

Update on LCME Rules Affecting Neurology Clerkships
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***Objective: After attending this lecture participants will be able to:
Discuss the LCME requirements as they pertain to the implementation of the clerkship objectives and curriculum.***

The Liaison Committee on Medical Education (LCME) is an organization formed jointly by the AMA and AAMC which is recognized by the US Department of Education as responsible for accrediting educational programs leading to the M.D. degree in the US and Canada. (Osteopathic schools are accredited by the American Osteopathic Association). The LCME is composed of 13 professional members (12 US and 1 Canadian) who are actively practicing medicine, 2 public members and 2 student members.

The LCME evaluates medical school programs on a regular basis to ensure that they are in full compliance with national standards. The accreditation cycle process begins with an institutional self-study with the gathering of a Medical Education Database regarding all facets of education of that institution. An accreditation *ad hoc* survey team visits the school after reports of this database are provided. Clerkship directors are among those who are interviewed by the accreditation team. Full accreditation may be awarded for a maximum of 8 years; many schools receive accreditation for lesser periods of time or may even be placed on probation if substantial concerns are identified.

The accreditation team's overall task is to determine if the medical school has

- 1) clearly established its educational objectives;
- 2) has programs and resources to meet the objectives;
- 3) is achieving the objectives; and
- 4) is documenting and able to prove successful achievement of the previous items.

More specifically, each institution, educational program and faculty member should be aware of the objectives and standards relevant to their individual roles. The LCME expectations of standards for medical education programs are published in a document entitled 'Functions and Structure of a Medical School – Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree. The October, 2004 edition with updates up to June 2006 is available in PDF form at <http://www.lcme.org/functions2006june.pdf>. Each clerkship director should study and be familiar with this document. It specifies standards accompanied by annotations for the institutional setting (IS), educational program (ED) for the M.D. degree, medical students (MS), faculty (FA) and educational resources (ER).

Clerkship directors should focus primarily on learning about the Educational Directives or EDs. There are 47 EDs which are listed in the LCME Standards document, but some deserve special attention from clerkship directors. I have quoted from this document but each clerkship director should read the document in its entirety.

Revised Standard ED-1: “The medical school faculty must define the objectives of its educational program. The objectives must serve as guides for establishing curriculum content and provide the basis for evaluating the effectiveness of the educational program.”

It is expected that medical schools will have a set of clearly articulated objectives that are broad learning objectives or goals. These objectives should be specific “statements of the items of knowledge, skills, behaviors and attitudes that students are supposed to exhibit as evidence of their achievement.” CDs should be knowledgeable about these objectives and be able to explain how they used them to design their own clerkship-specific objectives that tie into the broad institutional objectives and clerkship curriculum. Achievement of these objectives should be documented by specific outcome measurements such as performance on MCQ-based examinations, OSCEs, etc. There will be increasing focus on the use of outcome-based objectives and documentation for the achievement of expected competencies including professionalism.

Standard ED-2: “The objectives for clinical education must include quantified criteria for the types of patients (real or simulated), the level of student responsibility, and the appropriate clinical settings needed for the objectives to be met.”

ED-2 caused much consternation as this was interpreted to mean that the school should specify the disease/states or conditions and number of patients for each that all students should encounter and that the clerkships should monitor and verify the number and variety of patient encounters in which students participate in order to allow for adjustments during the clerkship to ensure that these specifications were met. In neurology, many clerkship directors opted to specify that students must see so many patients from broad categories such as “a degenerative neurologic illness”, a “paroxysmal illness such as stroke, epilepsy or migraine”, “an acute mental status change”, etc. This has been one of the standards most frequently cited for noncompliance because lack of monitoring through student logs, or lack of identification of student responsibility level or site of patient encounter such as inpatient/outpatient. There is also a lack of empirical evidence to guide and justify a particular numerical threshold for specific patient encounters. *See the proposed new revision for ED-2 below.*

Standard ED-3: “The objectives of the educational program must be made known to all medical students and to the faculty, residents, and others with direct responsibilities for medical student education.”

It is important that the clerkship director devise a mechanism to convey the clerkship objectives, curriculum, requirements and evaluation procedures to all faculty and residents who teach the medical students, including off-site faculty and residents.

