REPORT OF THE COUNCIL ON MEDICAL EDUCATION

The following report was presented by Jeffrey P. Gold, MD, Chair:

1. UPDATE ON EXPANDING ACCESS TO CLINICAL TRAINING SITES FOR MEDICAL STUDENTS

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED
See Policies H-255.988, D-295.320 and D-295.931

Policy D-295.320 (6), "Factors Affecting the Availability of Clinical Training Sites for Medical Student Education," asked that our American Medical Association (AMA) study the issue of limiting international medical student clerkship rotations to a maximum of 12 weeks, with a report back to the House of Delegates.

During the AMA 2012 Interim meeting of the House of Delegates, testimony related to this policy supported the concept of limiting international medical student clerkship rotations at a given site to a maximum of 12 weeks. However, this concept was referred for further study because it was not germane to the intent of the original Resolution 903-I-12 (introduced by the Medical Student Section) from which the policy was derived.

BACKGROUND

Clinical clerkships are required by Liaison Committee on Medical Education (LCME)- and American Osteopathic Association (AOA)-accredited programs, and are conducted, at least in part, within teaching hospitals with which the medical school has an affiliation or formal agreement for instruction of its students. The clinical phase of education traditionally occupies approximately 47 weeks of instruction in year three and 35 weeks in year four in LCME-accredited medical schools.[1]

Concerns have been raised about the availability of clinical clerkship training sites due to recent increases in the enrollment of US allopathic and osteopathic medical schools and in the absolute numbers of US medical schools, competition for placement sites from other health professions programs as well as the growth in the enrollments and number of international medical schools. LCME accreditation standards require that there be a sufficient patient base for medical students to achieve the core objectives of the medical education program (LCME Standard ER-6).[2] The Commission on Osteopathic College Accreditation (COCA) standards require adequacy of clerkship sites before new colleges can begin and before expansion of class size is approved.[3]

The growing number of medical students from offshore Caribbean schools also requires access to clinical clerkships. The number of US citizen-international medical graduates (US-IMGs) increased 44 percent between 2008 and 2012. Caribbean medical schools train the largest numbers of US-IMGs who eventually become certified by the Educational Commission for Foreign Medical Graduates (ECFMG). In 2011, 2,631 Standard ECFMG Certificates were issued to US citizens.[4]

Caribbean medical schools typically do not own teaching hospitals. It is common for these students to complete their required clinical clerkships in another country, and the level of supervision and instruction provided to the medical student can vary widely.[1] This group of IMGs tends to complete their required clinical clerkships in the US. One example, the American University of the Caribbean School of Medicine, has a total of 23 hospital affiliations in nine states (California, Connecticut, Florida, Illinois, Louisiana, Maryland, Michigan, New York, and Ohio). However, the access of international medical students to clinical clerkships in the US may be limited by state law and regulation.

As noted in two previous Council on Medical Education reports to the House of Delegates on this topic (Council on Medical Education Reports 4-I-09 and 2-I-08), it has become difficult for US medical schools to recruit and retain faculty as well as find a sufficient number of hospitals to serve as clerkship sites. In addition to the increasing number of learners, anecdotal evidence indicates that there also may be an increased need for medical schools to compensate clinical training sites in order to gain access for their students.

STANDARDS OF THE LIAISON COMMITTEE ON MEDICAL EDUCATION

US medical schools accredited by the LCME must demonstrate that they have adequate resources (faculty, patients, and teaching space for the medical school's own students) to support the clinical educational program and that the availability of these resources should not be compromised by the presence of other learners.

LCME Standard MS-12. Institutional resources to accommodate the requirements of any visiting…students must not significantly diminish the resources available to already enrolled medical students.[2]

In order to ensure that the appropriate faculty attention is available for students in an LCME-accredited program, the LCME expects that students visiting for clinical clerkships have comparable academic credentials.

