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2014

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Cheifetz E. Craig

*Virginia Commonwealth University, [craig.cheifetz@inova.org](mailto:craig.cheifetz@inova.org)*

McOwen S. Katherine

*Association of American Medical Colleges, [kmcowen@aamc.org](mailto:kmcowen@aamc.org)*

Gagne Pierre

*Universite de Montreal Faculty of Medicine, [pierre.gagne.1@umontreal.ca](mailto:pierre.gagne.1@umontreal.ca)*

Wong L. Jennifer

*Association of American Medical Colleges*

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## **Regional Medical Campuses: a New Classification System**

Craig E. Cheifetz, MD, Katherine S. McOwen, Pierre Gagne, MD, MSc, and Jennifer L. Wong

Dr. Cheifetz is Regional Dean, Virginia Commonwealth University School of Medicine Inova Campus, Falls Church, VA.

Ms. McOwen is Director, Educational Programs, Association of American Medical Colleges, Washington, DC.

Dr. Gagne is Senior Advisor, Regional Medical Campus Development, Universite de Montreal, Montreal, Qc.

Ms. Wong is the Former Senior Specialist, Regional Campus Affairs, Association of American Medical Colleges.

Correspondence should be addressed to Dr. Cheifetz, VCU School of Medicine Inova Campus, 3300 Gallows Road, Falls Church, VA 22042; e-mail: [craig.cheifetz@inova.org](mailto:craig.cheifetz@inova.org).

## **Regional Medical Campuses: A New Classification System**

### **Background**

In 2006, the Association of American Medical Colleges (AAMC) forecast a serious physician shortage in North America and put forth a call for all Liaison Committee for Medical Education (LCME) - accredited medical schools to increase medical student enrollment by 30 % over ten years.<sup>1</sup> As of 2011 half of that growth in U.S. medical schools had already occurred.<sup>2</sup> New medical schools as well as new 2 and 4 year campuses account for the some of the increase.<sup>3</sup> Canada faced a similar challenge and responded by creating one new medical school, 13 new regional medical campuses (RMCs), and expanding medical education training programs in local communities.<sup>4</sup> Recently the forecast of worsening shortages in the United States has garnered national attention because of increased scrutiny after the passage of the Accountable Care Act (ACA) associated with better access to care for more people, thus increasing demand.<sup>5</sup>

While RMCs are not new, in the recent years of medical education enrollment expansion, they have seen their numbers increase.<sup>6</sup> The first RMCs were established in the 1960's in conjunction with a previous medical school expansion wave in the United States.<sup>7</sup> Through the 1970's and 80's the establishment of RMCs was slow and steady and comprised mostly of clinical campuses, but from the time the AAMC made their call for expansion, the number of RMCs has grown rapidly. (Group on Regional Medical Campuses/Group on Faculty Affairs 2013 Regional Medical Campus Survey, Unpublished Data, March 2013.)

As described in a letter dated February 26, 2003 from Joseph Keyes, Jr., Senior Vice President and General Council at the AAMC at the time, to all U.S. medical school deans, the GRMC started when, in the late 1990's a small group of regional medical campus deans began to congregate during the annual meeting of the AAMC with the unofficial group name of "Organization of Regional Medical Campus Deans" (ORMCD). Regular meetings of the ORMCD led to their identification of common themes particular to RMCs. In 2002, the ORMCD successfully applied to the AAMC for recognition, and in September of 2003, the AAMC Executive Council officially recognized a new professional development group of the AAMC entitled the Group on Regional Medical Campuses (GRMC).<sup>8</sup> From its inception, the GRMC has struggled to define *what* a RMC is, and *why* it is important to understand the population of students, residents, faculty, and staff who comprise them. During a session at their spring meeting in 2010 the group grappled with their identity and mission. By the end of the session it was clear to those attending that without a statement of *who* exactly was represented by the GRMC, it was impossible to engage members of the group in collaborative research projects across institutions to answer questions of what are RMCs and why do they exist.<sup>9</sup>

