada K1S 2E1
Telephone: 613-730-0687   Fax: 613-730-1196

**Visit the LCME Web site at
www.lcme.org**

INTRODUCTION

The report of an accreditation survey is the formal record of the survey team's findings related to accreditation standards. It serves as the primary source of information for accreditation decisions by the Liaison Committee on Medical Education (LCME) and the Committee on the Accreditation of Canadian Medical Schools (CACMS).

Each survey team must take the utmost care to ensure that its summary findings are fully explained and documented in the body of the report, and that all accreditation standards are accounted for. The medical school or college should take great care in verifying that the information contained in the report is factually correct for the time during which the survey visit took place. The survey report is based on information contained in the Medical Education Database and provided to the survey team on-site. No new information will be considered for the report after the survey team concludes the visit. If the dean of the medical education program involved disagrees with the tone of the report or the findings of the survey team, that disagreement should be communicated to the team secretary when the draft report is reviewed. If a disagreement persists after the team has had an opportunity to discuss the dean's concerns, the dean may send a letter to the LCME Secretariat and, for Canadian programs, the CACMS Secretariat describing any objections to the process of the visit or the tone of the report. No new information may be supplied by the dean. That letter would then be included in the meeting agenda and considered along with the survey report when the LCME and the CACMS (for Canadian programs) evaluate the program's accreditation status.

BACKGROUND

The school has invested considerable effort in the preparation of the medical education database and the institutional self-study. Survey team members are expected to have reviewed this material before the visit. While on site, the team may also want to review the unabridged self-study committee reports and other relevant documentation.

Typically, each school completes a comprehensive, fair, and accurate self-study. There may be cases, however, in which the self-study may not accurately portray prevailing circumstances or may express greater optimism about the existing state of affairs than seems evident to the surveyors. Surveyors should validate the information in the medical education database and the bases of conclusions drawn by the school's self-study task force. Because some of this information was compiled as long as a year before the accreditation visit, it is important to note whether major issues have been addressed in the interim and whether any new concerns have emerged.

The Secretariat staff is available to assist team secretaries in preparing the draft report. For surveys of US medical schools, both LCME Co-Secretaries should receive a copy of the narrative of the draft report before the draft is sent to the team and the school. For surveys of Canadian schools, the draft report should be sent to the CACMS Secretary for first review.

The Secretariat will provide feedback to the team secretary based on a review of the draft report. After receiving the Secretariat feedback about the preliminary report and making any necessary revisions, the team secretary circulates the report to team members and the dean for final review and then makes any corrections. If the dean disagrees with the tone or findings of the report, that disagreements should be communicated to the team secretary. In his or her comments, the dean may not supply new information that was not contained in the database or supplied to the team on site. The dean's comments should be considered by the survey team and revisions to the draft report made, if warranted. The dean should then be informed of the changes that have, and have not, been made to the report. If the dean has remaining concerns about the tone of the report or the process of the visit, he or she may send a letter to the LCME

Secretariat and, for Canadian schools, to the CACMS Secretariat. This letter will be considered by the LCME and by CACMS, for Canadian schools.

RESPONSIBILITIES OF TEAM SECRETARY

Portions of the survey report specifically assigned to individual team members should be completed on site or sent to the team secretary within 7-10 days after the visit. The team secretary and the chair should require team members to use this guide when preparing their individual sections and to use the guidelines for report preparation contained the Style Guide (page 36 of this document). The team secretary should use the survey report template, including embedded tables, to ensure consistency across survey team reports.

The team secretary is expected to complete the draft report shortly after the visit (six weeks is optimum). The secretary is responsible for organizing and editing the contributions from the other team members to ensure that the overall report is complete, coherent, logical, and internally consistent. If important areas have been omitted from a team member's write-up, it is the team secretary's responsibility either to contact that member for additional details or to supply the missing content.

This guide lists some figures and tables, based on the medical education database, that should be included in the report as appendices. Team members and the team secretary should feel free to include additional appendix material; however, this extra material should be selected judiciously.

It is essential that the team secretary compare the body of the draft report with the set of strengths, areas of compliance with a need for monitoring, and areas of noncompliance identified by the survey team to ensure that all summary findings are well documented in the text and to ensure that the reported strengths, areas in compliance with a need for monitoring, and noncompliance areas are internally consistent. The team secretary should edit the report for the propriety of any attributions of comments made during the survey visit to individual faculty members, administrators, or students. Although the comments of individuals who met with the team may be important for documentation, citation of the source of such specific comments in the report should typically be avoided.

The draft survey report should first be sent by for initial review to the two LCME Co-Secretaries and, for reports of Canadian programs, to the CACMS Secretary. The draft report narrative should be sent by e-mail. There is no need to send the appendices; the LCME Secretariat will ask for a copy of the appendix materials, if needed.

After the team secretary has received feedback from the Secretariat, the report should be modified, as necessary. It is expected that the team chair and secretary will take the Secretariat comments very seriously and make the recommended changes. The report should then be distributed to each member of the survey team and to the dean of the medical school. The team secretary should ask for return of any comments within 10 working days. The communication with the dean should include the statement that no information that was not included in the medical education database or provided to the team on-site will be considered, even if the information (i.e., the policy) existed at the time of the survey visit. If feedback from team members requires changes in the report's findings, tone, or content that the dean has not had an opportunity to review, the secretary should call the dean or send revised pages for decanal review before finalizing the report. The team secretary should be aware of two important timing issues regarding survey reports: that LCME meetings typically are held in the first week of October, February, and June and that LCME members must have access to the final report a minimum of four weeks before the meeting. The CACMS meets in late September, January and May, and members must have access to reports for at least four weeks. This requires that the team secretary submit the final report to the LCME Secretariat at least five weeks before a scheduled LCME meeting (and CACMS meeting, for Canadian schools).

The dean should specifically be asked to correct, by email or in writing, any errors of fact. When there are no corrections, the dean also should state that fact in writing.. The team chair and secretary should attempt to resolve any disagreements that the dean may have with the tone or conclusions of the report. The dean should be informed of the changes that have been, and have not been, made in the report. If significant irreconcilable differences remain, the dean should be invited to write a letter to the LCME Secretariat and, for Canadian programs to the CACMS Secretary. That letter must only address concerns about the process of the visit or about the tone of the report. No new information may be provided and no attachments will be accepted. The letter would be included in the meeting agenda and considered along with the survey report when the LCME (and, if relevant, the CACMS) evaluate the program's accreditation status.

The final, corrected report (with all appendices) should be sent electronically to the LCME Secretariat offices, along with copies of all correspondence between the team secretary and the dean regarding the draft report. Reports for Canadian programs should be sent to both the CACMS and LCME offices. See "Style Guide for Report Preparation" later in this document for details about how to format and submit the final report.

COMPLIANCE DEFINITIONS

It is the responsibility of the survey team to make a judgment of whether the medical education program is in compliance with each accreditation standard. Teams should use the following definitions when making this determination for each accreditation standard:

In Compliance:
The required policy, process, resource, or system is in place and, if required by the standard, there is evidence to indicate that it is effective.

In Compliance with a Need for Monitoring:
1) The medical education program has the required policy, process, resource, or system in place, but there is insufficient evidence to indicate that it is effective. Therefore, monitoring is required to ensure that the desired outcome has been achieved.
2) The medical education program is currently in compliance with the standard, but known circumstances exist that could lead to future noncompliance [replaces the previous finding of "area in transition"]

Noncompliance:
The medical education program has not met one or more of the requirements of the standard. The required policy, process, resource, or system either is not in place or is in place, but has been found to be ineffective.

THE REPORT OF A FULL ACCREDITATION SURVEY

COVER PAGE. Use the cover page from the survey report template, adding specific details such as school name and survey date.

TABLE OF CONTENTS (including that for the Appendix). See sample in the survey report template. Make sure that all Appendix documents are listed. The document should be paged sequentially, including the Appendix.

MEMORANDUM (from the survey team secretary to the LCME and, when relevant, to the CACMS). See sample in the survey report template.

INTRODUCTION AND COMPOSITION OF THE SURVEY TEAM

A typical example:

> A survey of the University of Eastchester School of Medicine was conducted on December 1-4, 2011, by an *ad hoc* team representing the Liaison Committee on Medical Education (LCME)[and the Committee on the Accreditation of Canadian Medical Schools *for Canadian medical schools]*. The team expresses its appreciation to Dean William Osler and the administrative staff, faculty, and students for their interest and candor during the survey visit. Associate Dean Benjamin Rush and Ms. Dorothea Dix deserve special thanks for the smooth coordination of the visit, tactful management of scheduling changes, and timely provision of additional items of information requested during the visit.

After the paragraph introduction, complete the section in the survey report template that lists the members of the survey team, with their names, titles, and institutions, as well as their roles on the survey team as chair, secretary, member, or faculty fellow:

Chair:
> Abraham Lincoln, MD   (Medicine)
> Dean, School of Medicine
> University of New Columbia
> Washington, DC

Secretary:
> Edwin Booth, MD   (Psychiatry)
> Associate Dean for Curriculum
> University of Baltimore School of Medicine
> Baltimore, MD

> Member: (Specialty/Discipline)

> Member: (Specialty/Discipline)

> LCME Faculty Fellow: (Specialty/Discipline)

For surveys of Canadian medical schools, indicate the LCME-appointed member and make appropriate edits as shown in the Survey Report Template for Canadian schools.

