ASSOCIATION OF AMERICAN MEDICAL COLLEGES

EXECUTIVE COMMITTEE OF THE COUNCIL OF DEANS
MEETING

Tuesday, June 24, 1969

7:30 a.m.
Bancroft Room
Washington Hilton Hotel
Washington, D. C.

1. Minutes of Meeting of April 9-10, 1969

2. Consideration of Topics on Agenda of Council of Deans Meeting

   A. National Service for Medical Graduates

   B. Proposed Bylaws

3. Revision of "Functions and Structure of a Modern Medical School of Basic Medical Sciences" and "Functions and Structure of a Modern Medical School"

4. Consideration of Agenda for Meeting of Council of Deans at Annual Meeting

5. Other Business

6. Adjournment

## THE TEAM REPORT

Subsequently the team prepares a written report containing comments on the school's strengths and weaknesses, suggestions for improvement, and recommendations to the sponsoring Councils regarding accreditation. Copies are submitted to the chief administrative officer of the institution, to members of the Council on Medical Education, and to the Executive Council of the Association of American Medical Colleges for their comments, criticisms, and votes regarding accreditation.

## ACTION ON THE REPORT

Currently the survey report is reviewed individually by each member of the two Councils, who submits his comments and vote to the executive officer of his respective organization. If accreditation is questioned by any member of either Council, or if the school has been in a status of probation or disapproval, or if the survey team has recommended a change of status to or from one of these categories, the report must be discussed and reviewed at a meeting of each sponsoring Council. In these instances, delegates from each Council to the Liaison Committee on Medical Education will have the benefit of discussion and recommendation of their own Council for subsequent discussion in the Liaison Committee.

In these cases, final action regarding accreditation may be taken by the Liaison Committee only after concurrence by the respective Councils. In other cases, the Liaison Committee may take final action guided by the votes and comments of members of the Councils.

Usually, but not necessarily, one or more members of the team which surveyed the school will be present when the Liaison Committee considers the team report.

The action taken by either Council or the Liaison Committee on Medical Education may be "approval" or "disapproval," and approval may be with probation or for a specified time or an indefinite time.

The conjoint action of the two Councils and the Liaison Committee is transmitted by the staff to the president of the institution and the dean of the medical school. At all times, the report is handled by the accrediting agencies as a confidential document, and the prerogative for the release of any information from the report resides with the administrative officials of the institution.

The list of accredited medical schools is published each year in the Education Number of The Journal of the American Medical Association. The membership of the Association of American Medical Colleges, which includes two foreign schools not accredited by the Liaison Committee, is listed in the annual directory of that organization.

Canadian schools of medicine are surveyed and accredited in the same manner as United States schools except that one or two Canadian educators are added to the visiting team. Canadian schools hold affiliate (non-voting) institutional membership in the Association of American Medical Colleges.

## APPEAL

An appeal from an accrediting decision may be made to each of the Councils. The Council on Medical Education has final authority for its accrediting actions within the American Medical Association. Within the Association of American Medical Colleges, final responsibility rests with the Executive Council except in cases of disapproval. Since disapproval is accompanied by removal from membership in the Association of American Medical Colleges, it requires recommendation and justification of the Executive Council and the affirmative vote of two-thirds of the Assembly members present at an annual or special meeting.

## REACCREDITATION

An effort is made to visit medical schools at approximately seven-year intervals. Provision may be made for more frequent visits to suit the needs of the schools and the accrediting agencies.

## COSTS

All costs of advice, consultation, evaluation, and accreditation of medical education leading to the Doctor of Medicine degree are borne by the two parent organizations, not the institution. Team members are reimbursed for their expenses, and the secretary for the team receives an honorarium for his effort in preparing the written report.

The work of the Council on Medical Education is financed by the American Medical Association and the work of the Executive Council of the Association of American Medical Colleges is financed by the Association. The Liaison Committee on Medical Education is supported jointly by the two agencies.

## RELATIONS WITH REGIONAL ASSOCIATIONS

The Liaison Committee's schedule of proposed visits is made available to the regional accrediting associations. Where the regional association is evaluating an institution during the same year, an effort is made to correlate the survey of the medical school with that of the parent institution.

[1] A History of the Council on Medical Education and Hospitals of the American Medical Association, 1904-1959. American Medical Association

[2] "About the Association," Association of American Medical Colleges Directory, 1964, page 13.

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# LIAISON COMMITTEE ON MEDICAL EDUCATION 19

**EVEN-NUMBERED YEARS:**
2530 Ridge Avenue
Evanston, Illinois 60201

**ODD-NUMBERED YEARS:**
535 North Dearborn Street
Chicago, Illinois 60610

## ACCREDITING AGENCY

The Council on Medical Education of the American Medical Association and the Executive Council of the Association of American Medical Colleges separately and conjointly serve as the accrediting agencies for medical education leading to the first professional degree. Through the Liaison Committee on Medical Education these two sponsoring agencies are recognized by the National Commission on Accrediting.

To be accredited, a medical school must be approved by the Council on Medical Education, by the Executive Council of the Association of American Medical Colleges, and by the Liaison Committee on Medical Education. Accreditation is granted on the finding of a sound educational program as a result of a survey conducted jointly by both Councils through the Liaison Committee on Medical Education.

Liaison Committee on Medical Education: ~~The Liaison~~

1)

**The Liaison Committee consists of twelve members, six from each sponsoring Council.**

**The chairmanship of the Committee alternates annually between the chairmen of the two Councils, while the duties of Committee secretary are handled by an executive officer of the corresponding Council.**

to develop new medical schools and for those schools that are in need of and request assistance.

Council on Medical Education of the American Medical Association: The 10-member Council on Medical Education, one of four standing committees of the House of Delegates of the AMA, has as its most important function "the development and maintenance of high standards of medical education in college preparation for medical study, in the medical school, in the internship and residency, and in postgraduate continuing education of the profession, . . . as well as education in the fields allied to medicine."[1] Organized by the AMA in 1904, the Council began inspecting medical schools in 1906, assisted in the Carnegie Foundation study of 1909 which resulted in the "Flexner Report," assumed responsibility for registering hospitals from 1929 to 1954, for approving examining boards in medical specialties since 1933, and for approving schools in the allied medical services since 1936. The Council publishes annually a report on medical education in the United States, a list of approved internship and residency programs, a list of continuing education courses for physicians, lists of approved schools in several allied medical services, and national medical licensure statistics. Its professional staff and offices are located at the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

2)

**The six representatives on the Liaison Committee of the Council on Medical Education consist of the Chairman of the Council, and five members chosen at large.**

Executive Council of the Association of American Medical Colleges: The Association of American Medical Colleges was first organized in 1876 and reorganized in 1890. It published its first list of member schools in 1896. The objectives of the Association are to encourage:

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(1) The improvement and advancement of medical education by developing increasingly effective means of selecting the most able students for the study of medicine, (2) Experimentation in curriculum development and teaching methods, (3) Studies and programs aimed at improving the ability of students to learn and teachers to teach, (4) Efforts to improve the hospital and broaden the influence of continuing medical education, . . . (6) The development of the knowledge and leadership necessary to provide for the long-range progress and stability of medical education, and (7) The creating and maintenance of effective avenues of communication between medical edu-

cators' and between medical educators and the American public.[2]

The Association sponsors the Medical College Admission Test, conducts teaching institutes, undertakes studies of medical students and fiscal and administrative operations of medical schools, and publishes the Journal of Medical Education. Its executive offices are located at 2530 Ridge Avenue, Evanston, Illinois 60201, and at 1501 New Hampshire Avenue, N.W., Washington, D.C. 20036.

3) To be re-written by AAMC except for next to last sentence to be re-written as follows: Cons

Approval of a medical school by the Executive Council of the Association carries with it eligibility for membership in the Association. The six representatives from the Executive Council on the Liaison Committee are the chairman, chairman-elect, two members from the Council of Deans and one each from the Councils of Academic Societies and Teaching Hospitals.

stages of organization and development.

## PURPOSES OF ACCREDITING

The accrediting process serves to maintain and promote improved standards of medical education. The findings of the accrediting organizations have been used to establish minimum standards by various government agencies, by professional societies, and by other organizations having working relationships with physicians.

One of the most important functions of accreditation of medical schools is to establish standards for medical education for the guidance of legally established licensing bodies in the 50 states, the District of Columbia, Puerto Rico, Canal Zone, Guam, and the Virgin Islands. In each instance, the licensing body, in accordance with law or regulations, utilizes the decision regarding accreditation of one or more of the accrediting agencies. CURRENTLY, 26 boards require applicants for licensure to be graduates of medical schools approved by the Council on Medical Education; two boards required membership in the Association of American Medical Colleges, and 20 boards specified both approval by the Council and membership in the Association.

