CACMS vs. LCME Quick Reference Guide

A quick reference on the similarities and differences between CACMS and LCME Standards.

Standard # & Title	LCME Requirement (U.S.)	CACMS Requirement (Canada)	Key Divergence
1 – Mission, Planning, Organization, and Integrity	Mission must be published and guided by school's values. Strategic plan, governance, and conflict-of-interest policies.	• All LCME items ✓ **+** Social Accountability: Mission must identify specific, regional "priority health concerns," embed them in admissions & curriculum, and measure outcomes.	CACMS explicitly mandates "priority health concerns" and measurable outcomes; LCME remains broader (no outcome-measurement language).
2 – Leadership and Administration	Dean with authority, qualified leadership team, proper governance.	• All LCME items ✓ • Minor wording shifts to align with Canadian university governance (e.g., provincial boards).	Substantially identical; differences are mostly in terminology (e.g., "Provincial Ministry of Health" vs. "State Department of Education").
3 – Academic & Learning Environments	Non-discrimination policies, free of bias, equitable access to resources.	• All LCME items ✓ **+** Diversity Programs & Partnerships: Must show proactive recruitment/retention for mission-appropriate diversity among students, faculty, leadership, and community partners.	CACMS shifts from passive non-discrimination to active DEI programming with measurable goals; LCME stops at "policies against bias."
4 – Faculty Preparation, Productivity, Participation, and Policies	Sufficient, qualified faculty; professional development; scholarly productivity; faculty involvement in governance.	• All LCME items ✓ • Minor adjustments referencing Canadian appointment/tenure structures.	Content aligns almost exactly; CACMS tweaks terminology to reflect Canadian faculty-union contexts.
5 – Educational Resources & Infrastructure	Adequate library, IT, clinical sites, teaching space; public disclosure of accreditation status; notify LCME of major changes (campus, enrollments).	• All LCME items ✓ **+** Prescriptive Notification Requirements: Must notify CACMS within 60 days if starting satellite campuses, changing governance, altering curriculum, or shifting enrolment substantially.	CACMS's "notify within 60 days" is more stringent/prescriptive than LCME's general "advance notice" clause.
6 – Competencies, Curricular Objectives & Design	Publish measurable competencies; ensure clinical experiences in inpatient/outpatient.	• All LCME items ✓ **+** "Context of Clinical Learning": Must guarantee clinical exposure in urban, rural/remote, and underserved settings (CACMS Element 6.4.1).	LCME demands breadth of clinical settings but doesn't explicitly call out rural/underserved; CACMS demands explicit rural/underserved placements.

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7 – Curricular Content	Foundations in behavioral & social sciences, ethics, patient safety, cultural competence (broad).	• All LCME items ✓ **+** Social Determinants of Health spelled out as its own element (7.5).• + Indigenous Health (Cultural Competence) as a standalone element (7.6).• + Professional & Leadership Development (7.10) requiring a dedicated leadership-skills thread.	CACMS breaks out "social determinants" and "Indigenous health" separately; LCME treats cultural competence more generally. CACMS also adds a required leadership-development strand.
8 – Curricular Management, Evaluation & Enhancement	Curriculum committee, program objectives, continuous evaluation, student feedback, comparability across sites.	• All LCME items ✓ • Minor phrasing differences on reporting frequency, but overall alignment.	Nearly identical—CACMS may specify slightly different review timelines (e.g., biannual vs. annual), but no substantive new requirement.
9 – Teaching, Supervision, Assessment & Student/Patient Safety	• Faculty supervision, fair assessment system, general patient-safety policies.	• All LCME items ✓ **+** Student Health & Patient Safety (9.10): Requires a formal "fitness for duty" policy, procedures for identifying health concerns (mental or physical), and ensuring no impaired learner is placed in a clinical setting.	LCME embeds student health under general standards; CACMS creates a standalone element demanding documented "fitness to learn" protocols.
10 – Medical Student Selection, Assignment & Progress	• Holistic admissions, broad undergrad prep, academic/nonacademic attributes; no mandated "entering competencies" framework.	• All LCME items ✓ **+** Core Competencies for Entering Students (10.5): Must publish and use a defined competency framework (e.g., interpersonal, thinking, sciences) that guides admissions.	CACMS requires a published pre-matriculation competency framework; LCME does not mandate formal "entering competencies."
11 – Student Academic Support, Career Advising & Records	• Academic support services, career advising, transparent records, MSPE timed to ERAS schedule (August/September).	• All LCME items ✓ **+** Privacy & Confidentiality (11.5–11.6): Must comply with Canadian federal/provincial privacy laws (e.g., PIPEDA). **+** MSPE Timing (11.4): Must align MSPE release with CaRMS timeline (January–February).	MSPE release schedule flips: LCME → ERAS; CACMS → CaRMS. + CACMS explicitly demands Canadian privacy-law compliance.
12 – Student Health Services, Counsel & Financial Aid	• Accessible health & counseling services, financial aid transparency, malpractice/disability insurance.	• All LCME items ✓ **+** Terminology switched to Canadian context (provincial health coverage, Canada-based insurance carriers, Student Assistance Programs).	Content is effectively the same; differences are strictly in U.S. vs. Canada naming/legislation references.