SUMMARY OF SURVEY TEAM FINDINGS

The summary of team findings should begin with the following text:

> **DISCLAIMER:** The summary that follows represent the findings of the *ad hoc* survey team that visited [school name] from [visit dates], based on the information provided by the school and its representatives before and during the accreditation survey, and by the LCME. The LCME may come to differing conclusions when it reviews the team's report and any related information. *(add CACMS for Canadian schools)*

Summarize the survey team's findings under each section of the standards, as contained in the LCME document *Functions and Structure of a Medical School,* which can be accessed from the LCME website at: www.lcme.org. The sections are "Institutional Setting," "Educational Program for the MD Degree," "Medical Students," "Faculty," and "Educational Resources." Under each of these sections, the team's

findings should be organized as:

> Areas of "Strength"
> Areas of "In Compliance with a Need for Monitoring"
> Areas of "Noncompliance."

Note that there may not be findings under each of these headings for each section. Each heading should be included and "none" should be listed if there are no findings for that section.

Areas of "Strength"

An area of strength is generally considered by the LCME and CACMS to represent either (1) an aspect of the medical school that has been shown to be critical for the successful achievement of one or more of the school's missions or goals or (2) a truly distinctive activity or characteristic that would be worthy of emulation. Strengths should contribute to positive institutional outcomes and should not simply reflect the school's compliance with accreditation standards.

Strengths should be linked to accreditation standards. Provide the number and text of the standard followed by a paragraph labeled "Finding" that describes why the area meets the definition of a strength.

An example of the preferred format follows:

> **ER-4. A medical education program must have, or be assured use of, buildings and equipment appropriate to achieve its educational and other goals.**
>
> Finding: The new medical education building is well-designed to support the needs of the revised curriculum and of students for comfortable and accessible study and relaxation space. Students in all years of the curriculum were consulted during the design of the building.

Areas of "In Compliance with a Need for Monitoring"

See the definition on page 3. Findings of in compliance with a need for monitoring require identification of the relevant accreditation standard. The preferred format for the report includes providing the number and text of the standard, followed by a paragraph or bulleted list labeled "Finding" delineating the specific outcome evidence that is lacking or the specific situation that could lead to noncompliance in the future.

Examples of the preferred format follow:

> **MS-23. A medical education program must provide its medical students with effective financial aid and debt management counseling.**
>
> Finding: There are individuals readily available to provide debt management counseling and other resources for debt management are available.. A debt management counseling system has been designed and sessions were implemented in the past academic year for students in third and fourth years of the curriculum. These have been positively received by students. Sessions for first and second year students began this academic year and data on student satisfaction are not yet available.
>
> **FA-2. A medical education program must have a sufficient number of faculty members in the subjects basic to medicine and in the clinical disciplines to meet the needs and missions of the program.**

Finding: There currently is a sufficient number of basic science faculty to support the educational program. Many faculty members are in the later stages of their careers and a number of retirements are anticipated in the next several years. There is no hiring plan and financial resources are limited to support new hires.

Areas of "Noncompliance"

Findings of noncompliance represent the team's judgment that a program does not fully comply with an accreditation standard at the time of the survey visit (see the definition on page 3). Findings of noncompliance require identification of the relevant accreditation standard. The preferred format for the report includes providing the number and text of the relevant standard, followed by a paragraph or bulleted list labeled "Finding" delineating the specific evidence indicating noncompliance. If the standard was cited as an area of noncompliance in the previous full or limited survey, include that information in the finding.

An example of the preferred format follows:

MS-24. A medical education program should have mechanisms in place to minimize the impact of direct educational expenses on medical student indebtedness.

Finding: Tuition has increased by an average of seven percent in each of the past four years, while the level of institutional funding for grants and scholarships has decreased by an average of three percent per year over that period. Student indebtedness has increased proportionally. On average, student indebtedness now exceeds $175,000, with federal loans comprising over 90% of the student debt portfolio. There is no concerted effort by the school of medicine or the university to increase the amount of scholarship support that is available. The level of student debt and the absence of scholarship support were cited as an area of noncompliance in the previous full survey.

If a noncompliance issue relates to multiple standards, the team should identify that standard which most closely reflects the underlying issue. Any related standards can be mentioned in the body of the report.

It is essential that areas of institutional strength, areas in compliance with a need for monitoring and areas of noncompliance be fully documented in the body of the report and, if relevant, supported by information in the Appendix. The documentation in the body of the report regarding noncompliance issues should give a sense of the relative magnitude of the problem, indicate if the problem has persisted for a lengthy period, and identify any progress that has been made toward resolution of the problem.

PRIOR ACCREDITATION SURVEY(S) AND STATUS REPORT(S)

Summarize the key findings, recommendations, and required follow-up actions of the most recent full accreditation survey. If there were one or more recent underlined limited surveys, summarize both these and the earlier full survey of the school. Briefly describe any status reports, as well as the resulting LCME action (or the LCME and CACMS action for Canadian schools) taken related to each cited area (for example, if it was determined that compliance has been achieved with an area of noncompliance). Give the dates of the prior survey(s) and reports. Feel free to use bullets, paraphrase, or combine items, as needed to be succinct. Summarize the progress made since the previous survey in addressing the areas of noncompliance and previous areas in transition (now defined as "in compliance with a need for monitoring") or indicate if the LCME determined that sufficient progress had not been made.

THE MEDICAL EDUCATION DATABASE AND INSTITUTIONAL SELF-STUDY

Comment on the quality of the medical education database, including its organization, completeness, and internal consistency Note if there were any gaps in the database or any difficulties for the team in securing needed information. Indicate whether quantitative data (e.g., applicant numbers, admissions data, USMLE/MCCQE scores, NRMP/CARMS results, financial information, etc.) were updated for the current year. Comment on the self-study in terms of the degree of participation by medical school faculty, administrators, students, and others; the comprehensiveness and depth of analyses; and the organization and quality of the conclusions and recommendations. Note the degree to which the survey team's major conclusions are consistent with those of the program's self-study. Include in the Appendix the listing of members of the various self-study task forces and committees and a copy of the overall or executive summary of the self-study findings (not the complete self-study report).

Comment on the methods used in the independent student analysis, including the level of student participation in he survey for each class year. Note whether/how the results of the student analysis will be used in the survey report. Also note if other sources of data, such as the Association of Medical Colleges Medical School Graduation Questionnaire (GQ) for US schools and the Canadian Graduation Questionnaire (AAMC CGQ) for Canadian schools, will be used in the report (and provide the response rate for the AAMC GQ or the AAMC CGQ, if these data are reported). Include in the Appendix the summary results of the independent student analysis, including summary data.

HISTORY AND SETTING OF THE SCHOOL

Briefly summarize the history of the school. Describe the medical school in terms of its public or private status and its organizational relationships with the parent university, health sciences center, geographically separate instructional sites/programs, and principal teaching hospital(s). Describe the geographic relationships of the main campus to major clinical teaching sites and, where appropriate, remote campuses; include relevant maps in the Appendix.

Conclude with the table from the Institutional Setting section of the medical education database. that compares selected data for the reference years used for the current database and for the previous full survey:

	[Previous Full Survey Year]	[Current Full Survey Year*]
Entering class size		
Total enrollment		
Residents & fellows		
Full-time basic science faculty		
Full-time clinical faculty		

($ in Millions)		
Total revenues		
Tuition and fees		
Parent University and state appropriations		
Research/training grants, direct		
Indirect cost recoveries		
Professional fee income		
Revenue from clinical affiliates		
Gifts and endowment		
Other revenues		

* data from (year)

Note on Organization of the Body of the Report

The body of the report should include the team's narrative description and comments, referring as needed to database items or other documents collated sequentially in the Appendix at the end of the report. **List each Appendix item at the beginning of the relevant section of the report.** Please make a reference in the narrative text to material that is included in the Appendix (e.g., "See charts of organization in the Appendix" or "See Appendix X for membership of admissions committee and characteristics of applicants and matriculants"). The Table of Contents should show the title and page number of each Appendix document.

In the narrative of the report, carefully differentiate between materials that represent team findings and quotes or excerpts from content provided by the institution.

Before and during the visit, the team secretary should collect original copies of handouts, database pages, and other information for incorporation, as appropriate, in the final report. Please follow carefully the "Style Guide for Report Preparation" at the end of this guidebook, especially the requirements that material be on one side of the page only and that the font style be Times New Roman, 11pt, as in the survey report template.

Note that the individual standards from *Functions and Structure of a Medical School* are linked to the items in this *Survey Report Guide*. This is meant to help the writer be complete in addressing the specific item. Do not include the reference to the standard number in the actual report write-up.