While class expansion explains much of the rapid growth in RMCs in recent years,<sup>10</sup> RMCs often have missions that differ from their main campus with an emphasis on community-based, rural, and longitudinal programs.<sup>11,12</sup> While conversation across institutions among the participants of GRMC meetings suggests students have unique and positive experiences at RMCs, it has been difficult for medical education researchers to study due to the lack of a standard definition of a RMC. Up until this point RMCs were not defined by the AAMC and so the term RMC was applied on a case by case basis, often including clinical campuses only, with conflicting

outcomes. For instance, results of the Graduation Questionnaire of the AAMC may be reported by campus, but defining exactly what campuses to include/exclude in the report is determined by each campus with no external guidelines. Further example of the need for a standardized nomenclature can be illustrated in Canada: between 2005 and 2009, RMC enrollment saw an almost five-fold increase, going from 152 enrolled medical students to 734. However, RMCs are still included in a loosely defined group, the Distributed Medical Education (DME) resource group of the Associate of Faculties of Medicine of Canada. The DME encompasses integrated longitudinal clerkship initiatives, rural medicine, community-based medical education, and more in addition to RMCs.<sup>13</sup> We know anecdotally that campuses exist in many forms: distributed medical education; distant sites; affiliate sites; and 1, 2, 3, and 4 year branch campuses to name a few. Until it is possible to understand the denominator, it is impossible to design studies comparing student, faculty, and community experiences at RMCs and their main campuses across the U.S. and Canada.

Past efforts to define RMCs have been used successfully for the purposes of a single paper, or study. Mallon et al. created a description utilizing unpublished materials and the published definition used by the LCME.<sup>7</sup> In their work they describe an RMC as a campus that is geographically separate from the main campus, with administrative ties to the office of the Dean, and offers at least four of the third year clerkships. This description was useful for the purposes of the authors' study, but inadequate to fully depict the breadth of RMCs who teach medical students in the United States and Canada, and who participate in the GRMC. For example, at times a RMC Dean reports to the Dean as at Texas Tech University Health Sciences Center School of Medicine, Amarillo Campus, but at other times to the Senior Associate Dean for Medical Education as at Michigan State College of Human Medicine, Lansing Campus.

While appropriate to each study, or use, multiple definitions make it virtually impossible to collect meaningful data about RMCs on a national/international scale for research purposes, as is evidenced by the small number of articles about RMCs in the current literature.<sup>14</sup> The ability of the GRMC to engage in any sort of relevant research hinges on identifying who the RMCs are in the U.S. and Canada. The purpose of this paper is to provide a clear classification or taxonomy of the various types of RMCs to standardize language in hopes of paving the way for future research.

## **Process**

The GRMC Steering Committee charged a subcommittee (the Committee) to develop a single description of a RMC which would encompass the wide distribution of campuses across the U.S. and Canada. The Committee worked via conference call and email, with presentations to the full steering committee at face to face meetings.

The first step of the Committee was to mount a pilot survey and distribute it via email. Designed to give a glimpse into the RMCs in the U.S., the survey would identify whether the campuses targeted thought of themselves as RMCs. The definition of RMCs used was “campuses of medical schools at which a portion of pre-clinical or clinical education of medical students occurs,” and went on to describe two types of campuses:

...a regional **basic science campus** is one at which (1) a portion of the first- or second-year medical student class receives their education separate from the main medical school and (2)

there is an administrative officer responsible for the oversight of the regional campus who reports to the medical school dean's office.

...a regional **clinical campus** is one at which (1) a portion of the third- or fourth-year medical student class does their clinical clerkships or electives at a site separate from the main medical school campus and (2) there is an officer responsible for the oversight of the regional campus who reports to the medical school dean's office.

