Management Principles to Drive the Creation of a 21st Century Medical School

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Abstract

**Introduction**
There are currently no data, blueprints, best practices, or financial models available to guide the creation of a new medical school. Yet, the United States is experiencing unprecedented growth of new allopathic medical schools.

**Findings**
This article brings logic to the process. It converts the complexity of what is often regarded as an administrative exercise into the first published framework of management principles. Those principles were then translated into a process map and a financial optimization model. All three elements can be successfully implemented for establishing an accredited, value-driven medical education program that minimizes time from inception to implementation, and ensures sustainability over time.

**Outcomes**
This case report provides a blueprint for planning and implementation of a new medical school. Outcomes include both process and optimization models, as well as valuable insights that have utility when considering a new medical school to mitigate the projected nationwide shortage of physicians.

**Keywords**
undergraduate medical education; physician workforce; medical schools; organizational models; case studies

**Introduction**
The United States will see a shortage of as many as 122,000 physicians by 2032, as demand for physicians continues to grow faster than supply. Therefore, we are witnessing remarkable growth of new allopathic medical schools in the U.S. The creation of a new medical school is a highly complex, expensive and daunting task, often resulting in the formation of an Academic Medical Center (AMC) composed of a medical school, clinic(s) and hospital(s) operations. It follows logically that they thus have enormous impact on host institutions, graduates, workforce and entire regional healthcare ecosystems. Aside from established accreditation standards, there are currently no data, blueprints, guidelines or financial models available that can guide the creation of a new medical school and provide some degree of standardization to a highly variable and complex process. A review of the literature revealed a plethora of articles in the 1960s and 1970s about the formation of new medical schools, however there is a paucity of contemporary literature addressing this topic.

**Objective**
This article brings logic to the process of creating a new medical school. It converts the complexity of what is often regarded as an administrative exercise into the first published framework of management principles. Those principles are then translated into a process map and a financial optimization model. All
three elements can be successfully implement-
ed for establishing an accredited, value-driven
medical education program that minimizes
time from inception to implementation, and
ensures sustainability over time.

Background
There is great urgency to prepare a new gen-
eration of physician leaders who are capable
of innovating higher quality medical care while
reducing cost. Now is a time when the newest
physicians entering medicine should be lead-
ing the way to improved delivery systems and healthier populations. In addition, technolog-
ical innovations are needed that compensate
for shortages of health care providers, enhance responsiveness to more demanding patients,
control rather than exacerbate costs, and en-
HCA Healthcare Journal of Medicine
the healthcare and health education sectors, as never seen before. In the last decade, twenty-three new medical schools have received full, provisional or preliminary accreditation. Table 1 lists new medical schools (since 2015) with preliminary and provisional accreditation status.

A review has revealed an additional seven schools that are at various stages of the accreditation planning phase (Table 2). Note that for the majority, targeted preliminary accreditations are imminent (2020-2021), with two institutions’ target years yet to be determined. It is recognized that hospital partnership is an essential component of the process. Table 2 lists hospital partners for those institutions where the information was available.

### Table 1. LCME-Accredited U.S. Medical Schools with Preliminary and Provisional Accreditation Status (Initial Year 2015-2019)

