

HOD ACTION: Council on Medical Education Report 2 adopted as amended and the remainder of the report filed.

COUNCIL ON MEDICAL EDUCATION REPORT 2-I-08

Update on the Availability of Clinical Training Sites for Medical Student Education
Reference Committee K

EXECUTIVE SUMMARY

This report: (1) describes the current and anticipated increases in the number of medical students in MD- and DO-granting medical schools, as well as expansion of medical education in the Caribbean region; (2) summarizes recent data about the adequacy of clinical training sites, along with current and potential concerns related to their availability; and (3) describes and evaluates the feasibility of potential strategies to assure adequate clinical teaching sites and faculty for US medical students.

There have been recent increases in the enrollment of US MD- and DO-granting schools, as well as increases in the absolute numbers of schools. In addition, in the Caribbean region, there were 21 medical schools that began instruction in 2000 or later.

In a recent survey, respondents from about two thirds of US MD-granting medical schools reported that it has become more difficult to recruit and retain sufficient community-based volunteer faculty, based on such things as increased enrollment, competition from other medical schools, and the inability to sufficiently compensate volunteer clinical faculty. There are some examples of medical schools having difficulty in finding sufficient hospitals to serve as clerkship sites as well. 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.

The various strategies that were considered to support clinical education for medical students in the context of increased student numbers include: (1) expanding teaching capacity by assigning more students to existing sites, (2) identifying new sites for training, (3) recommending the development or enforcement of regulations in that limit access to students from international medical schools to US teaching hospitals, and (4) increasing compensation to hospitals and community-based faculty.

The report recommends that our AMA: (1) study, in collaboration with other organizations, the current and projected availability of and need for clinical clerkship placements for US medical students; (2) study, in collaboration with other organizations, how to build additional institutional and faculty capacity to deliver clinical education in the US; (3) study options to assure that international medical students who wish to take clerkships in the US come from medical schools that are approved by an independent public or private organization that uses principles that are consistent with those used to accredit US medical schools; (4) 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 (5) 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.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-08

Subject: Update on the Availability of Clinical Training Sites for Medical Student Education

Presented by: Claudette E. Dalton, MD, Chair

Referred to: Reference Committee K
(Lynne M. Kirk, MD, Chair)

1 Recommendation #2 of Council on Medical Education Report 14-A-07, “Current and Future
2 Availability of Resources to Support the Clinical Education of Medical Students,” asked that our
3 American Medical Association continue to monitor the expansion of medical schools and the
4 increase in the number of medical students taking their clinical education in the US
5 (Policy D-295.944[2], AMA Policy Database).
6

7 Recommendation #2 of Council on Medical Education Report 6-A-07, “Recommendations on
8 Equal Fees for Osteopathic and Allopathic Medical Students,” asked that our AMA continue to
9 monitor...the adequacy of clinical resources and placements for allopathic and osteopathic
10 medical students (Policy H-295.876[2]).
11

12 Both reports specified that there was to be a report back to the House of Delegates.
13

14 Resolution 324 (A-08), “Competition for Clinical Training Sites,” which was submitted by the
15 Section on Medical Schools and adopted by the House of Delegates, asked that our AMA:
16 conduct an analysis of the adequacy of clinical training sites to accommodate the increasing
17 number of medical students in the US accredited medical schools and study the impact of
18 growing pressure, including political and financial, to accommodate clinical training in US
19 hospitals for US citizen international medical students (Policy D-295.937).
20

21 Medical school expansion in the US and elsewhere requires ongoing monitoring, since there are
22 many current uncertainties. This report will: (1) describe recent and anticipated increases in the
23 number of medical students in US MD- and DO-granting medical schools, as well as expansion
24 of medical education in the Caribbean region; (2) summarize recent data about the adequacy of
25 clinical training sites, along with current and potential concerns related to availability; and
26 (3) describe and evaluate the feasibility of potential strategies to assure adequate clinical teaching
27 sites and faculty for US medical students.
28