LCME Standard MS-17. A medical education program must ensure that any medical students visiting for clinical clerkship rotations and electives demonstrate qualifications comparable to those of the medical students he or she would join in those experiences.[2]

These accreditation standards allow LCME-accredited medical schools to ensure that the resources available for students taking clinical clerkships at affiliated hospital sites are not diluted nor are there other students who would compete for faculty attention. However, the LCME standards do not apply if an affiliated clinical teaching hospital ends the relationship with a US medical school in order to partner with an offshore medical school or another type of teaching institution (e.g., a school of nursing).

STATE REGULATIONS

Nine states evaluate the physician's clinical clerkships in connection with an application for licensure.[5] In most states, clerkships for US medical students must take place in hospitals affiliated with medical schools accredited by the LCME or that have residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). A number of states have special rules that apply to students of non-LCME-accredited medical schools in the Caribbean.

New York

In 1981, the New York State Board of Regents approved regulations governing the circumstances under which students enrolled in unaccredited/unregistered medical schools might engage in clinical clerkships totaling more than 12 weeks.[6] In sum, only students from international medical schools approved by the New York State Education Department (www.op.nysed.gov/prof/med/medforms.htm) are eligible to complete clinical clerkships totaling more than 12 weeks in teaching hospitals in the state. In addition, students wishing to participate in such clerkships must pass the United States Medical Licensing Examination (USMLE) Step 1, and the clerkship may only occur in a teaching hospital with which the medical school has an approved affiliation agreement.[6] The approval process for international medical schools, handled by the State Department of Education, is based on an assessment of educational quality similar to an accreditation review. Students from unapproved medical schools may spend up to 12 weeks in New York teaching hospitals. The New York State Department of Education, Office of the Professions, details clerkship eligibility in section 60.2 of its report entitled "Regulations of the Commissioner" (www.op.nysed.gov/prof/med/part60.htm).

Texas

In April 2013, the Texas legislature passed SB 215 to, in part, address growing concerns that affiliation agreements between foreign medical schools and Texas hospitals and other health care facilities would limit Texas medical students' options for clinical training. In Texas, SECTION 47. Section 61.306, Education Code, was amended by adding Subsection (c) to read as follows:

> (c) The board may not issue a certificate of authority for a private postsecondary institution to grant a professional degree or to represent that credits earned in this state are applicable toward a degree if the institution is chartered in a foreign country or has its principal office or primary educational program in a foreign country. In this subsection, "professional degree" includes a Doctor of Medicine (M.D.), Doctor of

Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Veterinary Medicine (D.V.M.), Juris Doctor (J.D.), and Bachelor of Laws (LL.B.) (www.legis.state.tx.us/tlodocs/83R/billtext/html/SB00301S.HTM).

AMA POLICY

Policies H-255.988, "Foreign Medical Graduates," D-295.931, "Update on the Availability of Clinical Training Sites for Medical Student Education," and D-295.320, "Factors Affecting the Availability of Clinical Training Sites for Medical Student Education," (Appendix) are relevant to this discussion.

Policy H-255.988 supports the concept that the core curriculum of a foreign medical school should be provided by that school and that US hospitals should not provide substitute core clinical experience for students attending a foreign medical school. The policy also states that the AMA does support US teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of US core clinical clerkships.

Policy D-295.931 directs the AMA to work with appropriate stakeholders to (a) study options to require that students from international medical schools who desire to take clerkships in US hospitals come from medical schools that are approved by an independent or private organization, such as the LCME, using principles consistent with those used to accredit US medical schools; (b) advocate for regulations that will assure that international students taking clinical clerkships in US medical schools come from approved medical schools that assure educational quality that promotes patient safety; and (c) advocate that any institution that accepts students for clinical placements be required to assure that all such students are trained in programs that meet requirements for curriculum, clinical experiences and attending supervision as expected for LCME and AOA accredited programs.

Policy D-295.931 also directs the AMA to oppose any arrangements of US medical schools or their affiliated hospitals that allow the presence of visiting students to disadvantage their own students educationally or financially. Policy D-295.320 directs the AMA to advocate for federal and state legislation or regulations to oppose any extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities of US LCME/COCA students in clinical rotations.

Policy D-295.320 also directs the AMA to encourage medical schools and the rest of the medical community with states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students.