(Roman numerals and titles below match those in the medical education database and corresponding sections of the institutional self-study)

I. INSTITUTIONAL SETTING

Insert at least the following items from the medical education database in the Appendix. In the list below, these documents are referenced to the relevant accreditation standards. Refer to the Appendix items in the text of the report

- Summary of the medical school strategic plan (IS-1)
- Current entry in AAMC *Directory of American Medical Education,* and any changes that occurred since the entry was published (IS-11)
- Organizational chart(s) showing relationship of medical school to university and clinical affiliates (IS-8, IS-9)
- Dean's position description and brief résumé (IS-10)
- Organizational chart for dean's office and information on dean's staff (IS-11)
- Table showing enrollment in graduate programs in basic sciences (IS-12)
- Table(s) showing number of residents by specialty (IS-12)
- If not included in the narrative, the table on institutional diversity (IS-16)

In an introductory paragraph, briefly summarize the institution's mission and goals. Comment on the school's planning process in relation to its mission and goals and on the level of participation in the planning process. Report on whether the strategic plan has been updated recently and whether school has developed a timetable and appropriate outcome measures to judge progress in achieving its aims. (IS-1)

A. Governance and Administration

Describe whether the medical school is part of a not-for-profit institution or if it is part of a for-profit/investor-owned company (IS-2) Note whether the school or university holds regional accreditation, the name of the accrediting body, and the year of the next survey for regional accreditation (IS-3).

Briefly describe the procedure for appointing or renewing members of the oversight board for the medical school, including terms of office (IS-6). Note any policies for governing board members related to conflict of interest, and include any evidence that existing policies are being followed (IS-5). Summarize the role of the board in reviewing or approving medical school policies and procedures, including administrative and faculty appointments (IS-7).

Note if there are medical school or university bylaws and describe how these are made available to the faculty (IS-4).

Summarize the dean's responsibilities and reporting relationship and access to university officials (IS-8). If the dean does not hold the title of vice president for health affairs (or equivalent), identify the person who holds that title and describe the dean's reporting relationship to that individual (IS-9). Indicate the administrative mechanisms that link the dean with the heads of major teaching hospitals owned or operated by the medical school (IS-8). Evaluate the effectiveness of these relationships and note any problems (IS-9).

Summarize the credentials of the dean and the date of his or her appointment (IS-10). Evaluate the dean's relationship with university officials, clinical affiliates, department chairs, and faculty members that affect the educational program. Comment on the stability and on the consistency of the school's leadership and direction since the last full survey. Describe the staffing and organization of the dean's office. Assess whether the staffing is adequate and whether the division of responsibility is reasonable, effective, and understood by the faculty and students. Report on whether the students and faculty perceive the dean's staff to be accessible and able to solve problems; include relevant data documenting these findings (IS-11)

Indicate whether department chairs are appointed for a fixed period. Describe the mechanisms that exist for the periodic review of departments and their chairs. Note current department chair vacancies or long-standing acting/interim arrangements (IS-11). Comment on the extent of departmental budgetary authority and the adequacy of departmental budgets to achieve departmental and institutional goals (IS-11).

B. Academic Environment

Describe the graduate program(s) in the biomedical sciences, including their total enrollment and funding sources. Note if other degree programs (e.g., MPH, Masters of clinical science) also are the responsibility of medical school faculty. Indicate whether the institution conducts a regular and systematic review of its graduate programs and the content and process of these reviews (IS-12). Describe the participation of medical students in graduate programs, such as in joint MD/PhD programs. Evaluate the appropriateness of the size, adequacy of funding, and value of the graduate programs to research and education in the medical school, including medical education (IS-12).

Briefly describe the number of residents and the specialties in which residency programs exist (refer the reader to the Appendix for details). Report on whether the medical school or some other unit provides central oversight of the quality of the graduate medical education programs. Comment on whether the institutions that sponsor graduate medical education programs meet the Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME) or the corresponding requirements in Canada. Note whether the institution or any graduate medical education programs are on probation or are in danger of losing their accreditation. Identify any major disciplines with required clerkships or clerkship sites, such as distributed campuses, in which students have little or no contact with residents (IS-12). Briefly summarize opportunities for medical students to participate in or learn about continuing medical education programs sponsored by the school or its clinical affiliates (IS-12).

Describe the extent to which research is an institutional priority. Indicate whether there is sufficient funding and an appropriate infrastructure to support research, as well as whether an explicit strategy has been defined to pursue specific research directions or to accomplish a specific level of research productivity. Report on the presence or absence of departmental or individual research incentives. Comment on the degree of research involvement in the basic science and clinical departments (IS-13).

Describe the extent of medical student participation in research and whether participation in research is required or optional. Summarize the research options available to students, such as summer programs and/or dual degrees, and describe any funding to support medical student research. Describe how medical students are informed about research opportunities (IS-14).

Describe the opportunities for medical students to participate in service-learning activities. Indicate whether service-learning is required or optional. Describe how medical students are informed about opportunities for service learning and how participation is supported and encouraged (IS-14-A).

Note if the medical school or its parent university has formal policies and goals related to institutional diversity. Describe whether and how the medical school has characterized diversity for its students, faculty, and staff. Briefly describe how the policies related to diversity are reflected in: 1) student recruitment, selection, and retention; 2) financial aid; 3) the educational program; 4) faculty and staff recruitment, employment, and retention; 5) faculty development; and 6) community liaison activities. Summarize, by referencing the table on institutional diversity, the school's success in achieving diversity in the categories that it has defined for medical students, faculty, and staff (describe how the school has defined staff) (IS-16).

II. EDUCATIONAL PROGRAM FOR THE M.D. DEGREE

Insert at least the following items from the medical education database in the Appendix:

- A schematic showing the placement of courses and clerkships within each academic period (ED-5)
- The educational program objectives linked to competencies expected of a physician (ED-1, ED-1-A)
- The required clinical experiences expected of students (total or samples from selected clerkships) (ED-2)
- The table indicating the presence in the curriculum and the number of required sessions addressing the subjects required for accreditation (ED-10)
- The organizational chart for management of the curriculum (ED-33)
- The outcomes used to determine educational program effectiveness (ED-46)
- USMLE Step 1 and Step 2/MCCQE Part I (Canadian schools) performance data (number of students examined, percent passing, mean total score, mean national total score) for first-time takers for the three most recently available years (ED-46)

A. Educational Objectives

Summarize the objectives of the educational program[1], as defined by the school and note if they are stated in outcome-based terms (ED-1). Describe the extent to which the institutional learning objectives reflect general physician competencies such as those delineated by the ACGME and the American Board of Medical Specialties (ABMS) or in the CanMEDS 2005 report (ED-1-A). Describe how the objectives have been used as guides for curriculum planning and evaluation and for student assessment. Have, for example, course and clerkship objectives explicitly been linked to the educational program objectives? If so, include samples in the Appendix. (ED-1/ED-1-A)

Report whether the school has established specific criteria for the types of patients that students must encounter, the expected levels of student responsibility, and the appropriate clinical settings needed for students to meet the learning objectives for clinical education. Note the groups responsible for the creation and the approval of the required clinical encounters. Describe how, when, and by whom student clinical encounters are monitored. Have effective means been created to assure that all students have the required patient encounters? Note if options have been created for students who have not had the required clinical encounters (ED-2).

Indicate the means by which medical students, faculty members, and others with responsibility in the educational program are made aware of the educational program objectives (ED-3).

B. Structure of the Educational Program

1. General Design

Describe the general structure of the curriculum. The schematic diagram of the curriculum may be included as a figure either in the text or the Appendix. Include the total weeks of instruction and the weeks of scheduled instruction in each year (ED-4, ED-5).

Describe the opportunities that are in place for students to engage in active learning and independent study, including opportunities for students to assess their own learning needs; identify, analyze, and synthesize

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[1] Educational program objectives are the general knowledge, skills, behaviors, attitudes/values that students are expected to acquire and demonstrate; they are not the mission or goals of the school nor are they the objectives of individual courses.

information relevant to these learning needs; and assess the credibility of information sources. Are students assessed on and do students receive feedback on the development of these skills? In the report narrative, provide several examples of active learning that meets the requirements of the standard (ED-5-A).

Describe where in the curriculum students are introduced to and assessed on their development of the skills of critical judgment based on evidence and of medical problem-solving (ED-6). Are there opportunities for students to acquire knowledge and understanding of societal needs and demands on health care (ED-7)? Are there opportunities for students to directly apply the scientific method and make observations of biomedical phenomena (ED-12)?

If instruction takes place at more than one educational site within a given discipline, evaluate whether processes and procedures are in place to ensure that educational experiences and methods of assessment are comparable. Are there opportunities for communication among the individuals responsible for education across sites within a given discipline? Report on whether the same objectives, assessment methods, and policies for determination of grades are used across educational sites. In what ways is comparability reviewed at the department and central curriculum governance levels and what data are used in the review (ED-8)?

Comment on any recent changes in the curriculum Note if the curriculum is currently undergoing revision and describe the changes that were or are being made and the timetable for completion of any ongoing revisions (ED-9).

If separate educational tracks are available, briefly describe the objectives, general content emphases, and methods of instruction and student evaluation used. Describe any differences between the objectives and curriculum of the track and the school's basic curriculum. Note the location of the track (ED-5, ED-8).

2. Content

Summarize whether and where all of the subjects required for accreditation, as specified in *Functions and Structure of a Medical School*, are included in the curriculum, as well as whether the coverage of these subjects is sufficient to meet accreditation standards (ED-10, ED-13, ED-17, ED-17-A, ED-19, ED-20, ED-21, ED-22, ED-23).). Include data from the AAMC GQ/CGQ and/or the independent student analysis to document any areas of concern related to the adequacy of content coverage identified by the survey team.