29 MEDICAL SCHOOL EXPANSION 30

31 This section summarizes current and projected increases in enrollment in MD- and DO-granting
32 medical schools. Data on enrollment in Caribbean medical schools are not available, so the
33 section tracks numbers of medical schools in that region. Caribbean medical schools were
34 selected for this analysis because they train the largest numbers of US citizen-international
35 medical graduates (IMGs) who eventually become certified by the Educational Commission for
36 Foreign Medical Graduates.¹⁻² This group of IMGs tends to complete their required clinical
37 clerkships in the US.³

US MD-Granting Schools

Concerns about an impending physician shortage have resulted in recommendations to increase medical school enrollment. For example, in 2006 the Association of American Medical Colleges (AAMC) issued a "Statement on the Physician Workforce" that recommended that there should, over the next decade, be a 30% increase in medical school enrollment over the 2002 level.⁴ Medical schools have, to date, responded variably to the calls for class size expansion. Data from Liaison Committee on Medical Education (LCME) Annual Medical School Questionnaires for the 2005-2006 and 2007-2008 academic years showed that significant class size increases (of more than 10 students in the entering class) occurred in about one-third of schools (see Table 1).

 Table 1 - Changes in Entering Class Size (2005 to 2007 Entering Classes)

Enrollment Change (Number of New First-Year Students)	Number of Schools
Increase of 6-10 students	12
Increase of greater than 10 students	40
Increase of 5 or less students or decrease	73

Between 2005 and 2007, the number of LCME-accredited medical schools increased from 125 to 126 and the number of entering first-year students increased from 17,039 to 17,851. In February 2008, the LCME granted preliminary accreditation to 3 developing medical schools, bringing the total number of LCME-accredited schools to 129. These 3 schools plan to admit their first classes in 2009. An additional 6 medical schools have formally applied for LCME accreditation. Data from a 2007 AAMC survey on potential enrollment increases project that there will be about 19,900 new students in the 2012 entering class.⁵ The increase will be due to both increased enrollment in existing schools and the formation of new schools.

US DO-Granting Schools

Between 2005 and 2007, the number of accredited DO-granting schools increased from 20 to 25 and the number of first-year students (including those repeating the year) in schools with enrolled students increased from 3908 to 4408. Of the 25 total, 2 schools will be admitting students for the first time in 2008. About one-half the schools intend to increase enrollment over the next several years. A 2007 survey of DO-granting schools projected a first-year enrollment of 5227 in 2012.⁶

International Medical Schools in the Caribbean Region

As noted previously, medical schools in the Caribbean region are a major site for US citizens to obtain their medical education. Of the 39 medical schools in the region listed in the directory of the Foundation for Advancement of International Medical Education and Research (FAIMER) that deliver the curriculum in English, 10 began instruction before 1990, 8 between 1990 and 2000, and 21 after 2000.³

1 In summary, the number of medical schools and students in the US medical schools has been
2 rising and additional significant increases are anticipated. In addition, the number of international
3 medical schools that will likely send students to the US for clerkships also has increased in recent
4 years.

5 6 ADEQUACY OF RESOURCES TO SUPPORT CLINICAL TRAINING 7

8 Clinical training for medical students requires access to appropriate inpatient and ambulatory
9 teaching sites and adequate numbers of physicians to serve as teacher and supervisors. Concerns
10 have been raised by the leadership of MD- and DO-granting schools about the current and future
11 adequacy of these resources as medical education expands.⁵⁻⁶ While data are incomplete there are
12 indications that current problems exist and that these problems will be exacerbated as student
13 numbers continue to rise.