## DEVELOPMENT OF POLICIES

The Liaison Committee on Medical Education and its two sponsoring organizations operate under comprehensive statements of standards which have been approved by the House of Delegates of the American Medical Association and the institutional membership of the Association of American Medical Colleges. The statement, "Functions and Structure of a Modern Medical School," was approved in 1957 and the companion statement for two-year schools, "Functions and Structure of a Modern School of Basic Medical Sciences," was approved in 1958. These statements of principle are the evolutionary outgrowth of continued study by both organizations over a period of years.

The Liaison Committee and its parent Councils are currently engaged in a study of their accrediting functions and procedures, aimed at altering them to meet present and future needs more effectively. (4)

TO BE ADDED (4)

Consideration is being given particularly to conducting the survey visits in conjunction with representatives of agencies responsible for surveying and accrediting activities in graduate and continuing education, areas with which the Liaison Committee has not in the past concerned itself. This may lead to broadening the role of the Liaison Committee to encompass more completely the field of medical education, but currently the Liaison Committee limits its role in accreditation to that phase of medical education leading to the first professional degree.

5) TO BE INSERTED AS INDICATED

The two organizations encourage experimentation throughout medical education - pre-medical, undergraduate medical, graduate and continuing education - and experimentation is proceeding actively. One of the aims of such experimentation is a higher degree of integration of these various phases of medical education

ment of teachers, investigators and [illegible]

through programs of graduate education including residency training.

Among the criteria of interest to both organizations in accreditation are (1) the objectives of a medical school program in light of the AAMC 1953 statement, "The Objectives of Undergraduate Medical Education," (2) the organization and administration of the medical school, which should be incorporated as a nonprofit institution, and, if possible, as part of a university, (3) the appointment, competence, and organization of the faculty, including the attending staff of a general hospital for clinical teaching, (4) student services and admissions policies, [redacted] (5) facilities, including the medical library, and (6) the educational program. "No rigid curriculum can be prescribed for accomplishing the objectives of medical education," according to the statement, but a four-year curriculum should

contain education in human anatomy, biochemistry, physiology, microbiology, pharmacology, pathology, clinical laboratory diagnosis, physical diagnosis, internal medicine, pediatrics, obstetrics and gynecology, preventive medicine and public health, psychiatry, radiology, and surgery, as well as medical ethics, legal medicine, biostatistics, and medical genetics, and a consideration of social, emotional, and environ-

However, the medical curriculum is going through a period of major redesign and offerings fitted for the individual needs of each student can be expected to be found with increasing frequency in the near future.

basic medical sciences must, in part, be conditioned by the general pattern of the first two year curriculum of four-year schools." Recent developments in medical education have introduced more clinical teaching early in the curriculum, have integrated the entire four years more than formerly and have blurred the previously sharp line between the first two and second two years of the medical curriculum. These developments have complicated the problems of the two-year school and complicated the smooth transfer of the student from a two-year to a four-year school. The program of the two year school should be structured primarily to provide students with an opportunity to acquire a sound background in the basic medical sciences and an introduction to the major clinical disciplines.

prior to entrance of its first class and also when its first students are in the second year of the program. Favorable action in this survey results in "provisional approval," which has the effect of assuring students, the school, and other organizations that the school is providing acceptable training up to that point. During the fourth year, a definitive formal survey is conducted. Favorable action at this time indicates that the school has met minimum standards for its entire four-year period of training. Provision is made for more frequent surveys as necessary.

The survey schedule of the Liaison Committee is planned on a yearly basis with due consideration of the need to survey all schools over a period of SEVEN years and with special consideration of particular institutional needs as identified by the school itself or by previous accrediting action of the sponsoring Councils. When a school is to be included in the survey, a representative of the Liaison Committee establishes with the dean mutually satisfactory dates for the visit, including a final conference with the chief executive officer of the parent institution.

At least three months prior to the scheduled visit, five sets of the survey questionnaire form are sent to the medical school. Each of the major departments is expected to submit data along with more general information compiled by the dean's office. One set of forms serves as a record for the school and the remaining four are completed and returned to the Liaison Committee at least four weeks prior to the date of the addition, copies of the school bulletin, re- d schedules are made available to the mem- e survey team when appropriate.

### ITING TEAM

visiting team usually consists of four members, of whom are representatives of the Association

TO BE ADDED

One or more members may be added to the team in response to special problems of the institution being visited.

Liaison Committee designates one of the senior ical educators on the team as chairman and spokes- for the team while at the institution. It appoints her member as team secretary to make the pre- inary arrangements with the school, write the ini- draft of the report, and, together with the chair- , coordinate the activities of the team at the time he visit. The secretary and a majority of the other n members will invariably have had prior survey erience.

### THE VISIT

The visit usually takes three to four days. While a pattern for the visit is provided, the team and the school are encouraged to alter the suggested schedule to provide flexibility and to meet the needs of the team and the school. The visit usually begins with a conference among the members of the team and the dean for general orientation and discussion of special problems of administration.

The team as a whole frequently conducts departmental visits on a 30- to 60-minute schedule. These departmental visits may be conducted with the departmental chairman and, according to his desires and those of the team, with members of his staff. These visits are concerned primarily with curriculum, teaching methods, staff, and facilities, but also cover service, research, and graduate education especially as they have importance for the undergraduate medical student program.

The team usually makes a special effort, often during lunch hours, to meet with a representative group of students and with junior members of the faculty. They may also hold conferences, where appropriate, with representatives of other interested or related organizations such as the local or state medical association.

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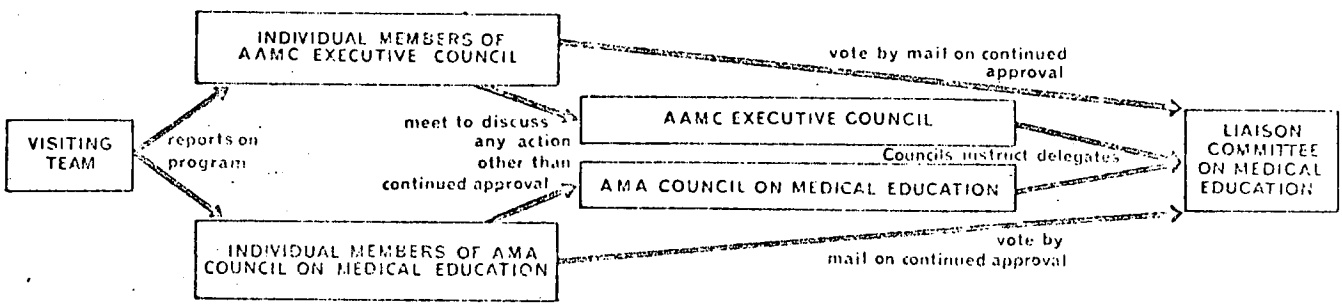

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[2] "About the Association," Association of American Medical Colleges Directory, 1964, page 13.

Prepared and distributed by the National Commission on Accrediting
1785 Massachusetts Avenue, N.W., Washington, D.C. 20036

*Functions and Structure of a*

# MODERN SCHOOL OF BASIC MEDICAL SCIENCES

Statement Prepared through Collaboration with

Council on Medical Education and Hospitals
American Medical Association

and the

Association of American Medical Colleges

Approved by the House of Delegates of the American Medical Association
December 1958

and the

Association of American Medical Colleges
October 1958

# Functions and Structure of a Modern School of Basic Medical Sciences

## I. Introduction

The Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association believe that two-year schools of Basic Medical Sciences under appropriate circumstances can make now and for the foreseeable future significant contributions to the established goals of medical education in the United States.

The increasing demands for medical services of a rapidly expanding and changing society can be served most effectively both by the development of new educational facilities in medicine and by the most efficient utilization of those facilities already in existence. Because of the early attrition of students and the ability of clinical facilities to accommodate greater numbers of students than basic science facilities, existing four-year schools can accept 300 to 400 more students for the last two medical school years than are presently enrolled.

The development of several new schools of basic medical sciences could result in the addition of more than 300 medical graduates annually. This increment would be obtained at least cost under these circumstances because of the lower capital and operating expenses of two-year programs and the more efficient utilization of already existing facilities for the last two medical school years. Students satisfactorily completing such two-year programs in the past have been successful in transferring to the third-year classes of four-year institutions.

The initiation of new two-year programs should offer interesting and effective opportunities for furthering a closer and more meaningful relationship between liberal education and early education in medicine. The faculty and facilities of the basic medical sciences would add breadth and depth in biological disciplines important to much of the overall university program. One such significant feature would be the development of graduate degree programs in these sciences for the education of future teachers and investigators.

In view of these facts, the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association wish to encourage universities with the necessary resources to establish new programs in medical education which would offer the first two years of the four-year medical course. These two organizations stand ready to consult with universities considering such a development.

It is intended that the following material be used as a guide in the development of two-year basic medical science programs with the hope that it may assist in attaining medical education of ever higher standards. Experience indicates that these are best nurtured in an environment in which there is not excessive concern with standardization. The concepts expressed here will serve as general but not specific criteria in the school accreditation program.