<table>
<thead>
<tr>
<th>Institution/Program</th>
<th>City, State</th>
<th>Accreditation Status</th>
<th>Initial Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Northstate University College of Medicine</td>
<td>Elk Grove, CA</td>
<td>Provisional</td>
<td>2015</td>
</tr>
<tr>
<td>CUNY School of Medicine</td>
<td>New York, NY</td>
<td>Provisional</td>
<td>2015</td>
</tr>
<tr>
<td>The University of Texas at Austin Dell Medical School</td>
<td>Austin, TX</td>
<td>Provisional</td>
<td>2015</td>
</tr>
<tr>
<td>Washington State University Elson S. Floyd College of Medicine</td>
<td>Spokane, WA</td>
<td>Provisional</td>
<td>2016</td>
</tr>
<tr>
<td>University of Nevada, Las Vegas School of Medicine</td>
<td>Las Vegas, NV</td>
<td>Preliminary Survey Pending</td>
<td>2016</td>
</tr>
<tr>
<td>The University of Texas Rio Grande Valley School of Medicine</td>
<td>Edinburg, TX</td>
<td>Preliminary Survey Pending</td>
<td>2015</td>
</tr>
<tr>
<td>Nova Southeastern University Dr. Kiran C. Patel College of Allopathic Medicine</td>
<td>Fort Lauderdale, FL</td>
<td>Preliminary</td>
<td>2017</td>
</tr>
<tr>
<td>Carle Illinois College Medicine</td>
<td>Urbana-Champaign, IL</td>
<td>Preliminary</td>
<td>2017</td>
</tr>
<tr>
<td>California University of Science and Medicine School of Medicine</td>
<td>San Bernardino, CA</td>
<td>Preliminary</td>
<td>2018</td>
</tr>
<tr>
<td>Hackensack-Meridian School of Medicine at Seton Hall University</td>
<td>South Orange, NJ</td>
<td>Preliminary</td>
<td>2018</td>
</tr>
<tr>
<td>TCU and UNTHSC School of Medicine</td>
<td>Fort Worth, TX</td>
<td>Preliminary</td>
<td>2018</td>
</tr>
<tr>
<td>Kaiser Permanente School of Medicine</td>
<td>Pasadena, CA</td>
<td>Preliminary</td>
<td>2019</td>
</tr>
<tr>
<td>New York University Long Island School of Medicine</td>
<td>Mineola, NY</td>
<td>Preliminary</td>
<td>2019</td>
</tr>
</tbody>
</table>

### The opportunity for new medical schools

A new medical school has significant impact on its host institution, its graduates, the workforce, the region and the entire healthcare ecosystem, while also reducing national physician shortages. Those programs that develop and implement radical curricular innovations, including integrating novel technologies within the curricula, are truly training the physician of the future.

New medical schools, unlike established medical schools, are relatively unencumbered by organizational inertia and legacy processes and systems. While they are frequently populated by experienced faculty and personnel from established schools, anecdotal evidence from newer medical schools established in the last
two decades indicates that the organizational ecosystem is inhibited by fewer encumbrances in new schools. Thus, new schools have the opportunity to dramatically innovate medical education. This can be achieved through curricula producing better learning outcomes, the strategic use of technology, novel organizational structure, the timing and sequencing of learning, the use of innovative pedagogy and the reorganization of clinical training. The new schools have the advantage of learning from educational experiments of the past, as well as using new and future technology to supplement traditional pedagogical techniques. Recognition of changing models of care delivery, new skill sets necessary for clinicians, rapidly advancing medical science and the need to restore trust, all call for radically new ways of training future physicians. Over the next decade, the new medical schools will catalyze change throughout the entire educational system. They will have a tremendous impact on health care delivery, the healthcare system, and the economy as a whole. Therefore, a newly accredited medical school can be a transformational academic asset within the ecosystem of a university. It affords significant prestige, which tends to grow, catalyzing biomedical research, fostering increased community interest and philanthropy, and enhancing recognition

<table>
<thead>
<tr>
<th>Institution</th>
<th>State</th>
<th>Hospital Partner</th>
<th>Target Date for Preliminary Accreditation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Houston</td>
<td>TX</td>
<td>HCA Healthcare</td>
<td>October 2020</td>
<td><a href="https://www.texastribune.org/2019/05/02/university-houston-medical-school-gets-approval-texas-legislature/">https://www.texastribune.org/2019/05/02/university-houston-medical-school-gets-approval-texas-legislature/</a></td>
</tr>
<tr>
<td>College of Henricopolis School of Medicine</td>
<td>VA</td>
<td>TBD</td>
<td>TBD</td>
<td>None available</td>
</tr>
</tbody>
</table>
and the ranking of the parent university on national and global scales.

**Challenges and disruptions of new medical schools**

Although the long-term benefits for establishing new medical schools are well-defined, the addition of such programs within universities can pose formidable challenges and disruptions. These are attributable to the cultural, academic, strategic and fiscal impact of the new school within the overall existing framework of the university. Moreover, aside from traditional accreditation standards, there is no available "blueprint" or "best practice model" that guides the creation of a fully accredited medical school pursuing the triple aims of academic medicine – education, research and clinical care. Finally, there are no established or published business models to achieve the fiscal sustainability of new medical schools without substantive hospital or government subsidies. Reflecting on the lack of generalizable management principles guiding this extraordinarily challenging task toward value enhancement, some institutions proposed a discovery-driven planning process. This has involved reverse engineering desired outcomes related to curriculum and facilities development, based on a set of core values. However, such models lack a generalizable blueprint and are limited to institutions with specific institutional settings and missions.10

