TO: The Professional Practice Committee

FROM: Douglas E. Lentivech

SUBJECT: Oversight of International Medical Schools Approved for Long-Term Clinical Clerkship Placements

DATE: December 2, 2011

AUTHORIZATION(S):

Summary

Issue for Discussion

Should the Professional Practice Committee (PPC) approve, in concept, the recommendations of the Regents Advisory Committee on Long-Term Clinical Clerkships? These recommendations relate to the process and standards for the approval of the didactic and clinical education provided by international medical schools that seek authorization to place their students in New York State hospitals for long-term clinical clerkships

Reason(s) for Consideration

Review of Policy.

Proposed Handling

The proposed process and approval standards are submitted to the Professional Practice Committee for conceptual approval at its December 2011 meeting. If approved, it is anticipated that implementing regulations will be brought before the committee in early 2012.

Procedural History

During the November and December 2010 meetings of the PPC, former Deputy Commissioner Muñoz, Executive Secretary Ramos, and Roger M. Oskvig, M.D., Chair of the New York State Board for Medicine, presented a rationale for reviewing and amending the Commissioner's regulations regarding the oversight of international medical schools seeking approval to place students in long-term clinical clerkships in New York State hospitals. The presentations before the Committee followed a series of

discussions with the Study Group on International Medical Schools. At the January 2011 meeting of the PPC, options and recommendations for future action were presented for Regents consideration. In April 2011, the Board of Regents approved regulations to establish an Advisory Committee on Long-Term Clinical Clerkships. The membership of the committee was appointed effective July 1, 2011. The Committee, which was appointed by the Chancellor after consultation with the Board of Regents, includes representatives from the Board of Regents, the State Education Department the Department of Health, registered New York State medical schools, dual-campus international medical schools, hospitals that serve as clinical clerkship sites and physicians experienced in evaluating medical education. The regulations adopted in April 2011 define the duties of the Committee, including the development of standards and processes by which dual-campus international medical schools seeking authorization to operate in New York State would be evaluated.

Background Information

When international medical schools seek to place their students in New York State hospitals to perform clinical clerkships of more than 12 weeks (long-term clinical clerkships), they must obtain departmental approval to do so in accordance with section 60.2 of the Commissioner's regulations. Currently, 14 international medical schools have been approved by the State Education Department to place students in long-term clinical clerkships in New York State. As noted in the recent discussions with the PPC, the regulations setting out the approval process were promulgated in 1981, and have not been amended since 1985. The Regents Advisory Committee on Long-Term Clinical Clerkships (hereinafter the "Advisory Committee") met three times in the fall of 2011 and unanimously approved recommendations for the Regents consideration that would update both the process and the approval standards (Attachments 1 and 2, respectively).

As recommended by the Advisory Committee, approval is based upon the applicant medical school's demonstration that it meets the standards contained in the New York State Approval Standards for International Medical Schools Seeking Long-Term Clinical Clerkships (hereinafter, the "Approval Standards") and the applicable NYS regulations. The foundation of the standards are built upon three principles: (1) the medical school is engaged in continual self-study, self-analysis, and quality improvement; (2) the medical education program has adequately prepared the medical student for clinical clerkships; and (3) the graduates of the medical school exhibit the general competencies of physicians prepared for the next stage of their training.

The Approval Standards recommended by the Advisory Committee contain criteria in the following categories:

I. Institutional Setting
   a. Governance and Administration
   b. Academic Environment

II. Educational Program for the Medical Degree
   a. Educational Objectives
   b. Structure
      i. General Design

ii. Content
c. Teaching and Evaluation
d. Curriculum Management
i. Roles and Responsibilities
e. Evaluation of Program Effectiveness

III. Medical Students
a. Selection
b. Medical Student Services
i. Academic and Career Counseling
ii. Health Services and Personal Counseling
c. The Learning Environment

IV. Faculty

V. Educational Resources

The Advisory Committee proposes the following process to determine whether a school meets the Approval Standards:

1. Each applicant will be required to submit a self-study.

2. At least two members of the Advisory Committee will review the application, each one independent of the other, each providing a report. The two members may request additional information from the school through the Executive Secretary of the Board of Medicine, who is responsible for generating any letters, correspondence, or reports throughout the process. The written reports will be given only to the Executive Secretary of the State Board for Medicine.

3. When the self-study is considered complete in that both Advisory Committee members assigned to review the application have determined that the self-study has adequately addressed all of the Approval Standards, a site visit will be scheduled.

4. Should the two Advisory Committee members assigned to review the application disagree as to the adequacy of the application, the reports will be presented to the full Advisory Committee for review and determination as to whether or not a site visit should be scheduled.

5. The State Board for Medicine will develop and maintain a list of qualified site visitors. The Advisory Committee will select an appropriate site review team of no less than three members from that list for each validation visit. Additional site visitors may be assigned if there are multiple training sites.

6. During the site visit, the medical program will be reviewed to validate the representations contained within the self-study. The medical program will bear the burden of demonstrating satisfactory compliance with the Approval Standards. Any standard that cannot be validated or appears to be non-compliant will be recorded as an observation.

7. The medical school will be provided with a copy of the observations within two weeks after the site visit, and the medical school will be given 30 days to respond. All site visit reports and responses must be completed no less than two months prior to the Advisory Committee meeting for which they are scheduled. Lateness will result in rescheduling for the next available meeting.

8. The Advisory Committee members who reviewed the self-study will be provided with the report of the site visit team and the institution's response, and, based on that information, will prepare a report to be presented to the Advisory Committee.

9. The Advisory Committee members will review all materials, with particular attention to recorded observations.

10. The Advisory Committee will make determinations with respect to compliance with the Approval Standards, and based on these findings, the Advisory Committee will make a recommendation to the Board of Regents on the appropriate disposition of a school's application. The recommendation will provide the rationale for the recommendation and will reflect majority and minority opinions. (The Advisory Committee recommends consideration of the adoption of two additional approval statuses beyond the approval or denial already in existence – "provisional" and "probationary".)