However, it is urged that this document not be interpreted as an obstacle to soundly conceived experimentation in medical education including its administrative patterns.

While the terms "school" and "dean" appear throughout this statement, this is not done with the intention of placing sharp limitations around the manner in which a university may approach the development of a program offering the first two years of the medical curriculum. These are days of rapid growth in the breadth and depth of the knowledge important to medicine. As a consequence, if a university should wish to develop a program in the basic medical sciences within the framework of existing liberal arts and graduate resources, even relating this program to others in the social, biological and related physical sciences, the Council on Medical Education and Hospitals and the Association of American Medical Colleges will look upon such with great, albeit critical interest. The objectives of such an arrangement must be to raise educational standards as well as to conserve and make for the more effective and efficient use of faculty and physical resources.

## II. The Responsibilities and Objectives of a School of the Basic Medical Sciences

As an institution of higher education, a school of the basic medical sciences has in common with four year medical schools three inherent responsibilities which are so closely related as to be inseparable.

1. It should provide for its students the opportunity to acquire a sound education in the sciences basic to medicine and should foster the development of lifelong habits of scholarship.
2. It should contribute to the advancement of knowledge through research.
3. It should contribute to the development of teachers, investigators and practitioners.

By virtue of its university orientation or as a result of the clinical facilities and personnel available, a school of the basic medical sciences should assume additional responsibilities such as those listed below to the degree that its resources permit without weakening its basic program:

1. Leadership in the development of adequate opportunities for the continuing education of practicing physicians.
2. Professional service to patients primarily to fulfill its educational and research obligations.
3. Participation in the educational programs of other professions in the health field, such as dentistry, nursing, and pharmacy, as well as in selected areas of the general university program.
4. Training of technical personnel in paramedical fields.

The school should develop a clear definition of its total objectives. When these objectives are clearly defined, they should be made familiar to faculty and students alike, so that efforts of all will be directed toward their achievement.

A statement of "The Objectives of Undergraduate Medical Education" has been prepared by the Association of American Medical Colleges. It is believed that this can well serve as the basis for a definition of this portion of the overall objective of a school of the basic medical sciences and is reproduced in part below. The full statement can be found in the Journal of Medical Education (28:57-59, March, 1953):

"Undergraduate medical education must provide a solid foundation for the future physician's development. It should not aim at presenting the complete, detailed, systematic body of knowledge concerning each and every medical and related discipline. Rather, it must provide the setting in which the student can learn fundamental principles applicable to the whole body of medical knowledge, establish habits of reasoned and critical judgment of evidence and experience, and develop an ability to use these principles and judgments wisely in solving problems of health and disease.

"Undergraduate medical education cannot achieve these aims if the student is relegated to a passive role. It must provide incentive for active learning on the part of the student. This can best be done by giving him definite responsibility in real day-to-day problems of health and disease. This responsibility must, of course, be carefully graded to the student's ability and experience and must be exercised under careful guidance by the faculty.

"Given incentive to learn and guidance toward the grasp of principles, with the problems of health and disease as a frame for reference, the student will build the necessary foundation for his career in medicine, be it practice (general or limited), teaching, research or administration.

"In working toward this fundamental objective, undergraduate medical schools must strive to help the student to: acquire basic professional knowledge; establish essential habits; attain clinical and social skills necessary to the best utilization of that knowledge; and develop those basic intellectual attitudes, and ethical or moral principles which are essential if he is to gain and maintain the confidence and trust of those whom he treats, the respect of those with whom he works and the support of the community in which he lives.

"These . . . aims are obviously not distinctly separable, but are mutually interdependent. Altogether they summarize the desirable characteristics of the responsible professional person medical education is attempting to produce."

Though a school of basic medical sciences provides only half of the four medical school years, the objectives of the two year school should embrace the foregoing rather than be undesirably limited. Whether he be in a two-year school of the medical sciences or in a four-year medical school, the medical student is essentially a student at the graduate level who benefits most from an educational program having such an orientation.

## III. Organization and Administration

**A. Governing Body.**—A school of the basic medical sci-

ences is conceived as an integral part of a university which alone can provide the milieu and support required for medical study.

Officers and faculty of the school should be appointed by the University Board of Trustees. In keeping with generally accepted principles of administration, it is usually not desirable for a member of the board of trustees to serve simultaneously as an administrator or a member of the faculty of the school of basic medical sciences.

The manner in which the school is expected to conduct its affairs, including the responsibilities and privileges of administrative officers, faculty, and students should be clearly indicated in bylaws approved for the school itself or adequately presented in the bylaws of the parent university.

**B. Administrative Officers of the School.**—There should be competent supervision of the school of basic medical sciences by the dean or other executive officer who, by training and experience, is qualified to provide leadership in interpreting high standards in medical education, and who has sufficient authority to implement such standards. The dean should have the respect and support of the faculty and ready access to the university president and other officials. The establishment and maintenance of a congenial and productive relationship with the local medical profession is desirable and important to the school and the profession. It can be best assured through discussions of mutual problems by representatives of the school and practicing profession.

Because of the diverse and heavy responsibilities placed upon the dean or executive officer, assistance by suitably qualified persons should be provided. In some schools, for example, there is an assistant dean who devotes major attention to student affairs. In the conduct of the fiscal affairs of the school, the dean should have the assistance of a capable business officer.

**C. Faculty Organization.**—The faculty should be organized into suitable departments representing those areas or disciplines with a major responsibility in the teaching program. It is to be noted that this is primarily an administrative convenience; it should not form the sole basis for structuring the curriculum. Each such department should have a voice, through appropriate committees of the faculty, in the administration of the academic affairs of the school. Foremost among these should be an executive committee of the faculty composed primarily of the responsible administrative officials and the chairmen of those departments which have a major role in the education program. In a school of basic medical sciences usually these would be Anatomy, Physiology, Biochemistry, Microbiology, Pharmacology and Pathology. The clinical areas of Medicine, Surgery, Pediatrics, Obstretics-Gynecology, Psychiatry, and Preventive Medicine and Public Health may be represented singly or as combined areas. In the latter instance, consideration should be given to allowing a reasonable voice to clinical viewpoints in the committee's major function of determining, with the dean, medical school policies for consideration, where indicated, by higher university authority.



It is recognized that the clinical disciplines in a school of the basic medical sciences have quantitatively less responsibility in the total program of the school than do the clinical departments of a four-year medical school. In consequence, it is possible that the clinical departmentalization of the school of basic medical sciences might follow a different pattern than of having a separate department for each major clinical field, as is the case with four-year medical schools.

There should be such additional committees of the faculty as admissions, promotions, curriculum, postgraduate medical education, library, and others needed to serve the welfare of the school.

The entire faculty should meet one or more times annually to provide an opportunity for all faculty members to become acquainted with and to discuss school policies and practices.

Nominations for faculty appointments should originate in the faculty under the leadership of the dean. Commonly, nominations for appointments at the lower academic ranks are made by the head of the department concerned, after thorough discussions of the nominees by the entire department. At the professorial and associate professorial levels this procedure may be profitably supplemented or supplanted by the appointment of a nominating committee composed of members of several departments, whose standing and judgment are generally unquestioned. Recommendations are made to the faculty executive committee and dean who, in turn, recommend to the president and board of trustees through esablished administrative channels.

**D. Finances.**—Experience has established that a school of the basic medical sciences cannot successfully carry out its many activities solely on the income derived from student fees. Furthermore, certain of these activities are not directed primarily to the education of the medical student and he should not be expected to support them. To fulfill its obligation adequately a school of the medical sciences should have other substantial sources of revenue.

Each department within the school should prepare its budget in consultation with the dean, who is ultimately responsible for the total budget and its presentation to the proper authority.

## IV. Faculty

The school should have a competent staff with demonstrated interest and ability in teaching and research. Such dual activity by the faculty is most likely to provide the educational milieu appropriate in a modern school of the basic medical sciences as well as to carry out best its objectives and responsibilities.

Reasonable security of tenure and possibility of advancement should be assured in order that the personnel of the faculty may have adequate stability.

The faculty in the basic science disciplines should be almost entirely on a full time basis. The number of such instructors in each basic science department should be sufficient to meet the requirements of the educational program as

well as allow adequate time for research by each instructor. The ratio of full time basic science teachers to students may vary in different departments and different schools, depending on course content, educational methods, the nature and extent of research activities and other factors.

In addition, there should be a nucleus of faculty, adequately representing clinical interests, who have as their major responsibility the planning and supervision of the clinical aspects of the teaching program, its relationship to the basic medical sciences, as well as the conduct of research. The size of this nucleus and the specific clinical fields represented will depend, among other factors, on the number of physicians qualified and available to serve as part time and volunteer staff in the major clinical disciplines which will have significant teaching responsibility. Close contact of medical students with clinical teachers as the latter relate themselves to patients in a hospital setting will aid in the inculcation of the ethics and ideals of medicine at an early stage in the students' career.