14 15 Current Areas of Concern 16

17 Current data about adequacy of clinical resources are incomplete and only touch on some aspects
18 of the issue. For example, the LCME Annual Medical School Questionnaire for 2007-2008 asked
19 whether it has been more difficult to recruit and retain community-based volunteer faculty in
20 recent years. A total of 81 schools (almost two-thirds of LCME-accredited medical schools)
21 indicated the difficulty had increased for the following reasons (schools could select more than
22 one reason):
23

- 24 • increased enrollment in the respondent's medical school (37 schools);
- 25 • expansion in enrollment in other (MD, DO, international) medical education programs
26 (37 schools);
- 27 • the creation of new MD or DO medical education programs in the region(15 schools;
- 28 • the inability to compensate or sufficiently compensate volunteer clinical faculty
29 (64 schools); and
- 30 • other reasons, such as clinical productivity pressures decreasing availability of volunteer
31 faculty (23 schools).
32

33 The reasons relate to increased need for volunteer faculty or to deficits in the ability to
34 compensate or otherwise reward volunteer faculty for their participation. Compensation of
35 volunteer faculty is an important issue for US schools, as international medical schools
36 compensate preceptors and training sites.⁶
37

38 In addition to compensating faculty, there may be an increased need to compensate training sites.
39 Recent news reports describe new contracts between international medical schools and private
40 and public hospitals in the New York City region. Information from the Associated Medical
41 Schools of New York indicates that some new or expanded MD- and DO-granting medical
42 schools have been unable to find clerkship sites for their students or are being displaced from
43 existing clinical partners due to compensation arrangements that have been created between the
44 clinical sites and international medical schools.⁷
45

46 Effects of Future Expansion 47

48 The situation is likely to be exacerbated if the number of medical students continues to increase.
49 A recent survey of internal medicine clerkship directors indicated that new inpatient and
50 outpatient (community-based) sites would be needed to support class size increases of 15% or

1 30% in existing schools. Concern was expressed by some respondents that this would lead to a
2 decrease in clerkship quality, as there would be insufficient availability of excellent teachers and
3 sites, as well as appropriate patients, to handle the increased student numbers.⁸
4

5 Potential Impact on Clinical Education
6

7 Availability of sites for clinical training for US medical students is being, and may in the future
8 increasingly be, affected by several circumstances: (1) increases in enrollment at existing US
9 medical schools; (2) creation of new medical schools; and (3) competition for training sites from
10 offshore medical schools. In addition to the basic costs related to expansion (such as additional
11 faculty, facilities upgrades), the competitive environment may result in a growing need to
12 compensate clinical faculty and training sites for their teaching efforts.
13

14 **POTENTIAL STRATEGIES**
15

16 There are a number of strategies that US medical schools could potentially consider to support the
17 maintenance of a quality clinical education program. Not all of these options are relevant to all
18 circumstances and all are not necessarily independent. Each, however, will be described and
19 analyzed for impact and feasibility.
20

21 Expand Teaching Capacity at Existing Training Sites
22

23 One option is to increase the number of students assigned to existing clinical teaching sites. This
24 could mean, for example, assigning more students to an inpatient team or adding new teams. In
25 order to maintain the quality of medical education, this option requires that a facility have an
26 adequate patient base, appropriate space, and sufficient faculty. For teaching in the community-
27 based ambulatory setting, additional preceptors will be required.
28

29 There are limited data on the adequacy of resources to support class size expansion within
30 medical schools' existing clinical partnerships. The results of the study of clerkship directors in
31 internal medicine⁸ indicated that, in many schools, not all students could be accommodated at
32 existing teaching sites and that additional teaching sites would be needed. The directors also did
33 not believe that additional resources to support expansion would be forthcoming.
34

35 Identify New Sites for Training
36

37 To accommodate class size increases, medical schools could identify additional sites for clinical
38 training that are located in the region of the medical school or at a distance.⁹ However, there has
39 not, to date, been a significant increase in clinical sites for most schools. In 2002-2003, the 126
40 LCME-accredited medical schools reported that they were using a total of 896 hospitals as
41 inpatient sites for required clinical clerkships. In 2007-2008, 123 medical schools reported using
42 899 teaching hospitals.^{10*}
43