Be consistent in the data used in the tables below. For example, use the same data source(s) to indicate student satisfaction. If you are using data from the AAMC GQ/CGQ, provide the normative (national) data as well. If you are using data from the independent student analysis, describe the scale once as a footnote.

Years One and Two

For the required courses in years one and two, complete the tables in the report template. The tables related to instructional hours and formats can be copied from the school's database ("Required Courses and Clerkships Forms, Part A"). If one or more courses employ other instructional methods not accounted for in the table, list them in the table or as a footnote. If one or more separate tracks exist, create similar tables and descriptions of the courses in each track. Also complete the tables for years one and two that ask for specific information for each course (e.g., the presence of course objectives). Data are available from the Course and Clerkship Forms, the independent student analysis, and other sources in the medical education database.

YEAR ONE

Course	Formal Instructional Hours					
	Lecture	Lab	Small Groups*	Patient Contact	Other†	Total

* Includes case-based or problem solving sessions
† List

YEAR ONE

Course	Objectives (Y/N)[1]	Formative Assessment[2] (Y/N)	Narrative Assessment[3] (Y/N)	Students' Rating(s) of Course (national comparison)[4]	Residents/graduate students used as teachers/ Supervisors[5] (Y/N)

1. Are there objectives for the course that are provided to students? (ED-3)
2. Do students have opportunities for formative assessment to test their knowledge/skills? For example, are their study questions or practice quizzes/tests? (ED-31)
3. Do students receive a narrative assessment for either formative or summative purposes? (ED32)
4. Indicate the source of the student rating and provide normative data if available (for example, if the AAMC GQ is used). Describe what is being rated (course quality, preparation for clerkship). More than one rating can be provided (expand the table)
5. Are residents and/or graduate students used as teachers/supervisors. (ED-24)

YEAR TWO

Course	Formal Instructional Hours					
	Lecture	Lab	Small Groups*	Patient Contact	Other†	Total

* Includes case-based or problem solving sessions
† List

YEAR TWO

Course	Objectives (Y/N)[1]	Formative Assessment[2] (Y/N)	Narrative Assessment[3] (Y/N)	Students' Rating(s) of Course (national comparison)[4]	Residents/graduate students used as teachers/ supervisors (Y/N)

1. Are there objectives for the course that are provided to students? (ED-3)
2. Do students have opportunities for formative assessment to test their knowledge/skills? For example, are there study questions or practice quizzes/tests? (ED-31)
3. Do students receive a narrative assessment for either formative or summative purposes? (ED-32)
4. Indicate the source of the student rating and provide normative data if available (e.g., AAMC GQ is used). Describe what is being rated (course quality, preparation for clerkship). More than one rating can be provided (expand the table)
5. Are residents and/or graduate students used as teachers/supervisors. (ED-24)

Note that descriptions of the individual year one and year two courses are not required. Instead, provide a summary that draws on information related to all year one and year two courses. Include the following table from the medical education database (ED-11), which the school should have completed with data derived from the AAMC GQ/CGQ.

Basic Science Disciplines	% Rating Preparation for Clinical Clerkship Rotations as Excellent or Good	National % Rating Preparation for Clinical Rotations as Excellent or Good
Biochemistry		
Genetics		
Gross Anatomy		
Immunology		
Microbiology		
Pathology		
Pharmacology		
Physiology		
Behavioral Science		

In the summary, note if residents and graduates students are prepared as teachers (more detail will be included in the section of the report related to standard ED-24). Also evaluate the adequacy of resources to support teaching in the first and second-year curriculum (faculty, facilities, IT). Note problems areas identified by the survey team or the school in one or more specific courses that could indicate noncompliance with an accreditation standard: for example, no narrative assessment in courses where this would be possible (ED-32), no opportunities for formative assessment (ED-31), residents or graduate students not prepared (ED-24), space and/or faculty resources not adequate (ER-4, FA-2). For the introductory courses designed to teach basic clinical skills (e.g., history-taking, communication skills, physical examination) also describe and evaluate the appropriateness of the settings used for teaching, the level of teaching and supervision, and the adequacy of the patient base. Note if standardized patient or other simulation methods are used in teaching, whether student clinical skills are observed, and if there is sufficient and appropriate space for clinical skills teaching (ED-27, ER-4).

Years Three and Four

There is no need to write individual descriptions of the clerkships in years three and four. Instead, complete the following tables from the database (as was done for years one and two) and from information contained in the medical education database, Required Courses and Clerkships Forms, Part A, and other sources. "Formal instruction" refers to the sum of lecture hours, conference time, and teaching rounds for all students (not the total time students spend during the day); report either an average or range, as appropriate, and note any major site-specific variations in the clerkship summary.

YEAR THREE

Course or Clerkship	Total wks	% Amb.	# Sites used*	Typical hrs/wk of formal instruction**	Patient criteria† (Y/N)	Patient log‡ (Y/N)

*Include the number of sites used for inpatient teaching and the number of sites used for outpatient teaching in the clerkship in the following format: # inpatient / # outpatient
**Sum of lectures, conferences, and teaching rounds; show the range of hours if there is significant variation across sites
† Have criteria for student clinical encounters been defined? (ED-2)
‡ Is a log kept of patients seen? (ED-2)

YEAR FOUR

Course or Clerkship	Total wks	% Amb.	# Sites used*	Typical hrs/wk of formal instruction**	Patient criteria† (Y/N)	Patient log‡ (Y/N)

*Include the number of sites used for inpatient teaching and the number of sites used for outpatient teaching in the clerkship in the following format: # inpatient / # outpatient
**Sum of lectures, conferences, and teaching rounds; show the range of hours if there is significant variation across sites
† Have criteria for patient encounters been defined? (ED-2)
‡ Is a log kept of patients seen? (ED-2)

Complete the following table for <u>years three and four</u>.

Clerkship	Objectives[1] (Y/N)	% Observed/ History[2] (National %)	% Observed/ Physical[2] (National %)	Mid-clerkship Feedback[3] (Y/N)	% Receiving Grades in 6 Weeks)[4]	Student Satisfaction (National Norm)[5]

1.   Are there objectives for the clerkship? (ED-1)
2.   Provide data from the AAMC GQ on the percent of students who report being observed performing a history and a physical examination (provide national normative data) (ED-27)
3.   Do students receive mid-clerkship feedback? (ED-31)
4.   Provide the percent of students in each discipline who received their grades within six weeks. (ED-30)
5.   Provide data on student satisfaction with the quality of the clerkship (if the AAMC GQ is used include normative data)

Also include the following table from the medical education database, which schools should complete using data from the AAMC GQ/CGQ (ED-15):

Topic	Percent of respondents indicating that instruction was:		
	Inadequate	Appropriate	Excessive
Diagnosis of disease			
Management of disease			
Health maintenance			
Disease prevention			
Health determinants			

In a summary that draws on information from the required third and fourth-year clerkships, note whether and how learning objectives are distributed to students, faculty, and residents (ED-3). Note how student clinical encounters are monitored, for example, by review of student logs. Comment on any mechanisms in place (e.g., mid-clerkship review of logs) to ensure that students are having the required clinical encounters and if there are alternatives if students have not encountered the required patients. (ED-2) Note any concerns about student "workload" (e.g., duty hours, amount of time required in clinical activities of low educational value) indicated in the student analysis or in student interviews. (ED-38) Note if students are receiving clerkship grades in a timely manner (i.e., within four to six weeks). (ED-30) Provide a summary across all clerkships that highlights any problem areas, including problems within a given discipline or rotation site, that could indicate areas of noncompliance in one or more clerkships, including adequacy of resources (faculty, patients) (FA-2, ER-6), availability of formative assessment (ED-31), preparation of residents as teachers (ED-24), and adequacy of teaching and supervision (ED-25).

Elective Courses

Summarize the amount of elective time available in each year of the curriculum. Indicate the maximum number of weeks in the final academic year that students may spend taking electives at another institution and the average number of weeks the most recent graduating class spent in away electives (ED-18).

Summary of Curriculum Structure

In summary, evaluate whether the curriculum is designed to allow students to achieve the objectives of the educational program. Does the educational program provide a general professional education that prepares students for all career options in medicine? Include data from the AAMC GQ/CGQ, and the independent student analysis if relevant, on student satisfaction with the quality of the educational program and their perceptions of preparation in a number of areas (ED-5). The following table can be used or modified:

I am confident that I have the following:	% Responding Agree/Strongly Agree
Clinical skills to begin a residency program	
Fundamental understanding of common conditions and their management	
Communication skills to interact with patients and health professionals	
Basic skills in clinical decision-making and the application of evidence	
Fundamental understanding of the issues in the social sciences of medicine	
Understanding of the ethical and professional values expected of a physician	
Adequately prepared to care for patients from different backgrounds	

Note whether appropriate balance exists among the methods of instruction used, between inpatient and outpatient clinical experiences (ED-16), and between clinical experiences in primary care and the specialties (ED-14).

C. Teaching and Assessment

Note if all student learning experiences are appropriately supervised. Do physicians who teach and assess medical students have faculty appointments? Describe any situations in which students are supervised by physicians who do not hold faculty appointments. (ED-25)

Summarize the roles of graduate students in the biomedical sciences, postdoctoral fellows, and residents in medical student teaching and assessment. Note any institutional programs available to residents or other instructional staff for improving their skills in medical student teaching and assessment (ED-24).