Modern trends in medical education have resulted in interdigitation of teaching in basic science and clinical areas, so that the latter occurs to a significant degree and in the first two years of the curriculum. Similarly, basic science and clinical faculty members find a close and continuing relationship of great benefit in their research efforts. These desirable trends should find expression in a school of basic medical sciences to prevent it from being simply a "preclinical" institution.

Recognition of the value of intimate teacher-student relationships and widespread use of methods favoring an active role for the student in his own education have decreased dependence on didactic exercises. Increasing use has also been made of interdepartmental teaching. These factors have tended to increase the size of the instructional staff.

## V. Students

The admission of students to a school of the basic medical sciences should be the responsibility of a committee of the faculty. Decisions regarding admission should be based not only on satisfactory prior scholastic accomplishment but also on such factors as personality and emotional characteristics, motivation, industry, resourcefulness, and health. Evaluation of these factors should be developed through personal interviews, college records of academic and non-academic activities, results of medical college admission tests, and pertinent letters of recommendation. All records dealing with admissions should be carefully filed and procedures periodically reviewed in a search for better methods. Of assistance in this would be the securing of information regarding student achievement from the four-year medical schools to which the students of the two-year school transferred.

At least three years of college education is required for most students and four years is recommended as a preparation for medical study. Only rarely and under exceptional circumstances will a medical school be justified in admitting a superior student after two years of college study.



The National Committee of Regional Accrediting Agencies maintains a listing of institutions of higher education which have been found to offer commendable educational programs. (A copy can be obtained by addressing the National Commission on Accrediting, 1785 Massachusetts Ave., N. W., Washington 6, D. C.) Prospective medical students should acquire their preparatory education at a college of arts and sciences so listed. The admissions committee of a school of the basic medical sciences should scrutinize with particular care the qualifications of applicants whose preparatory study has been done at other institutions.

Because basic knowledge of biology, physics, inorganic and organic chemistry and human behavior are the foundation stones of medicine, adequate college courses in these subjects, as well as demonstrated competence in English, should be required. It is important that any medical college restrict its admission requirements to this minimum so that a college student preparing for the study of medicine will have the opportunity to acquire a broad liberal education or to study a specific field in depth according to individual interest and ability. The complexity of modern medicine can be served best by physicians who in composite represent a variety of backgrounds in education and experience.

The number of students who can have an adequate medical education in the first two years is related to the laboratory and clinical facilities available and to the size and qualifications of the teaching staff (see also: IV. Faculty). A close personal contact between students and members of the teaching staff results in a quality of educational experience that is not possible in an institution where the number of students is excessive in relation to the staff and facilities.

There should be a system of student records showing conveniently and in detail the admissions credentials as well as the grades or other records of performance in the school, by means of which an exact knowledge can be obtained regarding each student's work and qualifications. Subjective evaluations of each student by instructors should be included in the student records.

An adequate provision for student counselling should be in effect. Many schools have an assistant responsible to the dean for such counselling.

There should be an active student health service providing for periodic medical examination and medical care for the student body. This is important not only in the maintenance of student health but also because of its inherent educational values.

## VI. Facilities

A school of the basic medical sciences should own or enjoy the assured use of buildings and equipment adequate quantitatively and qualitatively to provide an environment most conducive to productivity of faculty and students in the fulfillment of the total objectives of the school. If possible, all of the basic medical sciences should be housed in a building close enough to the clinical facilities so as to promote cooperative teaching efforts and allow all departments ready access to clinical material.

A well maintained and catalogued medical library that can be used conveniently and effectively by both students and faculty is essential to modern medical education. A trained librarian with experience in medical library work should be employed to supervise the development and operation of the library with the advice and assistance of an active representative committee of the faculty. The library should receive regularly the leading medical periodicals, the current numbers of which should be readily accessible. Adequate arrangements should be made by the librarian and the faculty to instruct all students in the use of the library at the beginning of their medical studies.

The school should have the assured use of a number of hospital beds adequate to meet the clinical needs of the teaching program. It is essential that the clinical teachers, either on nomination by the school or by agreement in conference between school and hospital, be appointed by the hospital trustees to appropriate positions on the hospital staff so that their direction of the teaching service will be unquestioned. It is desirable for the teaching hospital to be in close proximity to the school and it should provide sufficient patients for instruction in physical diagnosis and to introduce students to the clinical study of disease as well as to illustrate the clinical aspects of the basic medical sciences.

There should be sufficient offices, laboratories, and conference rooms in the basic science facility and either as a part of or conveniently close to the hospital to meet the needs of faculty and students.

## VII. Educational Program

Before the curriculum, methods and details of an educational program are determined, the objectives of the program should be formulated. The objectives should indicate clearly that the first two years of medical education are to provide the foundation for further education in a four-year medical school, in graduate programs, as well as throughout professional life. There is no objection to the awarding of an appropriate degree when indicated.

The educational program of a school of the basic medical sciences must, in part, be conditioned by the general pattern of the first two year curriculum of four-year schools. However, the program should be structured primarily to provide students with an opportunity to acquire a sound background in the basic medical sciences and an introduction to the major clinical disciplines. Because of the variations present in the curriculum of different medical schools, any attempt by a school of basic medical sciences to embrace the variations present in several four-year medical schools would lead to a confused preoccupation with coverage of the details of many subjects. This would hamper the students' acquisition of an understanding of basic principles upon which they can structure necessary facts and would inhibit the important development of sound attitudes of self-education and essential habits of reasoned and critical judgment.

No rigid curriculum can be prescribed for accomplishing the objectives of medical education. On the contrary, it is the responsibility of the faculty of each school continually



to reevaluate its curriculum and to provide in accordance with its own particular setting and in recognition of advances in science a sound and well-integrated educational program. Each school should utilize those methods and approaches that the particular interests and abilities of the faculty indicate would provide the most effective education in the framework of the available facilities. The traditionally separate disciplines are finding rewarding educational and research results in working together co-operatively.

Through the various educational methods and to the extent deemed best by the faculty to accomplish the objectives of medical education, each school of basic medical sciences should offer education in the following subjects during the two-year curriculum:

Human anatomy, biochemistry, physiology, microbiology, pharmacology, general pathology, physical and laboratory diagnosis, as well as an introduction to clinical medicine, surgery, obstetrics-gynecology, pediatrics, psychiatry, and preventive medicine and public health as appropriate to the curriculum of the first two years. Biostatistics and medical genetics should be included in the educational program, as also should an initial consideration of social, emotional and environmental factors in health and disease.

The traditional emphasis on lectures, demonstrations and amphitheater clinics in which the role of the student is passive has shifted to greater use of individual student and small group projects, conferences, seminars, and the "case method" of education, in all of which the student actively participates in his own education. The allotment of some unscheduled student time in the weekly program to allow for reading, research or other independent pursuits is desirable.

## VIII. Accreditation of Medical Schools

The American Medical Association through its Council on Medical Education and Hospitals and the Association of American Medical Colleges through its Executive Council serve as the recognized accrediting agencies for medical schools and for schools of the basic medical sciences. Though retaining their individual identities, both groups work very closely in this activity through the Liaison Committee on Medical Education. To be accredited, a school must be considered approved by the Council on Medical Education and Hospitals and by the Association of American Medical Colleges. Accreditation is granted on the observance of a sound educational program in a survey visit conducted jointly by both organizations.

It is the intent that newly developing two-year schools should be surveyed during each of the first two years of active existence, with definitive action taken during the implementation of the second year of the curriculum.

Existing medical schools are surveyed at regular intervals. Every attempt is made to fulfill requests for interim surveys as a consultant service to the medical schools and schools of basic medical sciences.

A school to be surveyed is requested to provide basic information on forms forwarded in advance. After careful study of this material, a joint survey team visits the school. On completion of its visit, the survey team confers with the responsible administrative officials of the school of basic medical sciences and its parent university, indicating to them the nature of the major findings and recommendations. A complete, written report is prepared and considered separately by the Council on Medical Education and Hospitals and the Executive Council of the Association of American Medical Colleges and then jointly by the Liaison Committee on Medical Education. The action of each group and the complete report is then transmitted to the school dean and the university president.

Application for and further information concerning this process can be obtained from the Secretary, Council on Medical Education and Hospitals, American Medical Association, 535 N. Dearborn St., Chicago 10, or the Executive Director, Association of American Medical Colleges, 2530 Ridge Ave., Evanston, Ill.

# FUNCTIONS AND STRUCTURE
# of a
# MODERN MEDICAL SCHOOL

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Statement Prepared through
Collaboration with

**Council on Medical Education
and Hospitals
American Medical Association**

and the

**Association of American Medical
Colleges**

•

Approved by the House of Delegates of
the American Medical Association
June 1957

and the

Association of American Medical
Colleges
October 1957

## I. INTRODUCTION

This statement has been prepared in collaboration, with the Association of American Medical Colleges and represents the general concepts of that organization as well as the Council on Medical Education and Hospitals of the American Medical Association. It is intended that this material be used as a guide with the hope that it may assist in attaining medical education of ever higher standards. Experience indicates that these are best nurtured in an environment in which there is not excessive concern with standardization. The concepts expressed here will serve as general but not specific criteria in the medical school accreditation program. However, it is urged that this document not be interpreted as an obstacle to soundly conceived experimentation in medical education.