11. The Board of Regents will make the final determination on the application for approval.

Recommendation

It is recommended that the Board of Regents approve the above-described recommendations.

Timetable for Implementation

If the PPC approves, in concept, the recommendations for the process and approval standards to be utilized in the approval of the didactic and clinical education provided by international medical schools that seek authorization to place their students in New York State hospitals for long-term clinical clerkships, staff will develop regulations implementing the process and approval standards, as described above, for submission to the Board of Regents in early 2012.

APPROVAL STANDARDS

I. INSTITUTIONAL SETTING

IS-1. A medical school must be recognized by the appropriate civil authorities of the country in which the school is located as an acceptable educational program for physicians. (Commissioner's Regulations Section 60.1(a)(2))

The institution must maintain in effect any charter, licenses or approvals required for it to function as a medical school in the jurisdiction in which it operates.

IS-2. An institution that offers a medical school must engage in a planning process that sets the direction for its program and results in measurable outcomes.

To ensure the ongoing vitality and successful adaptation of its medical school to the rapidly changing environment of academic medicine, the institution needs to establish periodic or cyclical institutional planning processes and activities. The institution must connect its learning outcomes assessment to its mission plans and objectives in order to continuously improve the quality of its medical education. Planning efforts that have proven successful typically involve the definition and periodic reassessment of both short-term and long term goals for accomplishment of the institutional mission. By framing goals in terms of measurable outcomes wherever circumstances permit, the institution can more readily track progress toward their achievement. The manner in which the institution engages in planning will vary according to available resources and local circumstances, but it should be able to document its vision, mission, and goals; evidence indicating their achievement; and strategies for periodic or ongoing reassessment of successes and unmet challenges.

A. Governance and Administration

IS-3. The manner in which an institution that offers a medical school is organized, including the responsibilities and privileges of administrative officers, faculty, medical students, and committees must be promulgated in programmatic or institutional bylaws.

IS-4. There must be clear understanding of the authority and responsibility for matters related to the medical school among the chief official of the medical school, the faculty, and the parent institution.

IS-5. The chief official of a medical school must be qualified by education and experience to provide leadership in medical education, scholarly activity, and patient care.

B. Academic Environment

IS-6. Medical students should have opportunities to learn in academic environments that permit interaction with students enrolled in other health professions, graduate, and professional degree programs and in clinical environments that provide opportunities for interaction with physicians in graduate medical education and continuing medical education programs.

These academic, graduate medical education, and continuing medical education programs should contribute to the learning environment of the medical school. Periodic

and formal review of these programs culminating in their accreditation by the appropriate accrediting bodies would provide evidence of their adherence to high standards of quality in education, research, and scholarship. Whenever appropriate, medical students would be able to participate in selected activities associated with these programs in order to facilitate achievement of their personal and professional goals.

II. EDUCATIONAL PROGRAM FOR THE MEDICAL DEGREE

A. Educational Objectives

ED-1. A medical school must have in place a system with central oversight to define the objectives of its program. The objectives must serve as guides for establishing curriculum content and provide the basis for evaluating the effectiveness of the program.

Objectives for the medical school as a whole serve as statements of what students are expected to learn or accomplish during the course of the program. It is expected that the objectives of the medical school will be formally adopted by the curriculum governance process and the faculty (as a whole or through its recognized representatives). Among those who should also exhibit familiarity with these objectives are the academic leadership of clinical affiliates who share in the responsibility for delivering the program.

ED-2. The objectives of a medical school 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.

The objectives of the medical school are statements of the items of knowledge, skills, behaviors, and attitudes that medical students are expected to exhibit as evidence of their achievement. The educational objectives, along with their associated outcome measures, should reflect whether and how well graduates are developing these competencies as a basis for the next stage of their training. There are several widely recognized definitions of the knowledge, skills, behaviors, and attitudinal attributes appropriate for a physician, including those described in the AAMC's Medical School Objectives Project, the general competencies of physicians resulting from the collaborative efforts of the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS), and the physician roles summarized in the CanMEDS 2005 report of the Royal College of Physicians and Surgeons of Canada.

ED-3. An institution that offers a medical school must have in place a system with central oversight to ensure that the faculty define the types of patients and clinical conditions that medical students must encounter, the appropriate clinical setting for the educational experiences, and the expected level of medical student responsibility. The faculty must monitor medical student experiences and modify them as necessary to ensure that the objectives of the medical school are met.

The institution that offers a medical school is required to establish a system to specify the types of patients or clinical conditions that medical students must encounter and to monitor and verify the medical students' experiences with patients so as to remedy any identified gaps. The system must ensure that all medical students have the required experiences. For example, if a medical student does not encounter patients with a particular clinical condition (e.g., because it is seasonal), the medical student should be able to remedy the gap by a simulated experience) or in another clerkship. When clerkships/clerkship rotations in a given discipline are provided at multiple instructional sites, compliance with this standard may be linked to compliance with standard ED-9,

which requires that the medical school demonstrate comparability of educational experiences across instructional sites.

ED-4. The objectives of a medical school must be made known to all medical students and to the faculty, residents, and others with direct responsibilities for medical student education and assessment. The school must to able to document compliance with this standard.

B. Structure

1. General Design

ED-5. A medical school must include at least 130 weeks of instruction.

ED-6. The curriculum of a medical school must provide a general professional education and prepare medical students for entry into graduate medical education in any discipline.

ED-7. A medical school must include instructional opportunities for active learning and independent study to foster the skills necessary for lifelong learning.

It is expected that the methods of instruction and assessment used in courses and clerkships will provide medical students with opportunities to develop lifelong learning skills. These skills include self-assessment on learning needs; the independent identification, analysis, and synthesis of relevant information; and the appraisal of the credibility of information sources. Medical students should receive explicit experiences in using these skills, and they should be assessed and receive feedback on their performance.