When an institution is considering starting a new medical school, the matter is traditionally addressed through the facilitation of an outside expert charged to develop, without bias, the institutional feasibility study. This is regarded as a first step in defining the prospective new medical school’s distinctive identity, and is the product of a multifactorial formula incorporating institutional priorities, assets, strategic goals, regional circumstances, as well as political and social considerations. The feasibility study further includes initial financial projections to estimate cost and revenue throughout the institutional planning stage and the ensuing accreditation phases, which conclude with the graduation of the inaugural student class.

Unfortunately, feasibility studies for new medical schools are developed by a small cadre of experts that provide best estimates of the prospective medical school’s future. Curricular and economic design, hospital affiliations and other factors greatly impact the overall economic model. Therefore, in most institutional settings, there are major differences between projected and actual costs during the medical school’s startup phase. This often causes tensions among institutional and medical school leadership, especially once the new medical school’s curricular design, staffing resources and business model have been developed by founding leadership, so that form can follow function.

**Case Report in Innovation, Quality, Value and Agility: NSU MD**

Nova Southeastern University (NSU), a private, not-for-profit institution, located in Fort Lauderdale, Florida, successfully planned (starting in 2016), initiated (2017), and rapidly received preliminary accreditation (2018) for a new medical school awarding the MD degree. With a distinct vision for medical innovation, NSU MD has kept total costs at a lower level than estimated by experts, while ensuring that quality metrics have been met or exceeded. For example, the charter class of students recently completed the first year of NSU MD’s progressive, case-based program, performing above the national average on six of the seven National Board of Medical Examiners exams. They performed at the national average on the seventh.

This programmatic success in the area of quality is in part attributable to NSU MD’s innovative approach to medical education, which enhances core principles,6 including the training of physicians on the science of health delivery and their role within the health system. The curriculum uniquely addresses health care finances and how to be responsible stewards of health care costs, preparing physicians to effectively lead teams of healthcare professionals. It also supports flexible pathways for physician training and assessing the competencies students acquire before and during medical school as well as readiness for residency training.

Lowering costs during the planning and initial accreditation phases was the result of NSU’s
centralized, shared resources model and a strong collaboration with the H. Wayne Huizenga College of Business and Entrepreneurship (HCBE) at NSU. This partnership enabled the implementation of management and process flow optimization strategies within the medical school. Moreover, these business tactics and a strong partnership model with hospital and regional partners contributed to the final economic model, putting the new medical school on a track toward rapid fiscal sustainability.

The intentional reduction of costs to produce better value was a key achievement in the operationalization of the business strategies employed. Cost is contingent on time and tactics and is also a function of regional factors. Time is a frequently overlooked expense dimension, with the cost-to-wait dramatically underestimated. In fact, the carrying costs of overhead while waiting to plan, initiate or receive preliminary accreditation can be substantial. The more time it takes an organization, the higher those costs will be. In addition, an institution’s ability to move forward through the process is contingent on LCME’s capacity to review it at any given time. If the capacity is not available, the time to preliminary accreditation is longer and the costs associated with carrying the overhead increase. In addition, it is not unreasonable to expect LCME policy changes over time. The sooner an institution plans, initiates and receives preliminary accreditation, the less the risk of unanticipated policy changes adding time, and hence expense, to the process.

Agility was also a key differentiator for NSU MD while planning, initiating and ultimately receiving preliminary accreditation. This agility mindset permeated its culture at every level, enabling the College to outpace typical institutional speeds while keeping costs to a minimum and reinvesting those cost savings to produce a higher quality program. Quality indicators that correspond to program metrics such as student recruitment, retention, performance on national standardized exams, curriculum, pedagogy, faculty-student ratios and graduation rates demonstrated that these tactics increased the value of the system overall.

### Findings and Outcomes

**Key management principles discovered and implemented**

From the NSU experience, the authors have detailed ten key management principles that were essential to meeting NSU MD’s financial plan. They are independent of the specific mission and curriculum chosen by the institution, thereby providing critical advice to anyone contemplating a similar challenge, or looking to improve ongoing operations. The ten key management principles are shown in Table 3. Not only have they been successfully used, but they are highly recommended, as they can dramatically impact a new medical school’s triple aims of education, research and clinical care.