Standard ED-8: “There must be comparable educational experiences and equivalent methods of evaluation across all alternative instructional sites within a given discipline.”

The CD must ensure that students have comparable educational experiences and be prepared at an accreditation interview to explain how they do this. One personal example from my clerkship is that I have students assigned to specialized clinical sites such as pediatric neurology but also assign these students to adult neurology clinics to ensure that they see adult as well as pediatric patients.

Standard ED-15: “The curriculum should include clinical experiences in family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery.”

It should be noted that neurology is not included in this list. However, the AAN, AUPN and ANA are currently requesting consideration to have neurology included in this list.

Standard ED-24: “Residents who supervise or teach medical students, as well as graduate students and postdoctoral fellows in the biomedical sciences who serve as teachers or teaching assistants, must be familiar with the educational objectives of the course or clerkship and be prepared for their roles in teaching and evaluation.”

As in ED-3, the CD must have a mechanism to familiarize residents and others about the educational objectives of the clerkship, and must have in place educational processes to prepare them for teaching and evaluation. Often the medical center will offer training on teaching and evaluation/feedback in a centralized venue. However, the clerkship director should consider what is needed for the neurology clerkship and be able to ensure and demonstrate that the residents are prepared to provide teaching. Residents and fellows ‘should receive a written copy of the clerkship objectives and clear education and guidance from the clerkship director about their roles in teaching and evaluating medical students.’ Students will be interviewed by the LCME accreditation teams and asked about whether residents are aware of objectives and their roles in teaching.

Standard ED-31: “Each student should be evaluated early enough during a unit of study to allow time for remediation.”

This means that there should be a mechanism by which each student can receive formative feedback during the course of the rotation early enough that they can work and receive help to improve their performance if it is unsatisfactory. This can be difficult in a clerkship of shorter length (most neurology clerkships are 4 weeks or less) but can be accomplished by a mechanism such as a mid-rotation personal feedback session or written feedback form. It is important that this feedback mechanism be a responsibility of the faculty/house staff and not dependent upon the individual student for completion.

Standard ED-41: “The faculty in each discipline at all sites must be functionally integrated by appropriate administrative mechanisms.”

The annotation for this standard discusses communication with faculty at outlying sites and the need to give feedback to faculty regarding performance of their educational responsibilities.

What's new in 2007?

Proposed new standards are being considered regarding 1) Insurance of a learning environment that promotes professionalism 2) Provision of opportunities for Service-learning 3) Provision of opportunities for participation in clinical and translational research.

Proposed Revisions of Existing Standards

ED-1: The proposed revision will be that “objectives of the educational program must be stated in outcome-based terms that allow assessment of student progress in developing the competencies that the profession and the public expect of a physician.”

ED-2: The proposed revised standard and annotation removes the requirement for “quantified” criteria. However, there will still be an expectation that clerkships will specify the types of patients or clinical conditions that students must see in order to achieve the objectives of the clerkship. If a student does not encounter patients with a particular specified condition, then the student must be provided with an opportunity to remedy the clinical gap by a simulated experience (such as a standardized patient experience, online or paper cases, etc. or in another clerkship). It is important that a mechanism be in place that allows deficiencies in patient experience to be monitored and remedied before the end of the clerkship. Low tech methods work as well as high tech.

Hints re the Clerkship Director's role in the LCME accreditation process:

- You can find out when your school will next be evaluated at this site:
<http://www.lcme.org/directry.htm>
- Many schools prepare their CDs for this process – do attend any such meetings.
- Be on time for meetings, dress professionally, be enthusiastic
- Show case your school's and clerkship's strengths
- Acknowledge but do not focus on known weaknesses, do be ready to describe any plans to improve
- Do not use the visit to air grievances or seek leverage with the dean and administration regarding desired resources, etc. Only the dean can effectively use the visit for leverage with the university administration.

References

Bachicha J, Barzansky B, and Simon FA. Chapter 15: The Clerkship Director and the Accreditation Process in *Guidebook for Clerkship Directors*, 3rd Edition.

Liaison Committee on Medical Education, www.lcme.org, *Accreditation Procedures and Functions and Structure of a Medical School*, 2004.