ED-8. The curriculum of a medical school must incorporate the fundamental principles of medicine and its underlying scientific concepts; allow medical students to acquire skills of critical judgment based on evidence and experience; and develop medical students' ability to use principles and skills wisely in solving problems of health and disease. The medical school must develop clearly defined outcome measures to assure that students have acquired the skills of critical judgment and the ability to apply evidence in the solution of problems of health and disease.

ED-9. The curriculum of a medical school must include comparable educational experiences and equivalent methods of assessment across all instructional sites within a given discipline.

Compliance with this standard requires that the educational experiences at all instructional sites be designed to achieve the same educational objectives. Course or clerkship length must be identical, unless a compelling reason exists for varying the length of the experience. The instruments and criteria used for medical student assessment, as well as the policies for the determination of grades, should be the same at all instructional sites. The faculty who teach at all instructional sites should be sufficiently knowledgeable in the subject matter to provide effective instruction and have a clear understanding of the objectives of the educational experience and the assessment methods used to determine achievement of those objectives. Opportunities to enhance teaching and assessment skills should be available for faculty at all instructional sites. Although the types and frequency of problems or clinical conditions seen at each instructional site may vary, each course or clerkship/clerkship rotation must identify any core experiences needed to achieve its objectives and ensure that students receive sufficient exposure to such experiences. Similarly, although the proportion of time spent in inpatient and ambulatory settings may vary according to local circumstances, in such

cases the course or clerkship/clerkship rotation director must ensure that limitations in learning environments do not impede the accomplishment of objectives. To facilitate the comparability of educational experiences and the equivalency of assessment methods, the course or clerkship/clerkship rotation director should orient all participants, both faculty and students, to the educational objectives and grading system used. This orientation can be accomplished through regularly scheduled meetings between the director of the course or clerkship/clerkship rotation and the directors at the various instructional sites that are used. The course and clerkship/clerkship rotation leadership should review medical students' evaluations of their experiences at all instructional sites to identify any persistent variations in educational experiences or assessment methods.

ED-10. An approved medical school must notify the New York State Education Department, when applicable, of any substantial change in the program including:

- Any change in ownership, governance, or leadership
- Plans for any major modification of its curriculum
- Any change of class size or total enrollment greater than 20% from the original application on file with the Department
- Any reasonably anticipated change of more than 10% in the number of students participating in long-term clinical clerkships in New York State as compared to the number of students participating in such clerkships at the time of the most recent approval review. Any change in existing hospital affiliation agreements or addition of new affiliation agreements.

The notification should include the explicitly-defined goals of the change, the plans for implementation, and the methods that will be used to evaluate the results. Planning for curriculum change should consider the incremental resources that will be required, including physical facilities and space, faculty and resident effort, library facilities and operations, information management needs, and computer hardware. In view of the increasing pace of discovery of new knowledge and technology in medicine, the Education Department encourages innovation that will increase the efficiency and improve the effectiveness of medical education.

2. Content

ED-11. The curriculum of a medical school must include current concepts in the basic and clinical sciences, including therapy and technology, changes in the understanding of disease, and the effects of social needs and demands on care.

ED-12. The curriculum of a medical school must include behavioral and socioeconomic subjects in addition to basic science and clinical disciplines.

ED-13. The curriculum of a medical school must include content from the biomedical sciences that supports students' mastery of the contemporary scientific knowledge, concepts, and methods fundamental to acquiring and applying science to the health of individuals and populations and to the contemporary practice of medicine.

It is expected that the curriculum will be guided by clinically-relevant biomedical content from, among others, the disciplines that have been traditionally titled anatomy, biochemistry, genetics, immunology, microbiology, pathology, pharmacology, physiology, and public health sciences.

ED-14. The curriculum of a medical school should include laboratory or other practical opportunities for the direct application of the scientific method, accurate observation of biomedical phenomena, and critical analysis of data.

Opportunities in the curriculum could include hands-on or simulated (e.g., computer-based) exercises in which medical students either collect or use data to test and/or verify hypotheses or to address questions about biomedical principles and/or phenomena. The medical school should be able to identify the location in the curriculum where such exercises occur, the specific intent of the exercises, and how the exercises contribute to the objectives of the course and the ability to collect, analyze, and interpret data.

ED-15. The curriculum of a medical school must cover all organ systems, and include the important aspects of preventive, acute, chronic, continuing, rehabilitative, and end-of-life care.

ED-16. The curriculum of a medical school must include clinical experience in primary care.

ED-17. The curriculum of a medical school must include content and clinical experiences related to each phase of the human life cycle that will prepare students to recognize wellness, determinants of health, and opportunities for health promotion; recognize and interpret signs and symptoms of disease; develop differential diagnoses and treatment plans; and assist patients in addressing health-related issues involving all organ systems.

It is expected that the curriculum will be guided by the contemporary content from and the clinical experiences associated with, among others, the disciplines and related subspecialties that have traditionally been titled family medicine, internal medicine, obstetrics and gynecology, pediatrics, preventive medicine, psychiatry, and surgery.

ED-18. A medical school must provide medical students with opportunities to pursue clinical experiences in both inpatient and outpatient settings. All clinical experiences, regardless of the setting in which they are undertaken, must be supervised by individuals appointed to the faculty of the medical school. The clinical experiences should provide the student with appropriate progressive responsibility.

ED-19. Educational opportunities must be available in a medical school in multidisciplinary content areas (e.g., emergency medicine, geriatrics) and in the disciplines that support general medical practice (e.g., diagnostic imaging, clinical pathology).

ED-20. The curriculum of a medical school must include specific instruction in communication skills as they relate to physician responsibilities, including communication with patients and their families, colleagues, and other health professionals.