**Process map**

The model in Figure 2 depicts the entire, multifaceted planning and implementation process. From the original feasibility study to full accreditation, it depicts the steps required to create a new medical school that is capable of achieving fiscal sustainability, while also achieving the highest standards of quality. It shows three major phases—planning, initial and final implementation—as well as key milestones that need to be achieved throughout the process. At the bottom of the figure, sources of revenue are identified. The model also frames the ten key management principles from Table 3 (numbered in the figure from 1 to 10) providing context for their utility.

This process map reflects actual structured sets of activities performed by NSU MD that transformed measurable inputs into outputs, along with key performance indicators. The process flow, as depicted, defines the sequence and interactions of related process steps, activities and tasks that comprise the entire planning and implementation process, from feasibility study to full accreditation. The Founding Dean and his team anticipated organizing the experience into a structured process, a priori. The structure, principles and optimization that emerged were not derived retrospectively after reflection on the experience, but rather they were fully derived during the planning phase, leading up to Provisional Accreditation, as shown in Figure 2. NSU MD views its process to be a strategic asset of the organization.
Table 3. Ten Key Management Principles

<table>
<thead>
<tr>
<th>Principles</th>
<th>Impact Areas</th>
<th>Financial Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Developed and utilized a comprehensive financial optimization and prediction model for planning, accreditation and sustainability over time that includes optimization of time required and reinvestment of savings for purposes of improving quality.</td>
<td>Strategic Analytics</td>
<td>Optimized resource allocation over the entire 6-10-year process.</td>
</tr>
<tr>
<td>2. Adopted Just-In-Time approaches to faculty and staff hiring.</td>
<td>Personnel</td>
<td>Minimized personnel lead time costs.</td>
</tr>
<tr>
<td>3. Implemented a licensing model with other university colleges, centers and institutes to secure program faculty.</td>
<td>Personnel</td>
<td>Minimized costs associated with program faculty lines.</td>
</tr>
<tr>
<td>4. Leveraged faculty effort through the delivery of pipeline or post-baccalaureate programs.</td>
<td>Personnel</td>
<td>Created new streams of revenue with existing faculty lines and by optimizing utilization of personnel.</td>
</tr>
<tr>
<td>5. Implemented lean and six sigma methodologies to optimize resource management and consolidate through acquisition and mergers of other programs with the medical school.</td>
<td>Resources Management and Program Consolidation</td>
<td>Streamlined operations, eliminated waste and minimized institutional overhead.</td>
</tr>
<tr>
<td>6. Maximized shared resources (student services/simulation/library/testing).</td>
<td>Program Services</td>
<td>Eliminated unnecessary duplication and minimized ancillary costs.</td>
</tr>
<tr>
<td>7. Developed and established strategic internal and external contractual partnerships.</td>
<td>Partnerships</td>
<td>Optimized synergistic activities and minimized risk and exposure.</td>
</tr>
<tr>
<td>8. Obtained in-kind revenue from hospital partners.</td>
<td>Partnerships</td>
<td>Reduced costs for services provided through hospital partners, and provided a stable platform for clinical care.</td>
</tr>
<tr>
<td>9. Initially utilized and re-purposed existing campus facility and space resources until funds are secured for major capital investment.</td>
<td>Facilities</td>
<td>Minimized initial investment in facilities.</td>
</tr>
<tr>
<td>10. Developed and implemented a fiscal sustainability model that includes aligning research product with a campaign that links donor interests with specific disease entities.</td>
<td>Sustainability</td>
<td>Complemented the initial tuition-based business model with other significant sources of revenue, ensuring the fiscal health of both the education and research enterprises.</td>
</tr>
</tbody>
</table>
Figure 2. Process Flow Strategies from Feasibility to Full Accreditation for the Formation of a New Medical School