Complete the following table indicating support for resident participation in medical student education (ED-24):

Clerkship	Objectives provided to residents (yes or no) and describe how the objectives are provided	Departmental programs for teaching & assessment skills (yes or no and summarize)	Resident participation centrally monitored (yes or no) and describe

.

Complete the following tables in the report template or copy and insert the tables from the medical education database that summarize methods for assessing student performance. Place an "x" in each cell to indicate that that assessment method is used. The tables are contained in Part A (Summary Data) in the Required Courses and Clerkships Form.

YEAR ONE

Course	# of Exams	Contribute to Grade (Check all that apply)						
		Internal Exams	Lab or Practical Exams	NBME Subject Exams	Faculty/ Resident Rating*	OSCE/SP Exam	Paper or Oral Pres.	Other†

* Include assessments by faculty members or residents in clinical experiences and in small-group sessions (e.g., a facilitator evaluation in small group or case-based teaching)
† List the specifics here

YEAR TWO

Course	# of Exams	Contribute to Grade (Check all that apply)						
		Internal Exams	Lab or Practical Exams	NBME Subject Exams	Faculty/ Resident Rating*	OSCE/SP Exam	Paper or Oral Pres.	Other†

* Include assessments by faculty members or residents in clinical experiences and in small group sessions (e.g., a facilitator evaluation in small group or case-based teaching)
† List the specifics here

YEARS THREE AND FOUR

Course or Clerkship	Contribute to Grade (Check all that apply)						Clinical Skills Observed (Y/N)†	Mid- Course Feedback (Y/N)
	NBME Subject Exams	Internal Exams	Oral Exam or Present	Faculty/ Resident Rating	OSCE/SP Exams	Other*		

* List the specifics here
† Are all students observed performing core clinical skills? (yes or no)

Summarize the methods used to assess student performance in the preclinical and clinical disciplines. Note how the methods of assessment and the standards of achievement were set (ED-29) and if the timing of assessments seems to be appropriate (ED-26). Is an appropriate variety of assessment methods used (ED-26)? Do faculty have the requisite knowledge about assessment or do they have access to individuals with expertise in assessment (ED-30)? Comment on whether the methods in place assess the problem solving, clinical reasoning, communication, and other skills, behaviors, and attitudes needed in subsequent medical training and practice (ED-28). Summarize whether and how students are systematically observed for their core clinical skills, behaviors, and attitudes (ED-27). In the discussion of observation of core clinical skills (ED-27), include the following table from the medical education database:

Rotation	School % agreeing they were observed		National % agreeing they were observed	
	History	Physical Examination	History	Physical Examination
Family Medicine				
Internal Medicine				
Obstetrics-Gynecology				
Pediatrics				
Psychiatry				
Surgery				

Indicate whether students regularly receive formal mid-course and mid-clerkship feedback. If so, comment on the perceived sufficiency and format of this feedback (e.g., oral, written) and the system(s) in place to ensure that such feedback is provided (ED-31) (utilize the table from ED-31 to inform the comment on the sufficiency of feedback). Comment on the timeliness of reporting of final grades (ED-30). Note if narrative assessments are provided in those preclinical courses where the format of the course would permit such feedback (ED-32) Also note any clerkships that do not include narratives as part of their assessment of student performance (ED-32).

D. Curriculum Management

1. Roles and Responsibilities

Describe the committee responsible for the management of the curriculum, including its composition and the composition of its subcommittees (if any). Describe the mechanisms used for curriculum planning, implementation, evaluation, management, and oversight, including the roles of faculty, faculty committees (e.g., the curriculum committee and its subcommittees, if any), the departments, and the central medical school administration. Refer, as needed, to the organizational chart for curriculum management, which should be included in the text or the Appendix. Provide the team's assessment of the effectiveness of the school's curriculum management processes. Provide evidence that there is integrated institutional responsibility for the curriculum, including examples of problems identified and changes made by the curriculum committee/subcommittees. Cite any evidence that the curriculum is coherent and coordinated. For example, note the extent of content monitoring and coordination/integration among courses and across academic periods, and describe how this integration is achieved (ED-33, ED-34).

Indicate whether a regular (systematic) review takes place of the courses and clerkships, as well as of segments of the curriculum and the curriculum as a whole, including a review of learning objectives, content, and methods of teaching. Describe when and how these reviews are conducted and which individuals and/or groups participate in the review process and receive the results (ED-35). Comment on whether an effective system is in place to ensure that problems identified during curricular reviews are corrected (ED-33). Indicate how curricular content is monitored, including the presence of a formal curriculum inventory. What processes are in place to ensure that there are no gaps or unintended redundancies in content and that content is coordinated across the curriculum (ED-37).

Note if there is a formal policy related to the amount of time students spend in required activities. Describe whether and how the educational workload of students is monitored to ensure that there is appropriate time for independent learning. Is there a policy related to duty hours in the clinical years and are duty hours monitored (ED-38)?

Describe the resources available to the chief academic officer to support the design, implementation, and evaluation of the curriculum, including individuals who can assist in program implementation and evaluation (such as an Office of Medical Education). In the opinion of the survey team, are these resources adequate? (ED-36). If not, summarize the nature of the deficiency and describe any issues in greater detail in Section IV (Faculty) and/or Section V (Educational Resources). Note if the chair of the curriculum committee, if not an administrator, has protected time (data for this can be found in the response to FA-2).

2. Geographically Separate Campus[2]
[*Complete this section if the school operates one or more geographically separate campuses*]

For each geographically separate campus, describe the phase(s) of the curriculum involved (e.g., the first two years, the third and fourth years, all four years). Use the table in ED-39/40 to describe the number of students (i.e., proportion of a given class) per year at each site, including the "central campus." Note if the curriculum at each campus is the same as or different from that at the central campus (more detail should be provided in the section on Educational Program, General Design and Educational Program, Content) and briefly describe any differences.

Comment on the administrative relationship between the school and its geographically separate campuses. An organizational chart describing the relationship between the principal academic officer at each campus and the medical school's chief academic officer should be included in the Appendix (ED-39, ED-40). Note also the reporting relationships of individuals with responsibilities for student affairs at the campus and the medical school student affairs dean. Describe the mechanisms that exist to support functional integration and communication among the campuses (at all levels, including administrative, departmental, and faculty). Are the faculty at the campuses integrated into the medical school governance structure and into the central medical school departments(ED-41)?

Describe the mechanisms used for selection and assignment of students to the distributed campus(es). Describe the process that allows students to request an alternative assignment (ED-43).

Indicate whether students at the various sites have access to the same levels of support services, including academic and career counseling, financial aid advising, personal counseling, and health services (ED-44). Are the standards for promotion and graduation consistent across campuses (ED-42)? Summarize the appropriateness of the infrastructure to support education at each geographically-separate campus (select the appropriate standards from Faculty, Educational Resources for any areas of concern). For example, if distance learning is used to deliver didactic instruction across campuses, describe how well the distance learning process functions and the technology and other resources that are available to support it (ER-13). If available, provide student perceptions from the independent student analysis of the adequacy of instruction and of technology support services at the distributed campuses.

E. Evaluation of Program Effectiveness

Describe the measures that are used to evaluate the effectiveness of the educational program (ED-46). For students' evaluations of their courses and clerkships, describe how and by whom the data are collected (e.g., by a central office of medical education, by individual departments). Indicate whether standardized evaluations are used for courses and clerkships and note the general level of student participation in these evaluations (ED-47). Provide a summary of those individuals or groups that receive the data on each

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[2] A geographically separate campus is an instructional site that offers a significant portion of the curriculum (at least one year for a given student) at a distance from the central campus of the medical school. If a common curriculum is used, the educational program objectives at the geographically separate campus must not differ substantially from those of the standard program, and mechanisms must be in place to ensure educational comparability.

measure of program effectiveness and report on how the data are used for educational program review and change (ED-33, ED-46).

Cite evidence for educational program effectiveness, including data on program outcomes. Comment on the availability of evidence indicating that the objectives of the educational program are being met. Provide data on student performance in the framework of national norms of accomplishment. Include data for the past three years on USMLE Step 1 and Step 2 CK and CS performance, as well as on USMLE Step 3 performance, if available. For Canadian schools, provide the results of the MCCQE Part I (ED-46).

III. MEDICAL STUDENTS

Insert at least the following items from the medical education database and the independent student analysis in the Appendix:

- Student enrollment by class year (MS-5)
- Mean MCAT scores and premedical GPAs for past three entering classes (Key Quantitative Indicators, MS-5, MS-6)
- Table of the number of students who left school, exhibited academic difficulty, or took a leave of absence (MS-18)
- Sample Medical Student Performance Evaluation/Medical Student Performance Record (MS-19)
- For US schools, a copy of the most recent LCME Part I-B Financial Aid Questionnaire (MS-24)
- Narrative section of the independent student analysis and data from the student-administered survey (if not included previously)

[Be sure to include relevant AAMC GQ/CGQ data throughout this section]

A. Admissions

List the requirements for admission, including any courses or topics that are recommended, but not required (MS-1, MS-2).