The survey was distributed on September 9, 2009 via email to forty members of the GRMC representing twenty-four institutions in the United States and Canada. Twenty-four survey responses were ultimately collected. While the response rate was 60%, it was immediately realized by the Committee that at the time many RMCs did not participate in the GRMC, and therefore were not included in the distribution of the survey. Without a definition of a regional campus, though, it was impossible to understand how underpowered the results were. The survey results were used for little more than brief verbal presentations during the November 7, 2009 Chair's Address at the GRMC Business Meeting of the AAMC Annual Meeting in Boston, MA, and the Welcome Address at the GRMC Spring Meeting in San Diego, CA on March 10, 2010. The Committee hypothesized that nearly twice as many RMCs existed in the U.S. and Canada than were sent the pilot survey. This survey did not include animal or human subjects and IRB was not applicable.

In 2010 the Committee used the survey responses to shape their conversations with existing regional medical campus deans, the AAMC and LCME leadership. Using the definition from the 2009 survey, along with more recent work of the AAMC on RMCs by Mallon et.al.<sup>15</sup>, the Committee set out to develop a new RMC description. It was decided that the definition used in the 2009 survey was too broad, without a clear recommendation for exactly how much clinical education must take place on the campus for it to be considered a RMC. So for example, a clinical location that offered only the pediatric clerkship and sub-internship could be considered a RMC. From the GRMC's perspective, the clinical location that only offers a single discipline does not require the same level of administration, collaboration, or innovation as an RMC, all traits they believe necessary. The Committee also thought the definition lacked the ability to categorize campuses which if present would facilitate comparative research on a national and international scale. Finally, it was apparent to the Committee that basing a definition for the future solely on the model of two years of basic science followed by two years of clinical education didn't make sense in the face of the growing existence of integrated and longitudinal curricula.<sup>16</sup> Ultimately, the 2009 survey definition would not satisfy the goal of the committee which was to develop a widely used standard for determining if a campus was a RMC, recognizable by deans, administrators, and the LCME alike; and easily determined and verified using readily available information.

The committee developed a list of factors that may or may not contribute to a campus' designation as an RMC. Discussion and debate continued within the committee over the course of a year about distance from the main campus, location (in-state/out-of-state), number of students, breadth and depth of education offered, student services offered and mission of the



campus. As the year progressed it became clear that, try as they might, the Committee was unable to develop a succinct two or three line definition that would incorporate all of the RMCs known to exist in the U.S. and Canada. At this point, as with efforts to define an RMC in the past, it appeared as if the population of campuses was too diverse to define at all. Rather than giving up, the Committee decided to approach the definition in a new way, returning to the 2009 survey to identify factors all RMCs have in common.

The first list of common factors included:

- Type of campus
- Existence of external research funding
- Sources of funding
- Student class years on campus
- Residency programs on campus

Ultimately the Committee abandoned the factors of existence of research funding, sources of funding, and type of campus, in favor of a model including student class years on campus along with some description of the type of education, allowing the definition to be applied externally, and leaving less room for ambiguity. Basing the model on the core undergraduate educational program focused the Committee on that characteristic that is common to all RMCs. As diverse as they are, with 6 students or 200, the Committee noted that education across disciplines is present on every RMC.

## **Results**

The Committee developed the following attributes of a campus separate from the main campus that comprises the “classification” of a campus as a RMC. The system is broken into four models: Basic Science; Clinical; Longitudinal; and Combined. For clarity’s sake, the Committee also included a clear statement that RMCs do not receive independent accreditation from the Liaison Committee on Medical Education (LCME) or the Committee on Accreditation of Canadian Medical Schools (CACMS) but are included in the accreditation process for the home institution. To assure quality and consistency all programs that wish to meet the definition of a RMC must comply with the following LCME standards: ED-40; ED-41; ED-42; and ED-43.

### **The Classification System for Regional Medical Campuses**

**Basic Science Model:** Basic Science Year 1 only; Basic Science Year 2 only; Basic Science Year 1 and 2 in entirety.

**Clinical Model:** Year 3 in full-100% of required third year rotations occur at the regional campus; Year 3 and 4 in full-100% of required third year rotations and fourth year rotations/curriculum occur at the regional campus; Year 3 in part-greater than 50% of required third year rotations occur at the regional campus (Clerkships must be offered in their entirety and be managed directly by the regional campus).