44 As medical schools are not evenly distributed throughout the US, the teaching sites and faculty in
45 some regions already may be "saturated." For example, there are 9 MD- and DO-granting
46 medical schools in the New York City region, 6 around Chicago, and 5 in Philadelphia. In
47 response to the density of students requiring clinical instruction, some medical schools are having
48

49 -----
50 * If the number of sites used in 2002-2003 by the 3 schools that did not report data in 2007-2008 are included, the total
51 number of hospitals would be 923. These data do not address whether the same hospital is used by more than one
medical school.

1 to expand the geographical radius of teaching sites in their immediate region, for example, by
2 sending students to teaching hospitals and preceptors located at a greater distance from the
3 medical school.

4
5 As one strategy to support expansion, medical schools have formed “branch campuses” or
6 “geographically separate campuses.” The LCME defines a branch campus as a site at a distance
7 from the main campus that offers at least one full year of the medical curriculum. As of 2006, 28
8 MD-granting medical schools had one or more branch campuses that offered the clinical
9 curriculum, or at least the core clinical clerkships.¹¹ Since then, additional medical schools have
10 formed or are in the process of forming clinical branch campuses. In the 2007-2008 LCME
11 Annual Medical School Questionnaire, 17 schools reported that they were planning to start a new
12 branch campus within the next 3 years and 10 schools reported that they planned to expand an
13 existing branch campus to offer more years of the curriculum.¹⁰

14
15 Forming a new clinical branch campus, or expanding an existing campus, has considerable
16 resource implications¹¹ similar to, but not as extensive as, starting a new medical school. Based
17 on location, a new or expanded clinical branch campus may encounter the same difficulties
18 related to competition with other sites as a full medical school. For example, two four-year
19 campuses of osteopathic medical schools have been created in the vicinity of Phoenix, the site for
20 a developing four-year campus of the University of Arizona College of Medicine.

21 22 Develop Regulations that Limit Access to Clinical Teaching Sites

23
24 There are various types of standards and regulations currently in place that act to limit access of
25 students from international medical schools to US teaching hospitals.

26 27 *Standards of the Liaison Committee on Medical Education*

28
29 US medical schools accredited by the LCME must demonstrate that they have adequate resources
30 to support the clinical educational program. LCME accreditation standards explicitly state that
31 visiting students must not dilute available resources.

32
33 Standard MS-12. Institutional resources to accommodate the requirements of any
34 visiting...students must not significantly diminish the resources available to existing
35 enrolled students. (*Functions and Structure of a Medical School*, June 2008 edition)

36
37 In general, this standard is interpreted to mean that there must be adequate faculty, patients, and
38 teaching space for the medical school’s own students.

39
40 In order to assure that appropriate faculty attention is available for students in an LCME-
41 accredited school, the LCME expects that students visiting for clinical clerkships have
42 comparable academic credentials.

43
44 Standard MS-17. Students visiting from other schools for clinical clerkships and
45 electives must possess qualifications equivalent to students they will join in these
46 experiences. (*Functions and Structure of a Medical School*, June 2008 edition)

47
48 These accreditation standards allow LCME-accredited medical schools to assure that the
49 resources available for students taking clinical clerkships at affiliated hospital sites are not
50 diluted. However, strict enforcement of the standard in the case of teaching hospitals where
51 students from LCME-accredited and international medical schools are present could put the

1 medical school's accreditation in jeopardy. Also, the LCME standards do not apply if an
2 affiliated clinical teaching hospital ends the relationship with a US medical school in order to
3 partner with an offshore medical school.