LIMITATIONS ON AMA ACTIONS

The types of actions that our AMA can take are limited by antitrust considerations. That is, the AMA as a private entity cannot act in concert with others to limit competition by attempting to deny or restrict access of international medical schools to US teaching hospitals. The AMA can, however, advocate to governmental entities for such limitations in support of specific actions to assure the ongoing quality of the US medical education system.

DISCUSSION

The availability of clinical teaching sites and faculty to support the education of US medical students is a matter of ongoing and serious concern. Medical schools in some regions of the country already are experiencing difficulties gaining access to appropriate clinical teaching sites. Unfortunately, since there are little national data, it is uncertain how extensive the problem is or will become. Data compiled from the 2012 LCME Annual Medical Questionnaire showed that in the past 2-3 years, 52 percent of medical schools have found it more difficult to find inpatient clinical placements for students in core clinical clerkships, and 18 percent attributed the increased difficulty to "competition for placement sites from offshore international medical schools."

The educational experience of US medical students could be compromised by their having to compete for faculty attention and access to patients with visiting students. Furthermore, to gain access, some for-profit offshore medical schools pay hospitals in the United States for their students' clinical training. For example, St. George's University School of Medicine, signed an exclusive 10-year contract in 2008 with the New York City Health and Hospitals Corporation to pay the medical schools $400-$425 per student per week.[7] Many of the teaching hospitals that are

accepting the payments from offshore schools are financially distressed and need the money to cover operating costs. This revenue is likely to become more critical as federal and state funding to hospitals is cut as part of the deficit reduction efforts.

In theory, US medical schools could provide similar financial incentives to gain access to clinical sites or faculty. However, the cost would most likely have to be passed on to students the way such costs are covered for students who are attending international medical schools. In New York, there is growing concern that to provide medical students with clerkship opportunities, medical schools must match payments from international medical schools.[8] This could very well result in raised tuition, and ultimately increase US medical student debt.

The quality of education provided to graduates of offshore medical schools has also raised some concern. US medical school accreditation standards require both a broad and significant portfolio of undergraduate experiences and a rigorous and specifically defined standard of preclinical education in the earlier stages of medical school before US medical students are allowed to participate in their clerkships. In addition, LCME accreditation standards require that medical schools specify the clinical conditions that students must encounter and the procedures that students must complete. However, many for-profit offshore medical schools do not provide standardized or equivalent systems of preparation and evaluation. Van Zanten and Boulet studied the performance of physicians who attended medical schools in the Caribbean and found considerable variation in quality indicators and first-attempt pass rates on the USMLE.[9, 10] On the other hand, in a more recent study, Norcini, et al., found that the rigorous clinical training in ACGME-accredited residencies and the US medical licensing process result in no differences in clinical outcomes between foreign-trained and US graduates following graduate medical education.[11]

It is important to recognize that IMGs provide much needed patient care since many of them enter primary care specialties and serve in underserved and shortage areas, including both inner city and rural areas.[12] Without these international graduates, thousands of patients would be lacking access to a physician in their communities. International graduates play a critical role in caring for the country's neediest patients. Furthermore, the demand for physician services will increase as approximately 30 million Americans will need more health care services with the implementation of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). Both IMGs and US medical graduates are needed to address the looming physician shortage, and all physicians need adequate clinical training as preparation. Nevertheless, the increasing enrollment of US allopathic and osteopathic medical students is putting pressure on the system. It is critical that the AMA continue to encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students.

RECOMMENDATIONS

The Council on Medical Education recommends that the following statements be adopted and that the remainder of the report be filed.

1. That our American Medical Association reaffirm Policy H-255.988, "Foreign Medical Graduates," which supports the concept that the core curriculum of a foreign medical school should be provided by that school and that US hospitals should not provide substitute core clinical experience for students attending a foreign medical school, and which states that the AMA does support US teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of US core clinical clerkships.