Describe the admissions process, including the processes for review of initial applications, for selection of applicants to receive supplementary application materials and to be interviewed, and for selection of applicants to receive offers of admission (MS-3, MS-6). Comment on the appropriateness of selection criteria in light of the school's mission, goals, and educational objectives and describe how the criteria are shared with potential applicants and their advisors (MS-3). Evaluate the sufficiency of qualified applicants, including the premedical GPAs, MCAT scores, and any other relevant data predicting academic success and appropriate professional development in medical school (MS-5, MS-6). Evaluate the total number of students enrolled (including students in combined or joint degree programs) relative to the resources available for their education (MS-5).

Describe the composition of the admissions committee and how committee members are selected and oriented. Comment on the perceived integrity of the admissions process, including the role of the admissions committee in making the final admissions decision without external influences (MS-4, MS-7).

Note the existence of programs, partnerships, and/or processes in place (e.g., pipeline programs, institutional collaborations) to support development of a pool of well-qualified applicants to medical school. Describe the resources (staffing, funding) to support these programs. Describe how the school is tracking the success of these programs (MS-8).

Note whether the school possesses and disseminates technical standards for admission (MS-9).

Comment on the accuracy of the school catalog or equivalent materials in portraying the educational program and admission requirements. Indicate how informational materials about the school and its requirements are disseminated (e.g., hard-copy and/or electronic formats) (MS-10, MS-11).

Describe the policy for accepting transfer students, including the requirement for the comparability of their academic achievement, and discuss the academic qualifications of transfer students relative to currently enrolled students (MS-13, MS-14). Note if transfer students are accepted into the final year of the program (MS-15). Evaluate whether adequate resources are available to accommodate the numbers of transfer students accepted by the school (MS-12

How does the medical school ensure that visiting students do not diminish the resources available to enrolled students (MS-12). Assess the effectiveness of the system for verifying the credentials of and registering visiting students (MS-16). Note the process used to ensure that visiting students have comparable credentials to those of enrolled students (MS-17).

B. Student Services

Please include information from the independent student analysis and/or the AAMC GQ/CGQ, as available, on student satisfaction with student services.

1. Academic and Career Counseling

Summarize the academic advisory system in place at the school, including any programs designed to identify and assist potentially high-risk students in the entering class or students who experience academic difficulty during the curriculum. Describe the resources that are available within the school and its parent university to support students who are or may be in academic difficulty. Include data on the four-year and overall graduation rates. Discuss the level of attrition and the proportion of students who have taken a leave of absence. Comment on the effectiveness of the school's efforts to identify students experiencing academic difficulty and on the efficacy of remediation activities. Identify how the school assures that there are mechanisms in place to prevent conflicts of interest in the academic advisory system (MS-18).

Describe the system for career counseling and for counseling about application to residency, including formal and informal activities offered by curriculum year. Describe the availability of advisors who are available to students and the training that they receive for their role. Report on how well students perform in the NRMP or CaRMS (MS-19). Briefly summarize the process for generating the Medical Student Performance Evaluation/Medical Student Performance Record (MS-19, MS-22). Comment on the mechanisms used by the school to prevent the residency application process from interfering with scheduled academic activities and to provide flexibility for students to engage in the application process (MS-21).

Summarize the process of advising students about their choice of electives and describe how and by whom elective choices are screened (MS-19, MS-20).

2. Financial Aid Counseling and Resources

Comment on the organization, staffing, operation, and accessibility of the financial aid office and note if the office serves students enrolled in other schools in addition to the medical school. Indicate whether there are sufficient knowledgeable financial aid staff to meet the needs of enrolled medical students. Briefly summarize the formal and informal programs and services for counseling students about financial aid and debt management, and provide data on student perceptions of the availability and utility of such efforts (MS-23).

Describe recent trends in tuition and fees and in the overall cost of attending the medical school (MS-24). Report on whether the school's policies for tuition and fee refunds are equitable and appropriate (MS-25). Indicate whether the loans and scholarships that are available to students meet their needs. Note any trends in the amount of institutional funding for grants and scholarships, and describe any institutional initiatives for enhancing funding for student scholarship support. Note any initiatives to limit increases in or to reduce tuition. Include data from the AAMC GQ/CGQ on the average total educational debt and the average medical school educational debt of indebted students (with national comparisons), along with the percent of indebted graduating students with debt over $200,000. Comment on trends in debt levels in the context of institutional initiatives to limit educational debt (MS-24).

3. Personal Counseling and Health Services

Describe the personal counseling services available to students, and comment on their accessibility and confidentiality (MS-26). Describe the school's efforts to ensure that those responsible for providing psychiatric or psychological counseling and other sensitive health services to medical students are not also involved in their academic assessment or in decisions about their promotion or graduation (MS-27-A). Provide an assessment of the effectiveness of those efforts, and summarize student opinion on that matter. Report on any programs available to promote student well-being and/or facilitate their adjustment to the demands of medical school (MS-26).

Summarize the health services available to students, and evaluate their cost, accessibility, and confidentiality. If there is a student health center, note its location, staffing, and hours of operation (MS-27). Are students provided with information on how to access health services and personal counseling services (MS-26, MS-27)?

Note the school's requirements for student health insurance, including the availability of insurance for students' dependents, and the cost of insurance for students and their dependents (MS-28). Note also the availability and cost of disability insurance for students (MS-28).

Report whether students are adequately screened for immunization status and have access to appropriate vaccinations (MS-29). Note how students are instructed about infectious and environmental hazards and about protocols for treatment and follow-up after exposure. Summarize the school's policies related to exposure to infectious and environmental hazards, and note if students are familiar with the policies and procedures to follow after exposure (MS-30).

C. The Learning Environment

Comment on the school's efforts to create an appropriate learning environment for medical students. Is there an antidiscrimination policy (MS-31)? Has the medical school defined the professional attributes that students are expected to develop? How are students informed of and assessed related to these attributes? Describe how the school is working with its clinical partners to evaluate the learning environment and to mitigate any negative influences. How effective are the mechanisms by which students, faculty, residents and others can report observed incidents of unprofessional behavior? Is the joint responsibility of the medical school and its clinical partners codified in written (affiliation) agreements (MS-31-A, ER-9)?

Provide data from the AAMC GQ/CGQ on the incidence of negative behaviors experienced by students or observed by students directed against another student that could be defined as mistreatment. Are there standards of conduct in the teacher-learner relationship and are students, faculty, and residents familiar with these standards? Is there policy that describes the procedures for the prompt handling of violations of these standards and are students familiar with the process for reporting incidents? Comment on the school's student mistreatment policies and educational efforts implemented by the school to prevent

mistreatment. Assess whether students perceive that the school's policies and procedures regarding mistreatment are effective (MS-32).

Are the school's standards and procedures for student evaluation, advancement, graduation, disciplinary action, dismissal, and appeal clear? Note whether the standards and procedures are widely understood by students, faculty members, and members of the administration (MS-33). Describe the due process mechanisms that apply in cases of possible adverse action regarding a student, including timely notice of the charge or action, specification of the particulars of the situation, and opportunity for a fair and impartial hearing. Briefly summarize the options for appealing recommendations for dismissal or disciplinary action. Is the survey team satisfied that the policies for taking an adverse action against a medical student are fair and formal? (MS-34)

Describe the location where students' academic records are stored. Describe the system for assuring the confidentiality of student records and for making student records readily accessible to students who wish to review them (MS-35). Describe the process for students to review and challenge their records. Note any impediments to student review or challenge of examinations or course grades (MS-36).

Comment on and provide student satisfaction data on the quality, quantity, and availability of study space, student lounge and relaxation areas, and storage facilities for personal belongings (MS-37).

D. Student Perspective on the Medical School

Briefly summarize general student opinion of the medical school and of the educational experience it provides, based on the information contained in the independent student analysis, AAMC GQ/CGQ, and discussions with students on site. If not mentioned elsewhere in the report, describe the specific strengths of the school from the student perspective and any concerns identified by the students. Report on the extent to which the administration and the faculty are perceived as responsive to student concerns. Report also on the extent to which students believe that they have adequate representation in decision-making bodies that directly affect their education and that their voice is heard on issues of importance to them.

IV. FACULTY

Insert at least the following items from the medical education database in the Appendix:

- Tables showing the current numbers of full-time, part-time, and volunteer faculty members in basic science and clinical disciplines, by department and total (Key Quantitative Indicators and FA-2)
- The table of teaching responsibilities by department (FA-2)
- The table on faculty scholarly productivity (FA-5)
- The table showing the major medical school faculty committees (FA-12)

A. Number, Qualifications, and Functions

Summarize trends in the total number of basic science and clinical faculty members since the previous survey visit. Evaluate whether the current size, composition, and qualifications of the faculty are appropriate for the educational and other missions of the medical school and whether the educational program is appropriately staffed independent of total faculty numbers (FA-2, FA-3). Note if there appears to be significant use of part-time or volunteer faculty, graduate students, or others and if any individuals with significant responsibilities in courses and clerkships are on site for fewer than three months during an academic year (FA-2). Indicate whether any decrease in the number of faculty is anticipated in the near future (e.g., through a significant number of retirements). Note the availability and adequacy of protected

time for course and clerkship directors. Is the amount of protected time adequate for them to meet the needs of the educational program? (FA-2).