ED-21. The curriculum of a medical school must prepare medical students for their role in addressing the medical consequences of common societal problems (e.g., provide instruction in the identification, diagnosis, prevention, appropriate reporting, and treatment of domestic violence and abuse).

ED-22. The faculty and medical students of a medical school must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.

Instruction in the medical school should stress the need for medical students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on patients' health. To demonstrate compliance with this standard, the medical school should be able to document objectives relating to the development of skills in cultural competence, indicate the location in the curriculum

where medical students are exposed to such material, and demonstrate the extent to which the objectives are being achieved.

ED-23. Medical students in a medical school must learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the process of health care delivery.

The objectives for instruction in the medical school should include medical student understanding of demographic influences on health care quality and effectiveness (e.g., racial and ethnic disparities in the diagnosis and treatment of diseases). The objectives should also address the need for self-awareness among medical students regarding any personal biases in their approach to health care delivery.

ED-24. A medical school must include instruction in medical ethics and human values and require its medical students to exhibit scrupulous ethical principles in caring for patients and in relating to patients' families and to others involved in patient care.

The medical school should ensure that medical students receive instruction in appropriate medical ethics, human values, and communication skills before engaging in patient care activities. As students take on increasingly more active roles in patient care during their progression through the curriculum, adherence to ethical principles should be observed, assessed, and reinforced through formal instructional efforts.

In medical student-patient interactions, there should be a means for identifying possible breaches of ethics in patient care, either through faculty or resident observation of the encounter, patient reporting, or some other appropriate method. The phrase "scrupulous ethical principles" implies characteristics that include honesty, integrity, maintenance of confidentiality, and respect for patients, patients' families, other students, and other health professionals. The program's educational objectives may identify additional dimensions of ethical behavior to be exhibited in patient care settings.

C. Teaching and Evaluation

ED-25. Physicians who supervise or teach medical students, and other professionals who serve as teachers or preceptors, must be familiar with the educational objectives of the course or clerkship and be prepared for their roles in teaching and assessment.

The minimum expectations for achieving compliance with this standard are that: (a) preceptors or instructors receive a copy of the course or clerkship/clerkship rotation objectives and clear guidance from the course or clerkship/clerkship rotation director about their roles in teaching and assessing medical students and (b) the institution and/or its relevant departments provide resources (e.g., workshops, resource materials) to enhance the teaching and assessment skills of preceptors and instructors. There should be central monitoring of the level of participation in activities to enhance their teaching and assessment skills. There should be formal evaluation of the teaching and assessment skills of preceptors and instructors, with opportunities provided for remediation if their performance is inadequate. Evaluation methods could include direct observation by faculty, feedback from medical students through course and clerkship/clerkship rotation evaluations or focus groups, or any other suitable method.

ED-26. A medical school must have a system in place for the assessment of medical student achievement throughout the program that employs a variety of measures of knowledge, skills, behaviors, and attitudes.

Assessments of medical student performance should measure the retention of factual knowledge; the development of the skills, behaviors, and attitudes needed in subsequent medical training and practice; and the ability to use data appropriately for solving problems commonly encountered in

medical practice. The system of assessment, including the format and frequency of examinations, should support the goals, objectives, processes, and expected outcomes of the curriculum.

ED-27. A medical school must include ongoing assessment activities that ensure that medical students have acquired and can demonstrate on direct observation the core clinical skills, behaviors, and attitudes that have been specified in the program's educational objectives.

ED-28. A medical school must include ongoing assessment of medical students' problem solving, clinical reasoning, decision making, and communication skills.

ED-29. The faculty of each discipline should set standards of achievement in that discipline and contribute to the setting of such standards in interdisciplinary and inter-professional learning experiences, as appropriate. The standards of achievement identified within any discipline must be consistent across all sites in which that discipline is taught.

ED-30. The directors of all courses and clerkships in a medical school must design and implement a system of fair and timely formative and summative assessment of medical student achievement in each course and clerkship/clerkship rotation.

Faculty of the medical school directly responsible for the assessment of medical student performance should understand the uses and limitations of various test formats, the purposes and benefits of criterion-referenced vs. norm-referenced grading, reliability and validity issues, formative vs. summative assessment, and other factors associated with effective educational assessment.

In addition, the chief academic officer, curriculum leaders, and faculty of the medical school should understand, or have access to individuals who are knowledgeable about, methods for measuring medical student performance. The medical school should provide opportunities for faculty members to develop their skills in such methods.

An important element of the medical school's system of assessment should be to ensure the timeliness with which medical students are informed about their final performance in courses and clerkships/clerkship rotations. In general, final grades should be available within four to six weeks of the end of a course or clerkship/clerkship rotation.

ED-31. Each medical student in a medical school should be assessed and provided with formal feedback early enough during each required course or clerkship to allow sufficient time for remediation.

Although a course or clerkship/clerkship rotation that is short in duration (e.g., less than four weeks) may not have sufficient time to provide a structured formative assessment, it should provide alternate means (e.g., self-testing, teacher consultation) that will allow medical students to measure their progress in learning.

ED-32. A narrative description of medical student performance in a medical school, including non-cognitive achievement, should be included as a component of the assessment in each required course and clerkship whenever teacher-student interaction permits this form of assessment.