## II. THE RESPONSIBILITIES AND OBJECTIVES OF A MEDICAL SCHOOL

As an institution of higher education, a medical school has three inherent responsibilities which are so closely related as to be inseparable.

1. *A medical school should provide for its undergraduate students the opportunity to acquire a sound, basic education in medicine and should foster the development of lifelong habits of scholarship.*

2. *A medical school should contribute to the advancement of knowledge through research.*

3. *A medical school should contribute to the development of teachers, investigators and practitioners through programs of graduate education including residency training.*

By virtue of its university orientation or as a result of the clinical facilities and personnel available, a medical school should assume additional responsibilities such as those listed below to the degree that its resources permit without weakening its basic program:

1. Leadership in the development of adequate opportunities for the continuing education of practicing physicians.

2. Professional service to patients primarily to fulfill its educational and research obligations.

3. Participation in the educational programs of other professions in the health field, such as

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dentistry, nursing, and pharmacy, as well as in selected areas of the general university program.

4. Training of technical personnel in paramedical fields.

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

A statement of "The Objectives of Undergraduate Medical Education" has been prepared by the Association of American Medical Colleges. It is believed that this can well serve as the basis for a definition of this portion of the overall objectives of a medical school and is reproduced in part below. The full statement can be found in the *Journal of Medical Education* (28:-57-59) (March) 1953.)

"Undergraduate medical education must provide a solid foundation for the future physician's development. It should not aim at presenting the complete, detailed, systematic body of knowledge concerning each and every medical and related discipline. Rather, it must provide the setting in which the student can learn fundamental principles applicable to the whole body of medical knowledge, establish habits of reasoned and critical judgment of evidence and experience, and develop an ability to use these principles and judgments wisely in solving problems of health and disease.

"Undergraduate medical education cannot achieve these aims if the student is relegated to a passive role. It must provide incentive for active learning on the part of the student. This can best be done by giving him definite responsibility in real, day-to-day problems of health and disease. This responsibility must, of course, be carefully graded to the student's ability and experience and must be exercised under careful guidance by the faculty.

"Given incentive to learn and guidance toward the grasp of principles, with the problems of health and disease as a frame of reference, the student will build the necessary foundation for his career in medicine, be it practice (general or limited), teaching, research or administration.

"In working toward this fundamental objective, undergraduate medical schools must strive to help the student to: acquire basic professional knowledge; establish essential habits; attain clinical and social skills necessary to the best utilization of that knowledge; and develop those basic intellectual attitudes, and ethical or moral principles which are essential if he is to gain and maintain the confidence and trust of those whom he treats, the respect of those with whom he works and the support of the community in which he lives.

"These . . . aims are obviously not distinctly separable, but are mutually interdependent. All together they summarize the desirable characteristics of the responsible professional person medical education is attempting to produce."



## III. ORGANIZATION AND ADMINISTRATION

A. *Governing Body.*—A medical school should be incorporated as a nonprofit institution, if possible as a part of a university, since a university can so well provide the milieu and support required by a modern medical school.

If not a component of a university, a medical school should have a board of trustees composed like that of a university of public spirited men or women having no financial interest in the operation of the school or its associated hospitals. The trustees should serve for fairly long and overlapping terms.

Officers and faculty of the school should be appointed by the board of trustees. In keeping with generally accepted principles of administration, it is usually not desirable for a member of the board of trustees to serve simultaneously as an administrator or a member of the faculty of the medical school.

The manner in which the medical school is expected to conduct its affairs, including the responsibilities and privileges of administrative officers, faculty, and students should be clearly indicated in bylaws approved for the medical school itself or adequately presented in the bylaws of the parent university.

B. *Administrative Officers of the Medical School.*— There should be competent supervision of the medical school by the dean or other executive officer who, by training and experience, is qualified to provide leadership in interpreting high standards in medical education, and who has sufficient authority to implement such standards. The dean should have the respect and support of the faculty and ready access to the uni-

versity president and other officials. The establishment and maintenance of a congenial and productive relationship with the local medical profession is desirable and important to the school and the profession. It can be best assured through discussions of mutual problems by representatives of the school and practicing profession.

Because of the diverse and heavy responsibilities placed upon the dean or executive officer, assistance by suitably qualified persons should be provided. In many medical schools, for example, there is an assistant dean who devotes major attention to student affairs and another assistant for administering the postgraduate program. In the conduct of the fiscal affairs of the school, the dean should have the assistance of a capable business officer.

C. *Faculty Organization.*—The faculty should be organized into suitable departments representing the major basic science and clinical fields. It is to be noted that this is primarily an administrative convenience; it should not form the sole basis for structuring the curriculum. Each such department should have a voice, through appropriate committees of the faculty, in the administration of the academic affairs of the school. Foremost among these should be an executive committee of the faculty composed primarily of the responsible administrative officials and the chairmen of those departments which have a major role in the education program. Usually these are Anatomy, Physiology, Biochemistry, Microbiology, Pharmacology, Pathology, Medicine, Surgery, Pediatrics, Obstetrics-Gynecology, Psychiatry, and Preventive Medicine and Public Health. This commonly utilized pattern allows for balance between basic science and clinical viewpoints in the committee's major function of determining, with the dean, medical school policies for consideration, where indicated, by higher university authority.

There should be such committees of the faculty as admissions, promotions, curriculum, postgraduate medical education, library, and others needed to serve the welfare of the school.

The entire faculty should meet one or more times annually to provide an opportunity for all faculty members to become acquainted with and to discuss medical school policies and practices.

Nominations for faculty appointments should originate in the faculty under the leadership of



the dean. Commonly, nominations for appointments at the lower academic ranks are made by the head of the department concerned, after thorough discussions of the nominees by the entire department. At the professorial and the associate professorial levels this procedure may be profitably supplemented or supplanted by the appointment of a nominating committee composed of members of several departments, whose standing and judgment are generally unquestioned. Recommendations are made to the faculty executive committee and dean who, in turn, recommend to the president and board of trustees through established administrative channels.

D. *Finances.*—Experience has established that a medical school cannot successfully carry out its many activities solely on the income derived from student fees. Furthermore, certain of these activities are not directed primarily to the education of the medical student and he should not be expected to support them. To adequately fulfill its obligation, a medical school should have other substantial sources of revenue.

Each department within the school should prepare its budget in consultation with the dean, who is ultimately responsible for the total budget and its presentation to the proper authority.

## IV. FACULTY

The school should have a competent staff with demonstrated interest and ability in teaching and research. Such dual activity by the faculty is most likely to provide the educational milieu appropriate in a modern medical school as well as best carry out its objectives and responbilities.

Reasonable security of tenure and possibility of advancement should be assured in order that the personnel of the faculty may have adequate stability. Compensation of full time members of the faculty should be sufficient to enable them to support themselves and their families.

The number of instructors in each basic science and clinical department should be sufficient to meet the requirements of a modern medical educational program as well as allow adequate time for research by each instructor. Full time teacher-student ratios may vary widely depending on the course content, educational methods, research activities, the availability of competent part time or voluntary staff, and other factors. Recognition of the values of intimate teacher-

student relationships and widespread use of methods favoring the active role of the student in his own education have decreased dependence on didactic exercises. Increasing use has also been made of interdepartmental teaching. These factors have tended to increase the relative size of the instructional staff.

The faculty personnel in the basic science disciplines should be almost entirely on a full time basis. In the major clinical areas of medicine, surgery, pediatrics, psychiatry, obstetrics and gynecology, there should be a nucleus of full time instructors who have as their major responsibility the planning and supervision of the department's educational program and the conduct of research.

## V. STUDENTS

The admission of students to a medical school should be the responsibility of a committee of the faculty. Decisions regarding admission should be based not only on satisfactory prior scholastic accomplishment but also on such factors as personality and emotional characteristics, motivation, industry, resourcefulness, and health. Evaluation of these factors should be developed through personal interviews, college records of academic and nonacademic activities, results of medical college admissions tests, and pertinent letters of recommendation. All records dealing with admissions should be carefully filed and procedures periodically reviewed in a search for better methods.

At least three years of college education is required for most students and four years is recommended as a preparation for medical study. Only rarely and under exceptional circumstances will a medical school be justified in admitting a superior student after two years of college study. The National Committee of Regional Accrediting Agencies maintains a listing[1] of institutions of higher education which have been found to offer commendable educational programs. Prospective medical students should acquire their preparatory education at a college of arts and sciences so listed and a medical school admissions committee should scrutinize with particular care the qualifications of applicants whose preparatory study has been done at other institutions.