Describe whether, how, and by whom the teaching skills of faculty members are evaluated. Note whether a formal evaluation of faculty members exists as part of the course and clerkship review process and whether faculty members are notified about the results of these evaluations (FA-4). Describe any mechanisms that exist to remedy identified problems with faculty teaching or supervision skills. Note both informal and formal programs that are in place to assist faculty members and, if relevant, residents and others who teach medical students, in improving their teaching and assessment skills. Indicate whether the school provides faculty development programs focused on other areas (e.g., research enhancement, grant acquisition) and whether these programs are regularly utilized by faculty, residents, and others (FA-11).

Report on the extent to which the faculty maintains a commitment to scholarly productivity. Note any departments or units with low scholarly productivity and describe whether this is being addressed by the medical school. Comment on the extent to which scholarship is valued and fostered by the medical school and the extent of mentoring programs to support the development of faculty skills in this area (FA-5).

B. Personnel Policies

Indicate whether the policies for faculty appointment, renewal of appointment, promotion, granting of tenure, and dismissal are widely disseminated and understood by the faculty (FA-7). If there are separate faculty tracks, describe them and note how well the policies related to these tracks are understood by the faculty (FA-3, FA-7). Comment on the presence of a medical school or parent university policy on faculty conflicts of interest (FA-8).

Evaluate whether faculty members in all tracks receive formal notification about their terms of appointment and their responsibilities in teaching and other areas. Note whether faculty members appeared aware of the availability of this information (FA-9). Describe the system for providing all faculty members with regularly scheduled feedback about their performance and their progress toward promotion. Note the presence of medical school or university policies that require that such feedback be given to faculty members (FA-10).

C. Governance

Evaluate, in general, the medical school committee structure in terms of its functionality and the level of faculty participation (FA-6). Individual committees (e.g., curriculum, admissions) should be described in the relevant sections of the report. Note the mechanisms in place by which the dean obtains input from department heads and faculty leadership groups (FA-12). Comment, in general, on the sufficiency of individual faculty members' input into organizational decision-making, either through a committee structure or directly (e.g., through individual access to the dean or access at general faculty meetings) (FA-6, FA-13). Note the mechanisms the dean uses to communicate with the faculty at large, and indicate how often such communication occurs. Comment on the effectiveness of the methods used to communicate with and among the faculty (FA-14).

V. EDUCATIONAL RESOURCES

Insert at least the following items from the medical education database in the Appendix:

- Four-year Revenue and Expenditure Summary and current LCME Part IA Annual Financial Questionnaire (ER-2)
- The table(s) of teaching facilities (ER-4)
- The table of faculty offices and research labs (ER-4)
- Summary data and associated tables for each clinical teaching site (ER-6, ER-7)
- The tables of library and information technology facilities, library holdings, and library/IT staff (ER-11, ER-12, ER-13, ER-14)

If relevant, begin the section with a brief discussion of any planned changes in medical student enrollment or institutional resources (ER-1).

A. Finances

Complete the following table as contained in the survey report template describing the breakdown of revenue sources for the medical school as a whole compared to relevant norms. Select the appropriate normative data, depending on whether it is a public or private school The data for 2011 will be sent to survey team secretaries when available (about October 2012).

MEDICAL SCHOOL REVENUE SOURCES
($ in Millions)

Source	(Indicate year)	% of total revenues	% of total revenues all (private/public) schools*
Tuition and fees	$	%	%
State and parent university support	$	%	%
Federal appropriations (excluding grants)	$	%	%
Grants & contracts (direct)	$	%	%
Indirect cost recoveries	$	%	%
Practice plans	$	%	%
Gifts and endowments	$	%	%
Hospitals	$	%	%
Other revenues	$	%	%
Total revenue	$		
Total expenses & transfers	$		

* Insert appropriate national percentages based on the school's public or private status

Briefly describe recent trends in the school's revenue sources and expenditures, and describe the current and anticipated fiscal condition of the school. Note any major changes or anticipated changes in revenue sources or dependencies on particular revenue sources that might suggest present or future problems. If there is a current or potential fiscal imbalance, assess whether the school has a credible plan to address it (ER-2). Evaluate whether the school's educational programs are suffering from or being endangered by underfinancing, by undue productivity pressures for faculty research or patient care, by the need to increase class size to enhance tuition revenue, or by other factors (ER-3).

Using the Annual Financial Questionnaire and information obtained on site, briefly describe the clinical enterprise, (i.e., the system linking the principal hospital[s], the related healthcare system, the faculty practice plan, and the clinical faculty/hospital staff). Describe the condition of the healthcare market in which the school is located and the strength of the school's position in that market.

Note whether the school is planning to engage or is currently engaged in any major construction or renovation projects or other initiatives that require substantial capital investment. If so, describe how capital needs are being or will be addressed.

Comment on the general adequacy of funding to support departmental missions. If any departments have been identified as having financial problems, provide the specifics here, including departmental or school plans to resolve the financial issues.

Conclude with a statement about the school's overall financial status and prospects (ER-2).

B. General Facilities

Make brief summary comments about the age, size, appearance, and quality of the school's general facilities (not including hospitals). Assess whether the space available for teaching and research is adequate for the current number of students, for the current or desired curriculum structure, and for the number of existing and anticipated faculty, including the current research activity and any anticipated research expansion. Describe any changes that are anticipated in either enrollment or curriculum structure that could affect the need for or adequacy of the space dedicated to education. Comment on whether the space for research and educational activities is organized to best advantage (i.e., distributed vs. consolidated). If new construction is planned or underway, describe the proposed new facilities and the timetable for completion (ER-4). Summarize student opinion regarding the quality of educational space (ER-4).

Describe the security that is available on campus and at clinical teaching sites and provide data on student satisfaction with safety and security (ER-5).

C. Clinical Teaching Facilities

Describe in serial paragraphs the major hospitals and ambulatory-care facilities utilized for medical student education. If not included in the Appendix, provide data on admissions and numbers of patient visits. Provide a summary description of the adequacy of the network of teaching facilities, and comment on the overall quality and the collective sufficiency of resources for the clinical education of medical students (ER-6). Comment on any adverse effects on clinical teaching attributable to declining hospital utilization, shorter length of stay, increased patient acuity, and/or changed case mix. (ER-6)

Evaluate the overall quality of the educational resources for student education at the clinical teaching sites (e.g., conference and classrooms, on-call quarters, library, computers, Internet access, etc.) (ER-7). Note any clinical sites without accredited residency training programs (IS-12, ER-8).

Report on whether affiliation agreements exist with all inpatient sites used for required clinical clerkships. Are the affiliation agreements up-to-date and explicit on the role of and expectations for medical students. Note if the affiliation agreements or associated memoranda of understanding include the elements defined in the annotations to standards ER-9 and MS-31-A.

Describe whether the clinical service chiefs are appointed by or with the concurrence of the medical school. Note whether, in clinical affiliations, the medical school faculty have control and authority for the educational programs (ER-10).

D. Library Services and Information Resources

Describe the location of the library and its organizational relationship to the school of medicine (ER-11). Describe participation of library staff in the planning and implementation of the curriculum, including library staff serving as members of the curriculum committee or its subcommittees and/or providing instruction to medical students (ER-12). Evaluate the adequacy of the library's hours, services, holdings, staff, and facilities (ER 11). Note whether the library includes study and small-group conference space.

Describe the quality of the library's automated databases and bibliographic search, computer, and audiovisual capabilities (ER-11).

Assess whether the library is meeting the needs of the faculty, residents, and students and whether library resources are accessible to students who are off-site. Indicate whether the library is adequately funded and whether an effective mechanism is in place to ensure faculty and student input to the school/university administration on matters of library policy and procedures (ER-12).

Comment on the availability and accessibility of information technology resources (hardware and software) for the delivery and management of the educational program and for the other missions of the medical school (ER-13). Comment on the adequacy of the information technology staff and their responsiveness to the needs of medical students (ER-14). If audiovisual and/or information technology is used to deliver parts of the educational program, evaluate their quality and reliability, including student and faculty satisfaction with these resources. Note whether support is available to assist faculty in developing and utilizing information technology. Describe the adequacy of school efforts to cultivate self-learning behaviors and of school resources to help the faculty identify or develop educational software (ER-14).

Note any problems or discontinuities in the integration of information technology on the main campus with remote campuses and clinical training sites. Indicate whether medical students have access to electronic educational resources from off-campus locations (ER-12).

THE REPORT OF A LIMITED ACCREDITATION SURVEY

INTRODUCTION

An interim, limited survey is conducted when concerns of a serious nature arise and the LCME believes that a survey visit is necessary to review the corrective actions that have been taken. In general, the team conducting a limited survey should focus on these specific areas during the visit. However, any substantive new problems that have emerged in the interim should also be examined and reported by the team.

BACKGROUND

In preparation for the limited survey, the school is sent a letter by the Secretariat six months prior to the survey visit describing the elements of a "mini-database" of information addressing areas previously cited as not in compliance (noncompliance) and as in compliance with a need for monitoring issues. This information is used to provide supporting documentation for the text and appendices of the limited survey report, similar to the database in a full survey visit. The survey team chair and secretary are expected to review carefully the school's previous accreditation history, including prior survey report and any status reports. They should work with the school to organize the visit schedule and discussions around the issues highlighted in the letter to the school outlining the areas to be documented in the database.