1. Feasibility Study
2. Decision To Proceed
3. Institutional Setting
   - Mission/Configuration
   - Policies & Procedures
   - Legal/Compliance
4. Business Plan
5. Key Committees
   - Merit and Promotion
   - Admissions
   - Curriculum
   - Student Progress and Advising
   - Diversity
   - Faculty Practice
   - Quality and Policy
   - Library & IT Resources
   - Bylaws
6. Staffing Plan
   - FTE Matrix
7. Curriculum
   - Pre-clinical
   - Clinical
   - CQI Program
8. Communication & Marketing
   - Communication Plan
   - Marketing Plan
9. Admissions
   - Admission Committee
   - Recruitment
   - Student Service
   - Debt services
10. Admission & Student Affairs
11. Standing Committees
12. Strategic Plan
13. Affiliation Agreements
14. Program Evaluation & Monitoring
   - Achievement of Intended Mission
   - Student Performance
   - Program Assessment
   - Graduation and Attrition Rates
   - Feedback from Residency Directors
15. Standing Committees
16. Business Plan
17. Staffing
   - FTE Matrix
   - Critical Mass
18. New Hires
19. New Facilities
20. Facility Planning
   - Existing space
   - Needs Assessment
   - Allocation
21. Remodel if Needed
22. Plan New Construction
23. Contracted Faculty
24. New Hires
25. Recruitment
26. Student Service
27. Tuition
28. Revenues
29. Tuition
30. Gifts & Endowments
31. In-Kind Revenues
32. Research
33. Clinical Revenues
34. Program Revenues
35. Development
   - Scholarships
   - Faculty
   - Naming
36. Student Research
   - Scholarly Conduct
   - Translational Research
37. Clinical Services
   - Practice Plan
   - Health Management
38. Start of Clinical Curriculum
   - Site Identification
   - Student Placement
   - Rotations
   - Clinical Mentors & Preceptors
39. New Research Grants
   - Federal
   - State
   - Other
40. Research Integration
   - Existing Programs
   - Consolidation
   - Partnerships
   - New Research Grants
41. Start of Preclinical Curriculum
42. Submission for Preliminary Accreditation
43. Maximize Use of Existing Facilities
44. Remodel if Needed
45. Plan New Construction
46. Contracted Faculty
47. New Hires
48. Recruitment
49. Student Service
50. Tuition
51. Revenues
52. Tuition
53. Gifts & Endowments
54. In-Kind Revenues
55. Research
56. Clinical Revenues
57. Program Revenues
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62. New Research Grants
   - Federal
   - State
   - Other
63. Research Integration
   - Existing Programs
   - Consolidation
   - Partnerships
   - New Research Grants
64. Initial Implementation
65. Provisional Accreditation
66. Full Accreditation
67. Full Accreditation
68. Full Accreditation
69. Full Accreditation
70. Management Principles
Managed optimally, the process as defined has delivered a clear, competitive advantage. Schools that anticipate undertaking the launch of a new MD program can use this map to assist in defining process boundaries, ownership, responsibilities, internal controls, effectiveness measures and work standards for compliance, consistency and performance.

**Modeling approach**

As shown in the process map, a major starting point for the planning of a medical school is to decide on the nature and structure of the curriculum. Curricular design decisions then lead to major subsequent resources requirements including, but not limited to, staffing (faculty and staff), facilities, postgraduate training, hospital affiliations and research requirements. These requirements evolve over time, during initial and final implementation phases (see Figure 2), and can be met in several different ways. For example, one can decide to hire new faculty or leverage existing faculty from other schools/colleges on a part-time basis. Similarly, existing university resources (simulation facility, student services, etc.) can be shared or (re)created as part of the new medical school. Hospital affiliation agreements can be negotiated to offer in-kind revenue and other savings. Faculty can be leveraged to deliver additional revenue-generating programs beyond the MD curriculum.

Specific curricular design decisions drive resource requirements that can be met in different ways. Hence, we developed a comprehensive financial spreadsheet model that incorporates costs and revenues associated with different resourcing configurations. The model was populated with cost data specific to NSU and the local and regional community, thereby allowing us to project reliable cost estimates and systematically analyze different configurations for achieving the mission over time at minimum overall cost.

For example, given the curriculum design and specific choices made regarding how to deliver the curriculum (such as the faculty-to-student ratio, team/problem-based pedagogical approach), there are a number of possible options regarding how to set up and allocate the workload of existing and newly hired faculty members over time. Our objective was to find the mix of part-time existing faculty and new hires that would minimize the cost of delivering the educational services specified in the chosen curriculum over a set period of time (the first four years). This is commonly referred to as a staffing and scheduling optimization problem. While this can be done in a spreadsheet model through a series of “what-if” analyses, the problem can also be formulated as a “mixed integer linear programming” model and can be systematically solved using the Solver algorithm in a spreadsheet program such as Microsoft Excel. While a novel application in this particular context, this type of optimization model has been successfully used for just-in-time production planning, workforce scheduling and many other problems. One advantage of this approach is that the model can be updated, augmented and refined over time, although such models can rapidly become quite complex.