Because basic knowledge of biology, physics, inorganic and organic chemistry and human behavior are the foundation stones of medicine,

1. A copy can be obtained by addressing the National Commission on Accrediting, 1785 Massachusetts Ave. N.W., Washington 6, D. C.



adequate college courses in these subjects, as well as demonstrated competence in English, should be required. It is important that a medical college restrict its admission requirements to this minimum so that a college student preparing for the study of medicine will have the opportunity to acquire a broad liberal education or to study a specific field in depth according to individual interest and ability. The complexity of modern medicine can be best served by physicians who in composite represent a variety of backgrounds in education and experience.

Advanced standing may be granted to students for work done in other medical schools, but only when a student's previous work is qualitatively and quantitatively equivalent to that required of regularly enrolled students, as officially verified by correspondence with the school previously attended. Because of the diversity and greater integration of the total curriculum, transfers are becoming increasingly difficult but usually are least disruptive of the student's education at the end of the second year.

The number of students who can have an adequate education in a medical school is related to the laboratory and hospital facilities available and to the size and qualifications of the teaching staff (see also: IV. Faculty). A close personal contact between students and members of the teaching staff results in a quality of educational experience that is not possible in an institution where the number of students is excessive in relation to the staff and facilities.

There should be a system of student records showing conveniently and in detail the admissions credentials as well as the grades or other records of performance in the school, by means of which an exact knowledge can be obtained regarding each student's work and qualifications. Qualitative evaluations of each student by instructors should be included in the student records.

An adequate provision for student counseling should be in effect. Many schools have an assistant responsible to the dean for such counseling.

There should be an active student health service providing for periodic medical examination and medical care for the student body. This is important not only in the maintenance of student health but also because of its inherent educational values.

## VI. FACILITIES

A medical school should own or enjoy the as-

sured use of buildings and equipment adequate quantitatively and qualitatively to provide an environment most conductive to productivity of faculty and students in the fulfillment of the total objectives of the school. If possible, all of the basic medical sciences should be housed in a building which adjoins in some manner the clinical facilities so as to promote cooperative teaching efforts and allow all departments ready access to clinical material.

A well maintained and catalogued medical library that can be used conveniently and effectively by both students and faculty is essential to a modern medical school. A trained librarian with experience in medical library work should be employed to supervise the development and operation of the library with the advice and assistance of an active representative committee of the faculty. The library should receive regularly the leading medical periodicals, the current numbers of which should be readily accessible. Adequate arrangements should be made by the librarian and the faculty to instruct all students in the use of the library at the beginning of their medical studies.

The school should own or have the unquestioned right to appoint the attending staff of a general hospital for clinical teaching. In the event that a medical school depends for clinical teaching on an independent hospital, it is essential that the clinical teachers, either on nomination by the school or by agreement in conference between school and hospital, be appointed by the hospital trustees to appropriate positions on the hospital staff. The teaching hospitals should be either adjoining or in close proximity to the school and should provide sufficient patients to permit students individually to observe, work up, and study the progress of the common variety of medical and surgical cases as well as a fair number of patients in each of the other major specialties.

There should be a sufficient number of patients so that each student on a hospital clerkship can be assigned that number of new cases of teaching value each week for thorough study that the faculty judges to be of maximum educational value. For example, this may be two new patients a week in one department or five new cases weekly in another, depending upon the orientation, objectives, and teaching program of the department concerned. Therefore, no fixed number of hospital beds or patients per student



can be established because of the variables involved. Medical education should emphasize intensive long term study by each student of relatively fewer patients rather than superficial observation of many patients.

The school should own or have unquestioned use of well ordered facilities for the diagnosis, treatment and follow-up of ambulatory patients. The attending staff should be drawn from the faculty including those of senior rank. The number of new cases per day available to each student serving an outpatient clerkship should be compatible with the educational objectives and teaching program of the department as well as the school.

There should be sufficient offices, laboratories, and conference rooms as a part of or conveniently close to the hospital and outpatient clinical facilities to meet the needs of faculty and students. The hospital floors should provide adequate space and facilities for student clerks to study their patients.

## VII. EDUCATIONAL PROGRAM

Before the curriculum, methods and details of an educational program can be decided, the objectives of the program should be formulated.

The objectives should clearly indicate that an undergraduate medical education provides merely a sound foundation for further education during the internship and residency periods, as well as throughout professional life. Four years of education in medical school is not by itself sufficient to prepare a physician for practice today. In fact, the yearly advances in medicine demand that each physician continue his education throughout his career. It is also obvious that no physician can master the whole spectrum of medical knowledge.

No rigid curriculum can be prescribed for accomplishing the objectives of medical education. On the contrary, it is the responsibility of the faculty of each school continually to reevaluate its curriculum and to provide in accordance with its own particular setting and in recognition of advances in science a sound and well-integrated educational program. Each school should utilize those methods and approaches that the particular interests and abilities of the faculty indicate would provide the most effective education in the framework of the available facilities. The tra-

ditionally separate disciplines are finding rewarding educational research results in working together cooperatively.

Through the various educational methods and to the extent deemed best by the faculty to accomplish the objectives of medical education, each medical school should offer education in the following subjects during the four year curriculum:

Human Anatomy, Biochemistry, Physiology, Microbiology, Pharmacology, Pathology, Clinical Laboratory Diagnosis, Physical Diagnosis, Internal Medicine, Pediatrics, Obstetrics and Gynecology, Preventive Medicine and Public Health, Psychiatry, Radiology, and Surgery. Specialty areas in medicine and surgery are best integrated in the teaching of the major disciplines. Consideration of social, emotional and environmental factors in health and disease is properly the responsibility of all clinical departments. Medical ethics, legal medicine, biostatistics and medical genetics should be included in the educational program.

The traditional emphasis on lectures, demonstrations and amphitheater clinics in which the role of the student is passive has shifted to greater use of individual student and small group projects, conferences, seminars, and the "case method" of education, in all of which the student actively participates in his own education. The allotment of some unscheduled student time in the weekly program to allow for reading, research or other independent pursuits is desirable.

In the clinical years particularly, there is no substitute for the "case method" of clinical education, in which individual students work up individual patients under guidance in the hospital wards and in outpatient clinics. Such assignments should occupy most of the time and energy of third and fourth year medical students. The student should be encouraged to feel a genuine responsibility as part of a team of physicians studying the patient, and not as a classroom student with prescribed hours of work. The student's work-up of each case including progress notes should become part of the hospital's permanent record of the case. Such case studies should serve as the point of departure for informal conferences, rounds, and reading. Lectures and other didactic exercises cannot replace though they may supplement bedside learning.



## VIII. ACCREDITATION OF MEDICAL SCHOOLS

The American Medical Association through its Council on Medical Education and Hospitals and the Association of American Medical Colleges through its Executive Council serve as the recognized accrediting agencies for medical schools. Though retaining their individual identities, both groups work very closely in this activity through the Liaison Committee on Medical Education. To be accredited, a medical school must be considered approved by the Council on Medical Education and Hospitals and offered membership in the Association of American Medical Colleges. This is granted on the finding of a sound educational program as a result of a survey conducted jointly by both organizations.

It is the intent that newly developing medical schools should be surveyed during each of the first four years of active existence. Provisional accreditation is granted, when the program warrants, for the first two years of the curriculum and definitive action is taken during the implementation of the fourth year of the curriculum.

Existing medical schools are surveyed at regular intervals. Every attempt is made to fulfill requests for interim surveys as a consultant service to the medical schools.

A medical school to be surveyed is requested to provide basic information on forms forwarded in advance. After careful study of this material, the survey team of three or four members visits the medical school for three to five days. On completion of its visit, the survey team confers with the responsibile administrative officials of the medical school and its parent university, incating to them the nature of the major findings and recommendations. A complete, written report is prepared and considered separately by the Council on Medical Education and Hospitals and the Executive Council of the Association of American Medical Colleges and then jointly by the Liaison Committee on Medical Education. The action of each group and the complete report is then transmitted to the medical school dean and university president.

Application for and further information concerning this process can be obtained from the Secretary, Council on Medical Education and Hospitals, American Medical Association, 535 N. Dearborn St., Chicago 10, or the Secretary, Association of American Medical Colleges, 2530 Ridge Ave., Evanston, Ill.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
MINUTES
EXECUTIVE COMMITTEE OF THE COUNCIL OF DEANS
MEETING

April 9 - 10, 1969

DUPONT PLAZA HOTEL
Washington, D.C.

## I. Minutes of Meeting, February 8, 1969

The minutes of the Council of Deans meeting, February 8, 1969, in Chicago were accepted without change.

## II. Bylaws

The proposed bylaws of the Council of Deans, which had been drafted by Drs. Felix and Bostick and re-edited by Dr. Cooper and Miss Littlemeyer, were discussed in general terms.

ACTION: It was agreed that the proposed draft of bylaws would be circulated to the members of the Council of Deans in advance and discussed at the meeting on May 9.