LIMITED SURVEY REPORT FORMAT

Cover page. Use the cover page from the survey report template, but title the report "Team Report of the Limited Survey of the [School Name]".

Table of contents. Organize by category of concern, listed in the order that the items would appear in the full-survey database (i.e., Institutional Setting, Educational Program, Medical Students, etc.). Include a table of contents for the appendices, as well.

Memorandum from survey team secretary to LCME. As with a full report.

Brief introduction. As with full report.

Composition of survey team. As with full report.

Summary of Findings

The format of this summary differs from the list of institutional strengths, in compliance with a need for monitoring, and noncompliance issues presented in a regular full survey report. This summary is a listing of the descriptive findings for the issues addressed by the limited survey, including any new areas explored during the survey visit, arranged in the same order as the sections in *Functions and Structure of a Medical School,* which is accessible from the LCME Web site at: www.lcme.org. It describes the team's findings on each issue separately in summary terms; the detailed discussion is presented later in the report. An example of summary statements in a limited survey report follows

SUMMARY OF SURVEY TEAM FINDINGS

> **DISCLAIMER:** The summary that follows represent the findings of the *ad hoc* survey team that
> visited [school name] from [visit dates], based on the information provided by the school and its

representatives before and during the accreditation survey, and by the LCME. The LCME may come to differing conclusions when it reviews the team's report and any related information. *(add CACMS for Canadian schools)*

Role of the Vice President for Health Affairs (IS-9)

> Finding: With the reassignment of the previous vice president for health affairs, the confusion about responsibilities and reporting relationships has been eliminated by consolidating the offices of dean and vice president.

Integrated Institutional Responsibility for the Curriculum (ED-33)

> Finding: The previous barrier to curricular renewal has been eliminated as the dean has appointed a new curriculum committee and the Faculty Council has adopted new bylaws to empower this committee with responsibility for implementation and management of the curriculum

Financial Aid Management (MS-23)

> Finding: The school has made no appreciable progress in the administration of student financial aid. The hours of business of the university's centrally-administered office are not convenient to medical students; the number of lost applications continues to be high; and delays in processing applications, distributing checks, and handling problems continue unabated.

Accreditation History and Background of the Visit

The LCME does not receive a copy of the previous full survey report or any other limited survey reports when considering a limited survey. Therefore, this section should contain enough relevant information about the history and setting of the school to serve as a frame of reference for LCME and, for Canadian medical schools, CACMS discussion and decision-making.

Briefly summarize the accreditation history since the time of the previous full survey. List the findings and conclusions of the previous full survey and any other interim limited survey(s), quoting or paraphrasing the major strengths and problems identified by earlier observers. Describe the accreditation actions taken by the LCME/CACMS, including any requests for follow-up status reports and the nature (in summary terms) of the school's response(s).

Survey Findings

Address each issue in detail. For each topic, first include the relevant accreditation standard and describe the situation at the time of the previous full survey visit. Provide enough supporting data from the previous survey report to document the extent and seriousness of the issue. Indicate whether the problem is of long-standing or more recent duration. Then, describe in specific terms situation at the time of the current limited survey visit, including the actions that have been taken to address the issue and their outcomes. Provide evidence showing how well the issue has been resolved. Indicate any additional actions or any future plans related to the concern. Finally, provide the survey team's recommendation of whether the school has achieved compliance, is in compliance with a need for monitoring, or is not in compliance with the relevant accreditation standard.

If any substantive new issue is identified during the limited survey, describe it and provide the team's assessment of any institutional plans or initiatives to address the matter.

Examples of the more detailed exposition of issues follow below, based on two of the items in the summary above:

IS-9. There must be clear understanding of the authority and responsibility for matters related to the medical education program among the vice president for health affairs, the chief official of the medical education program, the faculty, and the directors of the other components of the medical center and the parent institution.

Findings from the 2011 full survey visit

The academic leadership of the medical school was critical of the duality of reporting relationships to university-level executives. Undergraduate education issues were discussed with the dean of the medical school, but, if they had clinical implications, they were expected to be taken to the vice president for health affairs. Moreover, the vice president's office had exclusive responsibility for hospital affairs and graduate medical education, sectors obviously interfacing with the clinical components of medical student education. The hospital's medical staff organization, largely composed of the clinical faculty of the medical school, was yet a third forum acting on matters affecting the medical education program. The survey team found that the absence of a common ground for planning resulted in high degrees of opportunism, fragmentation, and lack of coordination between departments.

Findings from the 2012 limited survey visit

Since the previous survey, the board of visitors authorized the president to combine the offices of dean and vice president for health affairs, eliminating a major dichotomy. A change in the hospital's medical staff bylaws has made the dean an *ex officio* member of the medical staff executive committee. In the survey team's opinion, reinforced by discussions with faculty leaders, the "interlocking directorate" now engaged in program planning and analysis is resulting in significantly improved coordination and collegiality. There is general understanding about how issues related to both clinical service and clinical education can be addressed organizationally.

Survey Team Recommendation

The survey team recommends that the medical education program has achieved compliance with accreditation standard IS-9.

ED-33. There must be integrated institutional responsibility in a medical education program for the overall design, management, and evaluation of a coherent and coordinated curriculum.

Findings from the 2011 full survey visit

Curricular reform, endorsed in general terms by the Faculty Council several years previously, had not been implemented. The student analysis was extremely critical of the lecture-driven curriculum in the first two years and the virtual absence of opportunities for active learning and independent study, and student concerns about this issue had not been addressed for several years. The curriculum committee was meeting on a quarterly basis, largely concerned with the review of new course offerings. There was no staff support for bringing critiques and plans to the attention of the committee, and no inventory of the curriculum to identify unnecessary redundancies and opportunities for innovation.

Findings from the 2012 limited survey visit

Since the last visit, the dean has appointed a new curriculum committee and staffed it with a newly recruited associate dean for undergraduate medical education. A curriculum inventory is being developed, using input from the student note service and a key words/phrases check list completed by students in classes. The Faculty Council has adopted changes in the faculty bylaws empowering the curriculum committee with greater responsibility for curriculum management and implementation. The committee is meeting every other week and expects to have a revised first year of the curriculum ready for implementation in the next academic year. The new curriculum includes an average 25% reduction in didactic teaching hours and an increase in small group, active learning sessions.

Recommendation:

The survey team recommends that the educational program now is in compliance with standard ED-33 with a need for monitoring.

STYLE GUIDE FOR REPORT PREPARATION

For full surveys, reports should be prepared using the survey report template supplied by the Secretariat. There is no template for limited surveys, so use the title page of the template for full surveys.

1. Use one-inch margins throughout since the pages will be printed front and back by the LCME office.

2. Use the font of the template supplied by the Secretariat (11-point, Times New Roman).

3. Original or copied material should be on <u>one side of the page only</u>. One-sided originals will facilitate printing by the LCME Secretariat.

4. Please carefully check the quality of all printing and photocopying. Copy machines may produce distortions, low contrast, or crooked pages. Be sure that originals are of high resolution for quality reproduction. Do not print in color.

5. After the entire report has been completed and assembled, put page numbers in the <u>bottom center of each page</u>, including database pages and appendices. Do not number each section separately.

6. Please use common style conventions:

    The word "dean" is not capitalized except when it begins a sentence or stands as "Dean Robert Jones." The same is true for vice president, provost, president, and chair.

    The words "medical school," "college," and "university" are not capitalized unless they begin sentences or are used as the school's full name (such as Dartmouth Medical School).

    The word "faculty" is not capitalized unless it begins a sentence or is the Canadian equivalent of school, e.g., "the president intends to allocate more funds to the Faculty for laboratory construction."

    Discipline names (e.g., "Physiology," "Biochemistry," "Medicine,") are capitalized when they refer to departments. Note that "department" is not capitalized unless it is used with reference to a specific discipline, as in "Department of Medicine."

7. Immediately following the title page is the Table of Contents (including that for the appendices) which can be numbered with lowercase Roman numerals in the <u>bottom center of the page</u>.

8. Following the Table of Contents (including that for the appendices) is the covering memorandum from the team secretary.

9. Carefully proofread the draft report to correct typographical, grammatical, and punctuation errors; at a minimum, the narrative portion of the report should be spell-checked before the draft report is submitted to the LCME Secretariat for review.

10. The narrative of the draft report should first be sent electronically to both LCME Secretaries and to the CACMS Secretary in Canada, where appropriate. For the reports of US schools, draft and final reports can be sent via email to lcmesubmissions@aamc.org. Please expect to receive an email confirming successful submission the next business day. If you do not receive confirmation, please contact Liz Rast at 202-828-0598 or erast@aamc.org. The Secretariat will request the appendix, if necessary. After receiving and incorporating the Secretariat feedback, the team secretary should circulate the revised draft to team members and the dean for review and correction of any factual errors.

11. The team secretary should sign the cover memo before submitting the final copy to the LCME Secretariat offices.

12. A clean, one-sided copy of the final report, including both the narrative and appendices, should be sent electronically to both AMA Secretariat offices and to the CACMS office for Canadian schools. The report may be sent as one document or the narrative portion and Appendix sent as separate documents. DO NOT send portions of the Appendix as separate documents. Copies of all correspondence between the dean and the team secretary should also be included with the final report.