D. Curriculum Management

1. Roles and Responsibilities

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

The phrase "integrated institutional responsibility" implies that an institutional body (commonly a curriculum committee) will oversee the medical school as a whole. An effective central curriculum authority will exhibit the following characteristics:
-Expertise in curricular design, pedagogy, and evaluation methods.
-Empowerment, through bylaws or decanal mandate, to work in the best interests of the institution without regard for parochial or political influences or departmental pressures.
The phrase "coherent and coordinated curriculum" implies that the medical school as a whole will be designed to achieve its overall educational objectives. Evidence of coherence and coordination includes the following characteristics:
-Logical sequencing of the various segments of the curriculum.
-Content that is coordinated and integrated within and across the academic periods of study (i.e., horizontal and vertical integration).
-Methods of pedagogy and medical student assessment that are appropriate for the achievement of the program's educational objectives.
Curriculum management signifies leading, directing, coordinating, controlling, planning, evaluating, and reporting. Evidence of effective curriculum management includes the following characteristics:
- Evaluation of program effectiveness by outcomes analysis, using national norms of accomplishment as a frame of reference.
-Monitoring of content and workload in each discipline, including the identification of omissions and unplanned redundancies.
-Review of the stated objectives of each individual course and clerkship (or, in Canada, clerkship rotation), as well as the methods of pedagogy and medical student assessment, to ensure congruence with programmatic educational objectives.
-Minutes of the curriculum committee meetings and reports to the faculty governance and deans should document that such activities take place and should report on the committee's findings and recommendations.

ED-34. Under the guidance of a central authority, the faculty of a medical school must be responsible for the detailed design and implementation of the components of the curriculum.

Faculty members' responsibilities for the medical school include, at a minimum, the development of specific course or clerkship objectives, selection of pedagogical and assessment methods appropriate for the achievement of those objectives, ongoing review and updating of content, and evaluation of course, clerkship/clerkship rotation, and teacher quality.

ED-35. The objectives, content, and pedagogy of each segment of a medical school's curriculum, as well as of the curriculum as a whole, must be designed by and subject to periodic review and revision by the program's faculty.

ED-36. A faculty committee of a medical school must be responsible for monitoring the curriculum, including the content taught in each discipline, so that the program's educational objectives will be achieved.

The committee, working in conjunction with the chief academic officer, should ensure that each academic period of the curriculum maintains common standards for content. Such standards should address the depth and breadth of knowledge required for a general professional education, the currency and relevance of content, and the extent of redundancy needed to reinforce learning of complex topics. The final year should complement and supplement the curriculum so that each medical student will acquire appropriate competence in general medical care regardless of subsequent career specialty.

ED-37. The committee responsible for the curriculum at a medical school, along with the program's administration and leadership, must develop and implement policies regarding the amount of time medical students spend in required activities, including the total number of hours medical students are required to spend in clinical and educational activities during clinical clerkships

ED-38. The chief academic officer of a medical school must be responsible for the conduct and quality of the educational program and for ensuring the adequacy of faculty at all instructional sites.

ED-39. The principal academic officers at each instructional site of a medical school must be administratively responsible to the program's chief academic officer.

ED-40. The faculty in each discipline at all instructional sites of a medical school must be functionally integrated by appropriate administrative mechanisms.

The medical school should be able to demonstrate the means by which faculty at each instructional site participate in and are held accountable for medical student education that is consistent with the objectives and performance expectations established by the course or clerkship leadership. Mechanisms to achieve functional integration may include regular meetings or electronic communication, periodic visits to all instructional sites by the course or clerkship rotation leadership, and sharing of student assessment data, course or clerkship/clerkship rotation evaluation data, and other types of feedback regarding faculty performance of their educational responsibilities.

ED-41. A medical school must have a single standard for the promotion and graduation of medical students across all instructional sites.

ED-42. A medical school must assume ultimate responsibility for the selection and assignment of all medical students to all instructional sites or educational tracks. There must be a process whereby a medical student with an appropriate rationale can request an alternative assignment when circumstances allow for it.

A medical school having multiple instructional sites or distinct educational tracks is responsible for determining the specific instructional site or track for each medical student. That responsibility should not preclude medical students from obtaining alternative assignments if appropriate reasons are given (e.g., demonstrable economic or personal hardship) and if the educational activities and resources involved allow for such reassignment. It is understood, however, that movement among campuses may not be possible (e.g., because the instructional sites may offer different curricular tracks).

ED-43. In a medical school, medical students assigned to each instructional site should have the same rights and receive the same support services.

E. Evaluation of Program Effectiveness

ED-44. A medical school must collect and use a variety of outcome data, including accepted norms of accomplishment, to demonstrate the extent to which its educational objectives are being met.

The medical school should collect outcome data on medical student performance, both during program enrollment and after program completion, appropriate to document the achievement of the program's educational objectives. The kinds of outcome data that could serve this purpose include performance on national licensure examinations, performance in courses and clerkships and other internal measures related to educational program objectives, academic progress and program completion rates, acceptance into residency programs, and assessments by graduates

and residency directors of graduates' preparation in areas related to medical school objectives, including the professional behavior of its graduates.

ED-45. The planning processes must incorporate formative and summative reviews of student achievement.

Strategic planning is essential to ensure the quality of the medical school. An assessment program should be an ongoing, systematic process that provides the means for assessing student achievement, program effectiveness, and opportunities for improvement.

ED-46. In evaluating program quality, a medical school must consider medical student evaluations of their courses, clerkships and teachers, as well as a variety of other measures.

It is expected that the medical school will have a formal process to collect and use information from medical students on the quality of courses and clerkships/clerkship rotations. The process could include such measures as questionnaires (written or online), other structured data collection tools, focus groups, peer review, and external evaluation.

III. MEDICAL STUDENTS

A. Selection

MS-1. The faculty of an institution that offers a medical school must develop criteria, policies, and procedures for the selection of medical students that are readily available to potential and current applicants and their collegiate advisors.

MS-2. To ensure an institution that offers a medical school meets its missions and goals, the institution must tie its admissions process to the outcome performance of its graduates.

MS-3. A medical school must select for admission medical students who possess the intelligence, integrity, and personal and emotional characteristics necessary for them to become effective physicians.

MS-4. A medical school’s catalog, other printed informational materials, or on its website must publish, at least every other year, information on policies and procedures on academic standards, grading, attendance, tuition fees, refund policy, student promotion; retention; graduation; academic freedom; students’ rights and responsibilities, including a grievance policy and appeal procedures; program's criteria for selecting students for admission and describe the application and admission processes, and other information pertinent to the student body.