## III. Appropriations for Student Loans

The problems that will be produced by the proposed reduction in the appropriations for student loans were discussed to a limited extent, and it was agreed that the Committee on Federal Health Programs should take up this matter.

## IV. National Service for Medical Graduates

The proposal that all medical graduates be obligated for two years of Federal service in the armed forces, the Peace Corps, Vista, or other programs to be established, to provide services in areas of need, and that a matching plan be used so that the preference of the individual for what type of Federal service, and at what stage in his post-M.D. education could be matched with the needs of the various programs, was discussed in general terms. Several members of the committee indicated their support of the idea and their belief that it would be wise for the AAMC to take a position favoring this development and to make that position publicly known. No opposition to the idea was expressed.

ACTION: It was agreed that this item should be on the agenda for the meeting of the Council of Deans on May 9.

V. Agenda for the May Meeting of the Council of Deans

After discussion, it was agreed that the following items would make up the agenda for the meeting of the Council of Deans in May:

1. Report from Students
Since the AAMC made a grant to partially support the SAMA's Conference on Medical Education, a representative of the organization will be asked to present a report on the conference. There was discussion of the desirability of also asking a representative of SHO and a representative of the SAMA to also make reports to the Council of Deans. The final decision on that point was left in the hands of the chairman of the Council of Deans.

2. Report from Federal Officials
Dr. Robert Marston, the Director of the National Institutes of Health, will be asked to make a relatively short presentation to be followed by a period of questions and answers. There was also some agreement on the desirability of inviting Dr. Joseph English, the Director of the Health Services and Mental Health Administration, to address the Council.

3. Report from Executive Council
Dr. Robert Glaser, Chairman, will report for the Council.

4. Report from Committee on Federal Health Programs
Dr. Carl Chapman, Chairman of the committee, will report for the committee.

5. Bylaws of the Council of Deans
The draft of bylaws will be distributed in advance and will be brought up on the agenda for information and discussion, but not for action at the May meeting.

6. Other Business
Since the southern and midwestern regional meetings will take place during April, the chairmen of those regions will be asked to make reports. If the other regions hold meetings before May 9, the chairmen of those regions will be asked to make a report also.

VI. Correspondence with Dr. Galletti - Discouragement of Innovation by the Accreditation Process

Correspondence between Dr. Galletti of Brown University and Drs. Anlyan and Smythe had been distributed in advance. Discussion brought out the

fact that Brown University has, indeed, developed an innovative program in that institution, the accrediting visits have actively encouraged the innovation, and have not been an inhibiting factor. But it was agreed that the accrediting process can be a strong influence toward conformity, and that it is important that continuous effort be made to see that it is not. It was pointed out also that the site visits in connection with applications for construction grants have been a stronger influence toward conformity than the accreditation process. A good bit of care has been invested in the selection of individuals to make accreditation visits, and this needs to be done continuously. There have been fruitful discussions between the staff of the AAMC, the AMA, and the staff of the Health Manpower Division, and these also need to be continued.

There was general agreement that it will be useful to plan for an afternoon session during the annual meeting devoted to the process of accreditation, site visitation, and institutional development. It is hoped that this session will attract some of the Federal officials involved in site visitation, as well as others, and that it will emphasize the importance of developing sound new patterns of medical education.

## VII. Date of Next Meeting

It was agreed that the Executive Committee of the Council of Deans will have a breakfast meeting in the Washington Hilton Hotel on June 25, just prior to the next meeting of the Executive Council.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2530 RIDGE AVENUE EVANSTON, ILLINOIS 60201
1346 CONNECTICUT AVE., N.W. WASHINGTON, D.C. 20036

April 16, 1969

CHEVES McC. SMYTHE, M.D.
ASSOCIATE DIRECTOR
EVANSTON, ILLINOIS

EVANSTON: 312: 328-9505
WASHINGTON: 202: 223-5364

TO: Executive Committee - Council of Deans

FROM: Cheves McC. Smythe, M.D.

SUBJECT: Statements

In the discussion of the correspondence between Drs. Anlyan, Galletti, Smythe, and Glaser concerning the accreditation of new medical schools a number of problems with the whole accreditation process were surfaced. Among these was the fact that our currently used statements on the "Functions and Structure of a Modern Medical School" were last revised in 1958. Dr. Chapman suggested that everyone on the Council receive a copy of the currently used version as well as a note on the statement we now circulate on accreditation in medicine. The last was revised in March of 1969.

The enclosures are: (1) A copy of the statement on "Functions and Structure of a Modern School of Basic Medical Sciences; (2) The same for a four-year school; and (3) A statement on accreditation in medicine. These are sent to you for your interest. This matter is also being introduced at the next meeting of the Liaison Committee on Medical Education.

Your staff thinks that the appropriate action to be taken at this time is the appointment of an ad hoc committee of not more than three to revise the 1958 statement.

CMS:pm
Enclosures

# ACCREDITATION IN MEDICINE

## LIAISON COMMITTEE ON MEDICAL EDUCATION

Years Beginning July 1 of Even-Numbered Years:
2530 Ridge Avenue
Evanston, Illinois 60201

Years Beginning July 1 of Odd-Numbered Years:
535 North Dearborn Street
Chicago, Illinois 60610

## ACCREDITING AGENCY

The Council on Medical Education of the American Medical Association and the Executive Council of the Association of American Medical Colleges separately and conjointly serve as the accrediting agencies for medical education leading to the first professional degree. Through the Liaison Committee on Medical Education these two sponsoring agencies are recognized by the National Commission on Accrediting.

To be accredited, a medical school must be approved by the Council on Medical Education, by the Executive Council of the Association of American Medical Colleges, and by the Liaison Committee on Medical Education. Accreditation is granted on the finding of a sound educational program as a result of a survey conducted jointly by both Councils through the Liaison Committee on Medical Education.

### Liaison Committee on Medical Education:

The Liaison Committee consists of twelve members, six from each sponsoring Council. The Chairmanship of the Committee alternates annually between the chairmen of the two Councils, while the duties of Committee secretary are handled by an executive officer of the corresponding Council.

Although the principal function of the Liaison Committee since its creation in 1942 has been the coordination of accrediting activities in medical education, in recent years it and the two Councils it represents have strengthened their consultative and advisory functions, particularly for institutions and organizations seeking to develop new medical schools and for those schools that are in need of and request assistance.

### Council on Medical Education of the American Medical Association:

The 10-member Council on Medical Education, one of four standing committees of the House of Delegates of the AMA, has as its most important function

"the development and maintenance of high standards of medical education in college preparation for medical study, in the medical school, in the internship and residency, and in postgraduate continuing education of the profession,...as well as education in the fields allied to medicine." [1] Organized by the AMA in 1904, the Council began inspecting medical schools in 1906, assisted in the Carnegie Foundation study of 1909 which resulted in the "Flexner Report," assumed responsibility for registering hospitals from 1929 to 1954, for approving examining boards in medical specialties since 1933, and for approving schools in the allied medical services since 1936. The Council publishes annually a report on medical education in the United States, a list of approved internship and residency programs, a list of continuing education courses for physicians, lists of approved schools in several allied medical services, and national medical licensure statistics. Its professional staff and offices are located at the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

The six representatives on the Liaison Committee of the Council on Medical Education consist of the Chairman of the Council, and five members chosen at large.

Executive Council of the Association of American Medical Colleges:

The Association of American Medical Colleges was first organized in 1876 and reorganized in 1890. It published its first list of member schools in 1896. The objectives of the Association are to encourage:

> (1) The improvement and advancement of medical education by developing increasingly effective means of selecting the most able students for the study of medicine,(2) Experimentation in curriculum development and teaching methods, (3) Studies and programs aimed at improving the ability of students to learn and teachers to teach, (4) Efforts to improve the hospital and broaden the influence of continuing medical education,... (6) The development of the knowledge and leadership necessary to provide for the long-range progress and stability of medical education, and (7) The creating and maintenance of effective avenues of communication between medical educators and between medical educators and the American public.[2]

The Association sponsors the Medical College Admission Test, conducts teaching institutes, undertakes studies of medical students and fiscal and administrative operations of medical schools, and publishes the Journal of Medical Education. Its executive offices are located at 1346 Connecticut Avenue, NW, Washington, D.C. 20036 and 2530 Ridge Avenue, Evanston, Illinois 60201.

Approval of a medical school by the Executive Council of the Association carries with it eligibility for membership in the Association. The six representatives from the Executive Council on the Liaison Committee are the chairman, chairman-elect, two members from the Council of Deans and one each from the Councils of Academic Societies and Teaching Hospitals.

Since 1948, all medical schools in the United States have been approved by the Liaison Committee, the Council on Medical Education, and the Executive Council of the AAMC. Currently there are 101 operational medical schools in the United States of which four have two year programs in the basic medical sciences and twelve have not yet graduated their first classes and consequently are not eligible for accreditation. All schools that have graduated students are fully accredited. Additional medical schools are in various stages of organization and development.

