

### Expanding the LCME Severe Action Decisions Analysis to Gauge the Effect of the 2002 Accreditation Standards Reformatting

The Liaison Committee on Medical Education (LCME) accredits U.S. M.D.-granting medical education programs (MEPs) and works with the Committee on Accreditation of Canadian Medical Schools to accredit these programs in Canada. LCME accreditation is a process of quality assurance that establishes eligibility for selected federal grants and programs and is required for licensure of medical school graduates. Every eight years, each established MEP undergoes a full review (i.e., a “full survey”) of its compliance with all LCME accreditation standards.

LCME standards guide medical schools in preparing for accreditation survey visits and shape accreditation decisions. In 2002, these standards were reformatted from prose to numbered format, but the content remained largely unchanged. This reformatting linked the numbered standards directly to the self-study questions medical schools respond to as they prepare for their full survey visit. This change clarified the information needed to demonstrate compliance with these standards, which, in turn, improved the LCME’s ability to both track compliance improvements and identify when a MEP was noncompliant with the standards.

Previous research<sup>1</sup> defined an LCME severe action decision (SAD) as one that grants a MEP an unspecified or shortened term of accreditation, places the program on warning or probation status, or withdraws the program’s

accreditation, while a non-severe action decision (N-SAD) is one that continues accreditation without a severe action decision. This research identified an increasing number of SADs in the years immediately following the 2002 reformatting of LCME standards and posited that the increase was partly because of the reformatting. This Analysis in Brief builds on this research on SADs by expanding the time periods of analysis to see if the finding of increased SADs following the standards reformatting in 2002 still holds.

#### Methodology

The LCME decisions made on full survey reports of established MEPs, which were reviewed at LCME meetings prior to and following the 2002 reformatting, were studied (i.e., the academic years 1992–1993 through 1999–2000, and 2005–2006 through 2013–2014, were studied<sup>2</sup>). Following the precedent set by Hunt et al.,<sup>1</sup> decisions on MEPs beginning a few years after the standards reformatting were studied to ensure that the full effect of the change had taken place.

Only established MEPs were included in these analyses. For the purposes of this paper, an established MEP was defined as a program in which the LCME had reviewed two or more full survey reports after its review of the program’s initial survey for full accreditation. MEPs were categorized as receiving either a single SAD or an N-SAD (a MEP could not receive more than one SAD).

#### Results

There were no withdrawals of LCME accreditation in either of the time periods analyzed, but all other types of SADs were present in both time periods. Whereas SADs comprised 15 percent of LCME decisions made in the first time period (1992–1993 through 1999–2000), SADs comprised 31 percent of decisions made in the second time period (2005–2006 through 2013–2014; see Table). There were significantly fewer SADs in the first time period compared to the second (Pearson Chi-Square = 111.88,  $p = .001$ ; small to moderate effect size (phi coefficient = .19,  $p = .001$ ).

**Table: Number and Percentage of LCME Non-Severe and Severe Action Decisions Before and After the 2002 LCME Standards Reformatting**

	Non-Severe Action Decisions (N-SADs)	Severe Action Decisions (SADs)	TOTAL DECISIONS*
Academic Year 1992-93–1999-00†	139 (85%)	25 (15%)	164
Academic Year 2005-06–2013-14†	109 (69%)	50 (31%)	159

†The date ranges specified are inclusive.

1. Hunt D, Migdal M, Eaglen R, Barzansky B, & Sabalis R (2012). The unintended consequences of clarity: reviewing the actions of the Liaison Committee on Medical Education before and after the reorganization of accreditation standards. *Acad Med.* 87(5):560–566.  
2. There were more full survey reviews per year in the time period prior to 2002 because accreditation terms were for seven years, instead of eight years as they have been since 2002. Therefore, an additional year’s worth of LCME full survey reviews were added in the second time period to have a number comparable to that of the first time period.

### Discussion

These findings are relevant to the LCME for its ongoing continuous quality improvement efforts and MEPs for their full survey preparation and quality improvement efforts. As noted, the 2002 LCME standards reformatting enhanced the clarity of each standard and more directly connected already existing annotations to their corresponding standards. As a result, the documents and communications sent to MEPs were directly tied to specific standards for the first time. This change enabled the LCME to more easily identify areas of noncompliance, and the results suggest

the realization of this effect through the increased prevalence of SADs in the second time period. That said, Hunt et al.<sup>1</sup> speculated that although the LCME improved its ability to assess compliance through this reformatting, MEPs were unaware of this improvement because their compliance with standards is assessed only every eight years. This assessment cycle may have resulted in the observed increase in SADs. As a result, in 2014, the LCME created a new standard requiring ongoing monitoring of compliance with the standards.

These results and the results from previous research suggest that the LCME standards reformatting has improved the LCME's ability to monitor MEPs. The expanded analysis of the unintended consequences of the 2002 reformatting is particularly relevant because, for the first time since 2002, the LCME has released a reformatted version of its standards,<sup>3</sup> again without significantly changing requirements. Future research should analyze the effect of this latest reformatting on the prevalence of SADs as well as gauge the effect of this latest reformatting from the MEP perspective.

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3. Liaison Committee on Medical Education. Functions and Structure of a Medical School. Accessed October 30, 2014 at: <http://www.lcme.org/publications/2015-16-functions-and-structure-march-2014.doc>.