MS-5. A medical school must ensure that any medical student visiting for clinical clerkship rotations and electives demonstrates qualifications comparable to those of the medical students he or she would join in those experiences.

B. Medical Student Services

1. Academic and Career Counseling

MS-6. A medical school must have an effective system of academic advising for medical students that integrates the efforts of faculty members, course directors, and student affairs officers with its counseling and tutorial services.

There should be formal mechanisms at the medical school for medical student mentoring and advocacy at each instructional site. The roles of various participants in the advisory system should be defined and disseminated to all medical students. A medical student should have the option of obtaining advice about academic issues or academic counseling from individuals who have no role in making promotion or assessment decisions about him or her.

MS-7. If a medical student at a medical school is permitted to take electives at another medical school or institution, there should be a centralized system in the dean's office at the home program to review the proposed extramural electives prior to approval and to ensure the return of a performance assessment by the host program.

2. Health Services and Personal Counseling

MS-8. A medical school must have an effective system of personal counseling for its medical students that includes programs to promote the well-being of medical students and facilitate their adjustment to the physical and emotional demands of medical education.

MS-9. A medical school must follow accepted guidelines in determining the health status and immunization requirements for its medical students in accordance with New York State and CDC guidelines.

C. The Learning Environment

MS-10: A medical school must ensure that its learning environment promotes the development of explicit and appropriate professional attributes in its medical students (i.e., attitudes, behaviors, and identity).

The medical school, including its faculty, staff, medical students, residents, and affiliated instructional sites, shares responsibility for creating an appropriate learning environment. The learning environment includes both formal learning activities and the attitudes, values, and informal "lessons" conveyed by individuals who interact with the medical student. These mutual obligations should be reflected in agreements (e.g., affiliation agreements) at the institutional and/or departmental levels. It is expected that a medical school will define the professional attributes it wishes its medical students to develop in the context of the program's mission and the community in which it operates. Such attributes should also be promulgated to the faculty and staff of the medical school. As part of their formal training, medical students should learn the importance of demonstrating the attributes of a professional and understand the balance of privileges and obligations that the public and the profession expect of a physician. Examples of professional attributes are available from such resources as the American Board of Internal Medicine's Project Professionalism or the AAMC's Medical School Objectives Project. The medical school and its faculty, staff, medical students, and residents should also regularly evaluate the learning environment to identify positive and negative influences on the maintenance of professional standards and conduct and develop appropriate strategies to enhance the positive and mitigate the negative influences. The program should have suitable mechanisms available to identify and promptly correct recurring violations of professional standards.

MS-11. A medical school must define and publicize the standards of conduct for the faculty student relationship and develop written policies for addressing violations of those standards.

The standards of conduct need not be unique to the medical school; they may originate from other sources (e.g., the parent institution). Mechanisms for reporting violations of these standards (e.g., incidents of harassment or abuse) should ensure that the violations can be registered and investigated without fear of retaliation. The medical school's policies also should

specify mechanisms for the prompt handling of such complaints and support educational activities aimed at preventing inappropriate behavior.

MS-12. A medical school must publicize to all faculty and medical students its standards and procedures for the assessment, advancement, and graduation of its medical students and for disciplinary action.

MS-13. A medical school must have a fair and formal process in place for taking any action that may affect the status of a medical student.

The medical school's process should include timely notice of the impending action, disclosure of the evidence on which the action would be based, an opportunity for the medical student to respond, and an opportunity to appeal any adverse decision related to promotion, graduation, deceleration, or dismissal.

MS-14. Medical student educational records at a medical school must be confidential and made available only to those members of the faculty and administration with a need to know, unless released by the medical student or as otherwise governed by laws concerning confidentiality.

MS-15. A medical student enrolled in a medical school must be allowed to review and challenge his or her records if he or she considers the information contained therein to be inaccurate, misleading, or inappropriate.

III. FACULTY

FA-1. A medical school must have a sufficient number of faculty members in the subjects basic to medicine and in the clinical disciplines to meet the needs and missions of the program.

In determining the number of faculty needed for the medical school, the program should consider the other responsibilities that its faculty may have in other academic programs and in patient care activities required to conduct meaningful clinical teaching across the continuum of medical education.

FA-2. A member of the faculty in a medical school must have the capability and continued commitment to be an effective teacher.

Effective teaching requires knowledge of the discipline and an understanding of curricular design and development, curricular evaluation, and methods of instruction. Faculty members involved in teaching, course planning, and curricular evaluation should possess or have ready access to expertise in teaching methods, curricular development, program evaluation, and medical student assessment. Such expertise may be supplied by an office of medical education or by faculty and staff members with backgrounds in educational science.

Faculty involved in the development and implementation of a course, clerkship (or, in Canada, clerkship rotation), or larger curricular unit should be able to design the learning activities and corresponding student assessment and program evaluation methods in a manner consistent with sound educational principles and the institution's stated educational objectives.

A community physician appointed to the faculty of a medical school, on a part-time basis or as a volunteer, should be an effective teacher, serve as a role model for medical students, and provide insight into contemporary methods of providing patient care.

FA-3. A faculty member of a medical school should receive regularly scheduled feedback on his or her academic performance and progress toward promotion and, when applicable, tenure.

Feedback should be provided by departmental leadership programmatic leadership, or institutional leadership.

FA-4. All faculty of a medical school should be provided with opportunities to develop their skills as undergraduate medical educators. Educator skills development must be provided by the medical school at all sites in which students participate in the clinical programs of a medical school.

V. EDUCATIONAL RESOURCES

ER-1. A medical school must have, or be assured the use of, buildings and equipment appropriate to achieve its educational and other goals.