## PURPOSES OF ACCREDITING

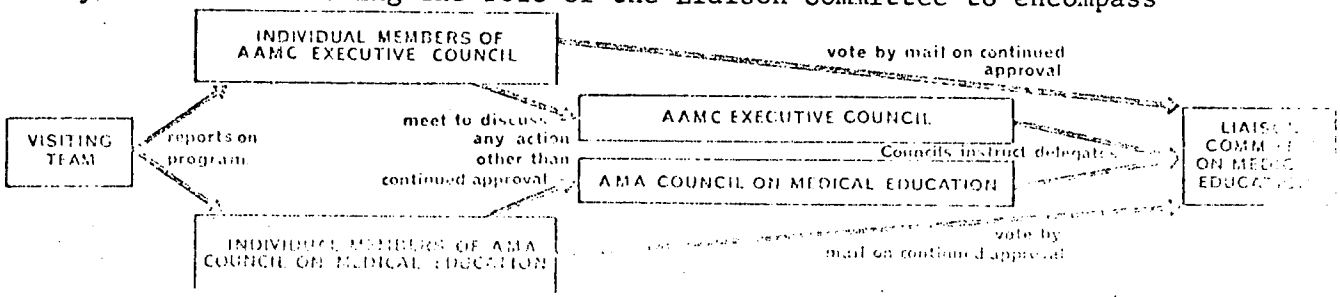
The accrediting process serves to maintain and promote improved standards of medical education. The findings of the accrediting organizations have been used to establish minimum standards by various government agencies, by professional societies, and by other organizations having working relationships with physicians.

One of the most important functions of accreditation of medical schools is to establish standards for medical education for the guidance of legally established licensing bodies in the 50 states, the District of Columbia, Puerto Rico, Canal Zone, Guam, and the Virgin Islands. In each instance, the licensing body, in accordance with law or regulations, utilizes the decision regarding accreditation of one or more of the accrediting agencies. Currently, 26 boards require applicants for licensure to be graduates of medical schools approved by the Council on Medical Education; two boards require membership in the Association of American Medical Colleges, 20 boards specify both approval by the Council and membership in the Association, while 7 boards maintain their own lists of approved schools.

## DEVELOPMENT OF POLICIES

The Liaison Committee on Medical Education and its two sponsoring organizations operate under comprehensive statements of standards which have been approved by the House of Delegates of the American Medical Association and the institutional membership of the Association of American Medical Colleges. The statement, "Functions and Structure of a Modern Medical School," was approved in 1957 and the companion statement for two-year schools, "Functions and Structure of a Modern School of Basic Medical Sciences," was approved in 1958. These statements of principle are the evolutionary outgrowth of continued study by both organizations over a period of years.

The Liaison Committee and its parent Councils are currently engaged in a study of their accrediting functions and procedures, aimed at altering them to meet present and future needs more effectively. Consideration is being given particularly to conducting the survey visits in conjunction with representatives of agencies responsible for surveying and accrediting activities in graduate and continuing education, areas with which the Liaison Committee has not in the past concerned itself. This may lead to broadening the role of the Liaison Committee to encompass



more completely the field of medical education, but currently the Liaison Committee limits its role in accreditation to that phase of medical education leading to the first professional degree.

## ELIGIBILITY

In their statement "Functions and Structure of a Modern Medical School," the AMA and the AAMA indicate that ever higher standards in medical education "are best nurtured in an environment in which there is not excessive concern with standardization." They hold that the concepts outlined in the statement are to serve as " general but not specific criteria in the medical school accreditation program" and not as obstacles to soundly conceived experimentation. The two organizations encourage experimentation throughout medical education - pre-medical, undergraduate medical, graduate and continuing education- and experimentation is a higher degree of integration of these various phases of medical education.

The AMA and the AAMC hold that a medical school has three inherent responsibilities:

1. A medical school should provide for its undergraduate students the opportunity to acquire a sound, basic education in medicine and should foster the development of lifelong habits of scholarship.

2. A medical school should contribute to the advancement of knowledge through research.

3. A medical school should contribute to the development of teachers, investigators and practitioners through programs of graduate education including residency training.

Among the criteria of interest to both organizations in accreditation are (1) the objectives of a medical school program in light of the AAMC 1953 statement, "The Objectives of Undergraduate Medical Education," (2) the organization and administration of the medical school, which should be incorporated as a nonprofit institution, and, if possible, as part of a university, (3) the appointment, competence, and organization of the faculty, including the attending staff of a general hospital for clinical teaching, (4) student services and admissions policies, (5) facilities, including the medical library, and (6) the educational program. " No rigid curriculum can be prescribed for accomplishing the objectives of medical education," according to the statement, but a complete curriculum should contain education in human anatomy, biochemistry, physiology, microbiology, pharmacology, pathology, clinical laboratory diagnosis, physical diagnosis, internal medicine, pediatrics, obstetrics and gynecology, preventive medicine and public health, psychiatry, radiology, and surgery, as well as medical ethics, legal medicine, biostatistics, and medical genetics, and a consideration of social, emotional, and environmental factors in health and disease. However, the medical curriculum is going through a period of major redesign, and offerings fitted for the individual needs of each student can be expected to be found with increasing frequency in the near future.

. According to the statement on two-year schools of basic medical sciences, " the educational program of a school of the basic medical sciences must, in part, be conditioned by the general pattern of the first two year curriculum of four year schools." Recent developments in medical education have introduced more clinical teaching early in the curriculum, have integrated the entire four years more than formerly and have blurred the previously sharp line between the first two and second two years of the medical curriculum. These developments have complicated the problems of the two-year school and complicated the smooth transfer of the student from a two-year to a four-year school. The program of the two-year school should be structured primarily to provide students with an opportunity to acquire a sound background in the basic medical sciences and an introduction to the major clinical disciplines.

## APPLICATION FOR EVALUATION

The two Councils through the Liaison Committee on Medical Education provide factual information, advice, and both informal and formal consultation visits to newly developing schools at all stages from initial planning to actual operation.

Under PL 88-129 (1963) for health education facilities construction and student loans, the U.S. Commissioner of Education depends upon the Liaison Committee to provide " reasonable assurance" that a developing school will meet accreditation standards.

A school is further offered a formal survey immediately prior to entrance of its first class and also when its first students are in the second year of the program. Favorable action in this survey results in "provisional approval", which has the effect of assuring students, the school, and other organizations that the school is providing acceptable training up to that point. During the fourth year, a definitive formal survey is conducted. Favorable action at this time indicates that the school has met minimum standards for its entire four-year period of training. Provision is made for more frequent surveys as necessary.

The survey schedule of the Liaison Committee is planned on a yearly basis with due consideration of the need to survey all schools over a period of seven years and with special consideration of particular institutional needs as identified by the school itself or by previous accrediting action of the sponsoring Councils. When a school is to be included in the survey, a representative of the Liaison Committee establishes with the dean mutually satisfactory dates for the visit, including a final conference with the chief executive officer of the parent institution.

At least three months prior to the scheduled visit, five sets of the survey questionnaire form are sent to the medical school. Each of the major departments is expected to submit data along with more general information compiled by the dean's office. One set of forms serves as

a record for the school and the remaining four are completed and returned to the Liaison Committee at least four weeks prior to the date of the visit. In addition, copies of the school bulletin, reports, and schedules are made available to the members of the survey team when appropriate.

## VISITING TEAM

The visiting team usually consists of four members, two of whom are representatives of the Association of American Medical Colleges and two of the Council on Medical Education. These are persons who have had broad experience in many facets of medical education, including administration, teaching, research, and practice. One or more members may be added to the team in response to special problems of the institution being visited.

The Liaison Committee designates one of the senior medical educators on the team as chairman and spokesman for the team while at the institution. It appoints another member as team secretary to make the preliminary arrangements with the school, write the initial draft of the report, and, together with the chairman, coordinate the activities of the team at the time of the visit. The secretary and a majority of the other team members will invariably have had prior survey experience.

## THE VISIT

The visit usually takes three to four days. While a pattern for the visit is provided, the team and the school are encouraged to alter the suggested schedule to provide flexibility and to meet the needs of the team and the school. The visit usually begins with a conference among the members of the team and the dean for general orientation and discussion of special problems of administration.

The team as a whole frequently conducts departmental visits on a 30- to 60-minute schedule. These departmental visits may be conducted with the departmental chairman and, according to his desires and those of the team, with members of his staff. These visits are concerned primarily with curriculum, teaching methods, staff, and facilities, but also cover service, research, and graduate education especially as they have importance for the undergraduate medical student program.

The team usually makes a special effort, often during lunch hours, to meet with a representative group of students and with junior members of the faculty. They may also hold conferences, where appropriate, with representatives of other interested or related organizations such as the local or state medical association. At the end of the visit the team confers with responsible administrative officers of the school and the parent institution, orally indicating to them the nature of the principal findings and recommendations.