**Discussion**

The creation of a new allopathic medical school within a university setting has often been characterized as one of the most complex and unpredictable tasks in an academic environment, often causing disruption, anxiety and stress within institutions and leading to, not surprisingly, a high turnover rate among faculty and founding deans. Unfortunately, there has historically been an absence of transparency when defining the journey from initiation to accreditation to successful implementation to fiscal sustainability over time. It has not been documented, to-date, what obstacles inevitably appear and it is not known what effective processes, approaches and models have been discovered that can accelerate achieving the mission.

In this manuscript, we seek to convey our experiences, processes, approaches and models deployed during the planning and creation phase of a new allopathic medical school in the populous South Florida region. We utilized financial optimization modeling, incorporating revenue and expense data, to yield a value-based economic design, in which deliberate cost savings in mission critical domains were re-invested in a higher quality educational product. Moreover, we used process flow analysis to identify distinct cost drivers that could be averted in a value-based and “lean” academic environment, giving serious consideration to the impact and interaction of this new economic model as it relates to other programs and services (Figure 2). As a potential limitation, the described
workflows, processes and tactics can vary considerably among institutions, due to variances in institutional settings and priorities, clinical affiliations, financial prowess and regional considerations.

Creating a more predictable and reproducible accreditation process and developing a sustainable undergraduate education model have become major strategic priorities for applicant institutions and accreditation agencies alike. Although the institutional feasibility study is a first step to define a future business model of the new school within the overall context of the university, these early forecasts rely on historic and institutional projections to estimate cost, but do not represent a balanced, non-tuition-driven financial model that demonstrates the long-term sustainability of the new venture. In order to develop an economically viable model, new medical schools must show a diversified income portfolio and, most importantly, demonstrate integration with affiliated hospital, community and other partners through agreements aligned with the missions of education, research and clinical care. Thus, securing affiliations with one (academic-medical-center-type accreditation) or several (community-type accreditation model) hospital partners and defining a reciprocal value system that would derive from such partnership(s) has become the top priority when a new medical school is considered. Areas of mutual interest may entail joint programs along the educational continuum, partnerships in the field of population health, data sciences, medical technologies or other projects.

This article makes important observations when considering a deliberate approach applied to the design of value-driven medical schools seeking to reduce cost, enhance quality and optimize educational, research and health outcomes. It further suggests that institutions of higher education considering the creation and development of new medical schools, or those seeking to dramatically improve current operations, should regard such challenges as opportunities to fundamentally transform the economic design of the educational and healthcare system through the application of “lean” methodologies and targeted re-investment of cost savings to yield a higher quality product. The real-time identification, enumeration and re-allocation of cost savings during the accreditation phase within the cost domains of staff and faculty recruitment, facilities development and resource management are designed to enable a value-based economic design. Thus, giving the school a unique opportunity to build its curriculum, facilities and priorities from the ground up. It is our conjecture, that value, as measured by health outcomes per dollar expended, should be the focus of every actor in modern healthcare.

We acknowledge that developing an innovative and sustainable economic model must be balanced with the constraints of meeting licensing and accreditation requirements. The most influential oversight body overseeing the accreditation of programs leading to the degree of Medical Doctor (MD) in the United States and Canada is LCME, jointly sponsored by the Association of American Medical Colleges (AAMC) and the American Medical Association (AMA). Fortunately, the planning and accreditation process involves frequent and productive communications with LCME to assure adherence to their 12 accreditation standards in the face of innovation, while transitioning from the planning stage to applicant and candidate status.

Often overlooked is early linking of research to the institutional planning and implementation processes. This eventually enables an organization, whose plans, policies and decisions are informed by a rich core of valid institutional data and a sophisticated understanding of the meaning of those data, to achieve institutional advancement and effectiveness.

We advocate a philosophy of a “science of institutional planning” that fosters new knowledge, allows new policies and better decision making through the reporting and analysis of institutional data. This philosophy not only impacts the planning or building process of a new medical school, but also allows transformation of community health and the region’s overall economy.

Conflicts of Interest

The authors declare they have no conflicts of interest.
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