The facilities of the medical school should include offices for faculty, administrators, and support staff; laboratories and other space appropriate for the conduct of research; medical student classrooms and laboratories; lecture hall(s) sufficiently large to accommodate a full year's class and any other students taking the same courses; space for medical student use, including medical student study space; space and equipment for library and information access; and space for the humane care of animals when animals are used in teaching or research.

ER-2. A medical school must have, or be assured the use of, appropriate resources for the clinical instruction of its medical students.

The clinical resources at the medical school should be sufficient to ensure thebreadth and quality of ambulatory and inpatient teaching. These resources include adequate numbers and types of patients (e.g., acuity, case mix, age, gender) and physical resources.

ER-3. Each hospital or other clinical facility of a medical school that serves as a major instructional site for medical student education must have appropriate instructional facilities and information resources.

Appropriate instructional facilities at each hospital or other clinical facility include areas for individual medical student study, conferences, and large group presentations (e.g., lectures). Sufficient information resources, including library holdings and access to other library systems, must either be present in the hospital or other clinical facility or readily available in the immediate vicinity. A sufficient number of computers must be readily available that allow access to the Internet and to other educational software. Call rooms and lockers, or other secure space to store personal belongings, should be available for medical student use.

ER-4. Required clerkships at a medical school should be conducted in health care settings in which resident physicians in accredited programs of graduate medical education, under faculty guidance, participate in teaching the medical students.

It is understood that, at some medical schools, there may not be resident physicians at some community hospitals or community clinics or the offices of community-based physicians.In those cases, medical students must be directly supervised by attending physicians.

ER-5. A medical school must have written and signed agreements in place with its clinical affiliates that define, at a minimum, the responsibilities of each party related to the educational program for medical students.

Written agreements are necessary with hospitals that are used regularly as inpatient sites for core clinical clerkships (or, in Canada, clerkship rotations). Additionally, agreements may be warranted with other instructional sites that have a significant role in the clinical education program.

Agreements should address, at a minimum, the following topics:

-The assurance of medical student and faculty access to appropriate resources for medical student education.

-The primacy of the medical school over academic affairs and the education/assessment of medical students.
-The role of the medical school in the appointment and assignment of faculty members with responsibility for medical student teaching.
-Specification of the responsibility for treatment and follow-up when a medical student is exposed to an infectious or environmental hazard or other occupational injury.
If department heads of the medical school are not also the clinical service chiefs at affiliated institutions, the agreement must confirm the authority of the department head to ensure faculty and medical student access to appropriate resources for medical student education.
The medical school must inform the Education Department of anticipated changes in affiliation status of the program's clinical facilities.

ER-6. In the relationship between a medical school and its clinical affiliates, the educational program for medical students must remain under the control of the program's faculty at each instructional site.

The responsibility of the clinical facility for patient care should not diminish or preclude opportunities for medical students to undertake patient care duties under the appropriate supervision of the medical school's faculty, instructors, and preceptors.

ER-7. An institution that provides a medical school must provide ready access to a well maintained resource center sufficient to support its educational and other missions.

Students, faculty, and others associated with an institution that provides a medical school should have physical or electronic access to the current and prior volumes of leading biomedical, clinical, and other relevant periodicals, self-instructional materials, and any other information resources required to support the institution's missions, including the educational program..

SELF STUDY

The self-study is a critical and integral part of the approval process. Self-study is a systematic process of institutional and programmatic self-assessment and used, in part, in preparation for the State Education Department review, site visit and evaluation for approval process. Self-study is an important part of the process of institutional and program improvement, and will be an ongoing activity required by the Education Department. A successful self-study will provide valuable information that may be used for modification and improvement of the educational program. Prior to a provisional or a full on-site visit, each institution that provides a medical school will complete and submit a self-study report. An institution that provides a medical school seeking approval for long term clerkships in New York should initiate the self-study process at least twelve (12) months before the scheduled site visit. Completed self-study reports must be sent to the Education Department at least sixty (60) days prior to the scheduled date of full and provisional on-site visits.

Guidelines for the Self-Study Process

The self-study must represent a factual picture, which demonstrates that the institution that provides a medical school can discriminate between the significant features of its education program and the less important details of its operations. It must be a critical and objective appraisal of the institution that identifies a medical school's weaknesses and problems, as well as its strengths, based on a careful analysis of the facts that are presented. The self-study must be a unified study that shows the relationship of the various activities of the institution that provides a medical school to its avowed purposes. A self-study presented on a standard-by-standard basis can demonstrate compliance with Approval Standards.

The self-study should be adequate in length to summarize the factual material and the interpretations or judgments based on them. However, the self-study report must contain, at a minimum, the following topics: historical overview of the institution; organization of the self-study process; mission and objectives of the institution; organization of the institution that provides a medical education program; facilities; faculty; students; academic resources; instructional program; evaluations; recent accomplishments and current concerns; achievement of its graduates in relation to the mission of the institution that provides a medical school; and should also include a statement of and plan for future curricular, staff, student, financial support services, and physical plant development.

Review and comment on the self-study by the institutional community helps to affirm that the document represents the views of the faculty, students, and staff. As noted above, the essential purpose of the self-study is to assess the results – the outcomes – of the institution that provides a medical school's efforts in pursuit of its mission and goals. Whereas mission and goals statements indicate the desired outcomes, the institution that provides a medical school should stipulate the specific criteria by which outcomes are assessed to validate outcome attainment.