**Longitudinal/Distributed Model:** Basic science and/or clinical experiences spanning a period greater than 12 weeks in one or more courses of study or core areas. There must be

continuous assignment of learners to the site over repeated cycles and administrative mechanisms to coordinate the academic experience, student affairs, and faculty oversight

**Combined Model:** Basic Science and Clinical years offered in some combination, for example: Years 1, 2, and 3 in whole or in part; Years 2, 3, and 4; Years 1, 2, 3 and 4.

After developing the classification system based on campus attributes and linked to LCME standards, the Committee invited review first by AAMC staff including the LCME secretary and then the GRMC membership. Ultimately, the GRMC membership was asked to vote on the classification system during their spring meeting in New Orleans, LA on March 23, 2011, and once approved, the GRMC adopted it as their standard, allowing the group to create the first ever list of RMCs in the U.S. and Canada that is stable over time. Using this classification system, or taxonomy of campuses, the GRMC maintains a list of current RMCs and how they fit into the model on their website, <https://www.aamc.org/members/grmc/>.

## **Discussion**

The establishment of a classification does not help us understand anything more about RMCs in itself. Two campuses that fit within the clinical model, for instance, can be radically different, with different student body and faculty sizes, different missions, or different distances between campuses. Until this model debuted however, GRMC discussions about RMCs often were stymied by a disagreement about factors that were impossible to discern for all campuses

everywhere, including what distance from the main campus, how many students, how many faculty, or what teaching styles were present at each RMC.

What the establishment of a definition does do is allow for the quantification of RMCs in the U.S. and Canada. The classification system simply paves the way for stakeholders like the GRMC, and medical education researchers to agree upon a denominator. How many RMCs are there? Are they growing or shrinking in number? Is one category thriving over another? Is one model more effective or cost efficient than another and should an imbalance be noted? These questions cannot be answered without a universally accepted classification system for RMCs. This simple set of clear categories is either applicable or not applicable to every campus where medical education takes place. Every medical school dean is able to quickly determine the status of their campus. The utility of the definition is in its simplicity and the practical ways in which it can be used in future research.

It was not until the idea that a classification does not have to accurately describe a RMC beyond categorizing it as a campus that the GRMC was able to bring all members to the table in agreement that yes, this may in fact be the place start. The current list of RMCs implies that just like the old adage about medical schools goes, “if you’ve seen one, you’ve seen one”. In the early part of 2013, the GRMC and the Group on Faculty Affairs embarked upon a survey of RMCs that will illuminate the differences and areas of commonality between campuses in the U.S. and Canada. Deans were provided with the classification system of a RMC and asked to apply it to the campuses in their system. If a model fit, they were asked to fill out the survey on domains ranging from student and faculty affairs to medical education and finances. Results will

be analyzed in 2013 with a report expected late in 2013 or early in 2014. Without this foundational work, the survey would have been incomplete at best, because if there was no criteria set out at the beginning each dean would apply a different set of factors when choosing which campuses to include.

A number of RMCs have studied various outcomes associated with their own creation, such as pedagogical success, local economic development, healthcare access, and quality of practice.<sup>14</sup> These studies lack global impact as it is almost impossible to draw solid conclusions if one cannot categorize RMCs into a sound model to compare data and avoid bias and confounding factors. The Committee likened the lack of a model with trying to calculate a class average when you don't know the class size. The GRMC hopes with the advent of the classification system and the RMC Survey made possible by it, to begin to fully describe the richness of RMCs and their impact on their students, faculty, staff, communities, and home institutions.

## **Conclusion**

There's burgeoning belief that RMCs are a significant part of the narrative about medical education, and the health care workforce in the United States and Canada. We expect this initiative will allow for basic medical education research to describe campuses, student outcomes, faculty experiences, and community impact. Further study is required to identify the impact of RMCs on their communities, their strengths and weaknesses, and eventually determine when and how they can be most effective in increasing their positive outcomes.