2. That our AMA reaffirm Policy D-295.931 (1), "Update on the Availability of Clinical Training Sites for Medical Student Education," which directs the AMA to work with appropriate stakeholders to (a) study options to require that students from international medical schools who desire to take clerkships in US hospitals come from medical schools that are approved by an independent or private organization, such as the Liaison Committee on Medical Education (LCME), using principles consistent with those used to accredit US medical schools; (b) advocate for regulations that will assure that international students taking clinical clerkships in US medical schools come from approved medical schools that assure educational quality that promotes patient safety; and (c) advocate that any institution that accepts students for clinical placements be required to assure that all such students are trained in programs that meet requirements for curriculum, clinical experiences and attending supervision as expected for LCME and American Osteopathic Association accredited programs.

3. That our AMA reaffirm Policies D-295.931 (4), "Update on the Availability of Clinical Training Sites for Medical Student Education," and D-295.320 (4), "Factors Affecting the Availability of Clinical Training Sites for Medical Student Education," which direct the AMA to oppose any arrangements of US medical schools or their affiliated hospitals that allow the presence of visiting students to disadvantage their own students educationally or financially, and to advocate for federal and state legislation or regulations to oppose any extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities of US LCME/Commission on Osteopathic College Accreditation (COCA) students in clinical rotations.

4. That our AMA reaffirm Policy D-295.320 (2), "Factors Affecting the Availability of Clinical Training Sites for Medical Student Education," which directs the AMA to encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students.

5. That our AMA Rescind Policy D-295.320 (6), "Factors Affecting the Availability of Clinical Training Sites for Medical Student Education," since that has been accomplished through this report.

APPENDIX - AMA Policies related to CME Report 1-I-13, Expanding Clerkship Site Access to Include US Medical Schools Undergoing Accreditation

H-255.998 Foreign Medical Graduates
Our AMA supports the following principles, based on recommendations of the Ad Hoc Committee on Foreign Medical Graduates (FMGs): Our AMA supports the practice of U.S. teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine. (CME Rep. F, A-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)

D-295.931 Update on the Availability of Clinical Training Sites for Medical Student Education
1. Our AMA will work with appropriate collaborators to study how to build additional institutional and faculty capacity in the US for delivering clinical education. 2. Our AMA, in collaboration with interested stakeholders, will: (a) study options to require that students from international medical schools who desire to take clerkships in US hospitals come from medical schools that are approved by an independent public or private organization, such as the Liaison Committee on Medical Education, using principles consistent with those used to accredit US medical schools; (b) advocate for regulations that will assure that international students taking clinical clerkships in US medical schools come from approved medical schools that assure educational quality that promotes patient safety; and (c) advocate that any institution that accepts students for clinical placements be required to assure that all such students are trained in programs that meet requirements for curriculum, clinical experiences and attending supervision as expected for Liaison Committee on Medical Education and American Osteopathic Association accredited programs. 3. Our AMA will study whether the "public service community benefit" commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level. 4. Our AMA opposes any arrangements of US medical schools or their affiliated hospitals that allow the presence of visiting students to disadvantage their own students educationally or financially. (CME Rep. 2, I-08; Modified: CME Rep. 4, I-09)

D-295.320 Factors Affecting the Availability of Clinical Training Sites for Medical Student Education
1. Our AMA will work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medical Education to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for medical school expansion. 2. Our AMA will encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students. 3. Our AMA will support the expansion of medical education programs only when educational program quality, including access to appropriate clinical teaching resources, can be assured. 4. Our AMA will advocate for regulations that would ensure clinical clerkship slots be given first to students of US medical schools that are Liaison Committee on Medical Education- or Commission on Osteopathic College Accreditation-approved, or schools currently given preliminary accreditation status, provisional accreditation status, or equivalent, from either of the above bodies. 5. Our AMA will advocate for federal and state legislation or regulations to oppose any extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities of United States LCME/COCA students in clinical rotations. 6. Our

AMA will study the issue of limiting international medical student clerkship rotations to a maximum of 12 weeks, with a report back to the House of Delegates. (CME Rep. 4, I-09; Appended: Sub. Res. 302, A-12; Modified: Res. 903, I-12)

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