The Annual Report

The Education Department will require, in September of each year, an annual report.
The annual report must contain, at a minimum, the following information:

- the number of students in current classes as compared to the number of students attending during the last evaluation cycle;
- the number of students decelerated, dismissed, on leave, or on academic probation
- new and terminated affiliation agreements;
- 5-year trends on benchmarks(such as USMLE) of student success applied to the entire class;
- numbers of students entering NYS for required clerkships of 12+ weeks over the last two years of their medical school training;
- the number of students securing accredited PGY1 positions in the US or Canada;
- instructional sites for basic and clinical education;
- all licensed institutions with which the medical school has affiliation agreements; and
- progress reports regarding compliance when Approval Standards are determined not met

The annual report will be reviewed by the Committee. The Committee's action on the annual report will be:

- Accept the report
- Decline to accept the report as fulfilling the requirement, in which case the Committee will recommend to the Deputy Commissioner the action that should be taken
- Accept the Progress Report in the Annual Report as requirements being met
- Determine the Progress Report in the Annual report as not meeting the requirements and recommend to the Deputy Commissioner the action that should be taken

Review Instrument

Example of a Standard, its review instrument, the use of the self study to indicate compliance, and the validation on site visit:

IS-2	A medical school should be, or be part of, an institution legally authorized under applicable law to provide medical school leading to the first medical degree in the country where the school is located.

Documents to review for verifying compliance, Standard IS-2:	Interviews to conduct for verifying compliance, Standard IS-2:

Current Findings (Only):

Standard IS-2Met _____	**Standard IS-2Not Met _____**
Check all that apply and write below:	

Requirement/Recommendation/Commendation:

Regents Advisory Committee on Long-Term Clinical Clerkships

A medical school that seeks to have its students be eligible to undertake "long-term clinical clerkships" (an aggregate of more than 12 weeks of required or elective clinical training over 2 years) in New York State hospitals must be approved by the Board of Regents. The approval process involves programmatic review and evaluation; it is not consultative and does not confer "accreditation".

The Regents Advisory Committee on Long-Term Clinical Clerkships (hereinafter, the "Advisory Committee") is appointed by the Board of Regents, it serves in a consultative and advisory capacity to the Regents on matters pertaining to the standards and process for approving international medical schools for the purpose of allowing their students to undertake long-term clinical clerkships in New York State. It acts to assure the Regents, the New York State Board for Medicine, and the public that such medical schools, which are not accredited by the Liaison Committee on Medical Education (LCME), The Commissioner on Osteopathic College Accreditation (COCA), or the Committee on Accreditation of Canadian Medical Schools (CACMS), are providing high quality pre-doctoral medical education, and that the medical education provided by those schools particularly the long-term clinical clerkships performed by their students in New York State, is in the public interest.

Approval is based upon the applicant medical school's demonstration that they meet the standards contained in the New York State Approval Standards for International Medical Schools Seeking Long-Term Clinical Clerkships (hereinafter, the "Approval Standards") and the applicable NYS regulations. The foundation of the standards are three fundamental principles: 1. the medical school is engaged in continual self-study, self-analysis, and quality improvement; 2. the medical education program has adequately prepared the medical student for clinical clerkships; and 3. the graduates of the medical school exhibit the general competencies of physicians prepared for the next stage of their training.

In order to attempt to have consistent language in this process, the following definitions will be used:

> **Medical School** shall mean an institution that offers a post secondary education program leading to an M.D. or other primary medical degree or a D.O. degree and which prepares graduates for the practice of medicine.
>
> **Assess and assessment** will be used to refer to evaluation of medical student performance.
>
> **Evaluate and evaluation** will refer to measures of faculty, program, course, curriculum, and clerkship rotations.

Clerkships and clerkship rotations will mean clinical experiences taken for credit, whether required or elective. Long-term clinical clerkship shall mean a clinical clerkship, taken for credit which, in the aggregate of all clerkship experience received during two academic years, exceeds 12 weeks.

Approval Standards will refer to the New York State Approval Standards for International Medical Schools Seeking Long-Term Clinical Clerkships.

Faculty shall mean individuals approved by the medical school to provide medical education for its students.

The purpose of the process outlined below is to determine whether a school meets the Approval Standards. The steps for initial application for, or renewal of, approval are as follows:

1. Each applicant will be required to submit a self-study.
2. At least two members of the Advisory Committee will review the application, each one independent of the other, each providing a report. The two members may request additional information from the school through the Executive Secretary of the Board of Medicine, who is responsible for generating any letters, correspondence, or reports throughout the process. The written reports will be given only to the Executive Secretary of the Board of Medicine.
3. When the self-study is considered complete in that both Advisory Committee members assigned to review the application have determined that the self-study has adequately addressed all of the Approval Standards, a site visit will be scheduled.
4. Should the two Advisory Committee members assigned to review the application disagree as to the adequacy of the application, the reports will be presented to the full Advisory Committee for review and determination as to whether or not a site visit should be scheduled.
5. The State Board for Medicine will develop and maintain a list of qualified site visitors. The Advisory Committee will select an appropriate site review team of no less than three members from that list for each validation visit. Additional site visitors may be assigned if there are multiple training sites.
6. During the site visit, the medical program will be reviewed to validate the representations contained within the self-study. The medical program will bear the burden of demonstrating satisfactory compliance with the Approval

Standards. Any standard that cannot be validated or appears to be non-compliant will be recorded as an observation.

7. The medical school will be provided with a copy of the observations within two weeks after the site visit, and the medical school will be given 30 days to respond. All site visit reports and responses must be completed no less than two months prior to the meeting for which they are scheduled. Failure to comply with the timeline for submission of responses may result in termination of existing approval, or, in the case of new applications, may result in rescheduling consideration for the next available meeting.

8. The Advisory Committee members who reviewed the self-study will be provided with the report of the site visit team and the institution's response, and, based on that information, will prepare a report to be presented to the Advisory Committee.

9. The Advisory Committee members will review all materials, with particular attention paid to recorded observations.

10. The Advisory Committee will make determinations with respect to compliance with the Approval Standards, and based on these findings, the Advisory Committee will make a recommendation to the Board of Regents on the appropriate disposition of a school's application. The recommendation will provide the rationale for the recommendation and will reflect majority and minority opinions.

11. The Board of Regents will make the final determination on the application for approval.

The Advisory Committee is committed to continual self-study and improvement