## **Disclosures**

Acknowledgments: The authors thank Sarina Luangkhot Petrocelli, Faculty Affairs and Academic Research Coordinator and Jared Cheifetz, Administrative Intern, VCU School of Medicine Inova Campus, for their administrative support of this project.

Funding/Support: None

Other Disclosures: None

Ethical Approval: Not Applicable

Previous presentations:

The definition of RMCs was presented and used previously:

9/7/2010 – RMC definition presented to the GRMC Steering Committee.

11/5/2010 – RMC definition presented and voted on by the GRMC Membership.

1/23/2013 – RMC definition used in 2013 GRMC/GFA Regional Medical Campus Survey.

## References

1. Association of American Medical Colleges. AAMC Statement on the Physician Workforce, June 2006. (<http://www.aamc.org/download/55458/data/workforceposition.pdf>). Accessed August 7, 2013.

2. Association of American Medical Colleges Center for Workforce Studies. Results of the 2011 Medical School Enrollment Survey.  
<http://www.aamc.org/download/281126/data/enrollment2012.pdf>). Published May 2012.  
Accessed August 7, 2013.
3. Whitcomb M. New and Developing Medical Schools: Motivating Factors, Major Challenges, Planning Strategies. New York, NY: Josiah Macy Jr. Foundation; 2009.
4. Association of Faculties of Medicine of Canada. Association of Faculties of Medicine of Canada Annual Report 2011 – 2012.  
[http://www.afmc.ca/pdf/Annual%20Report\\_2011\\_12\\_English.pdf](http://www.afmc.ca/pdf/Annual%20Report_2011_12_English.pdf)). Accessed August 7, 2013.
5. Fineberg HV. A Successful and Sustainable Health System – How to get There from Here. *New Engl J Med.* 2012; 366:1020-1027.
6. Bunton SA, Sabalis RF, Sabharwal RK, Candler C, Mallon WT. Medical School Expansion: Challenges and Strategies. Washington DC: Association of American Medical Colleges; 2008.

7. Mallon WT, Lui M, Jones RF, Whitcomb M. Mini-Med: the Role of Regional Campuses in U.S. Medical Education. Washington, D.C.: Association of American Medical Colleges; 2003.
8. Association of American Medical Colleges. About the GRMC. (<http://www.aamc.org/members/grmc/about>). Accessed August 7, 2013.
9. Lynn JG. Planning the Future of the GRMC. Session presented at the spring meeting of the GRMC; March 12, 2010; San Diego, CA.
10. Mallon WT. Medical School Expansion: Déjà vu All Over Again? Acad Med. 2007; 12:1121 – 1125.
11. Hurt MM, Harris JO. Founding a New College of Medicine at Florida State University. Acad Med. 2005; 80:973-979.
12. Norris TE, Coombs JB, House P, Moore S, Wenrich MD, Ramsey PG. Regional solutions to the physician workforce shortage: the WWAMI experience. Acad Med. 2006;81:857-862.
13. Association of Faculties of Medicine of Canada. Mapping Undergraduate Distributed Medical Education in Canada. ([https://www.afmc.ca/pdf/Mapping\\_Undergraduate\\_Distributed\\_Medical\\_Education\\_in\\_Canada\\_Oct2010\\_Eng.pdf](https://www.afmc.ca/pdf/Mapping_Undergraduate_Distributed_Medical_Education_in_Canada_Oct2010_Eng.pdf)). September 2010. Accessed May 2, 2013.
14. Fyfe T. Regional Medical Campuses: A Systematic Look at the Future. Session presented at the spring meeting of the GRMC; April 11, 2013; Atlantic City, NJ.)



15. Mallon WT, Lui M, Jones RF, Whitcomb M. Regional Medical Campuses: Bridging Communities, Enhancing Mission, Expanding Medical Education. Washington, DC: Association of American Medical Colleges; 2006.
  
16. Hirsch DA, Ogur B, Thibault GE, Cox M. “Continuity” as an Organizational Principle for Clinical Education Reform. N Engl J Med 2007;356:858-866.