4
5 *State Regulations*

6
7 The access of international medical students to clinical clerkships in the US may be limited by
8 state law and regulation. In New York, only students from approved international medical
9 schools are eligible to complete clinical clerkships totaling more than 12 weeks in teaching
10 hospitals in the state. The approval process for international medical schools, handled by the
11 State Department of Education, is based on an assessment of educational quality similar to an
12 accreditation review. Students from unapproved medical schools may spend up to 12 weeks in
13 New York teaching hospitals.¹²⁻¹³

14
15 Currently, New York is the only state that has such regulations.

16
17 *Other Types of Regulations*

18
19 Many teaching hospitals have a not-for-profit designation that requires them to engage in public
20 service activities that benefit the community. The corporate purpose of these teaching hospitals
21 often refer to providing community benefit to their community or service area. Since US medical
22 schools also are not-for-profit entities, it may be argued that teaching hospitals' public service
23 commitment includes granting priority access for teaching purposes to medical students from
24 schools located in their service area community.

25
26 Increase Compensation to Volunteer Faculty and Affiliated Hospitals

27
28 Access to clinical teaching sites and to community-based preceptors could potentially be
29 enhanced if medical schools provided or increased compensation. However, this may not be easy
30 to accomplish.

31
32 *Compensation to Volunteer Faculty*

33
34 Responses to the 2005-2006 LCME Annual Medical School Questionnaire indicated that 47 of
35 the 125 LCME-accredited medical schools (38%) provided monetary payments to some or all
36 volunteer faculty involved in teaching medical students. The number of schools providing such
37 compensation has been approximately stable for a number of years. As noted previously in this
38 report, about one-half of medical schools in 2007-2008 stated that they were experiencing
39 difficulty in recruiting or retaining community-based volunteer faculty to provide teaching
40 services because of the school's inability to compensate or adequately compensate these faculty.

41
42 *Compensation to Hospitals*

43
44 There are limited data on the amount paid to US hospitals by international medical schools to
45 provide their students with teaching services. In one recent example, a contract between St.
46 George's University of Medicine and the New York Health and Hospitals Corporation, the
47 medical school is paying \$400-425 per student per week. This amounts to considerably more
48 than the total payment of about \$250,000 from some New York medical schools.¹⁴ New York
49 medical schools express concern that having to match the payments from international medical
50 schools would require them to raise tuition considerably, thereby increasing US medical student
51 debt.

1 AMA POLICY AND RELATED POLICIES

2
3 AMA policy supports the concept that “the core curriculum of a foreign medical school should be
4 provided by that school and that US hospitals should not provide substitute core clinical
5 experience for students attending a foreign medical school” (AMA Policy Database,
6 Policy H-255.988). In addition, the “AMA strongly objects to the practice of substituting clinical
7 experiences provided by US institutions for core clinical curriculum of foreign medical schools”
8 (Policy H-255.998). The AMA does support “US teaching hospitals and foreign medical
9 educational institutions entering into appropriate relationships directed toward providing clinical
10 educational experiences for advanced medical students who have completed the equivalent of US
11 core clinical clerkships” (Policy H-255.998).

12
13 The Federation of State Medical Boards Special Committee on the Evaluation of Undergraduate
14 Medical Education was formed in 2004 to review US and international accreditation standards
15 and processes and to evaluate the feasibility of establishing criteria that could be used by state
16 medical licensing boards in classifying international medical schools. The 2006 final report of
17 the committee¹¹ recommended that clinical clerkships for students should be conducted in the
18 country where the medical school is located. If clinical education is conducted in another
19 country, there should be a written affiliation agreement between the medical school and the
20 teaching hospital where the clerkship occurs. The hospital should have graduate medical
21 education programs approved by the ACGME or AOA or the clerkship should have comparable
22 standards to those conducted by LCME- or AOA-accredited medical education programs.

23
24 LIMITATIONS ON AMA ACTIONS

25
26 The types of actions that our AMA can take are limited by such things as antitrust considerations.
27 For example, the AMA as a private entity cannot act in concert with others to limit competition
28 by attempting to deny or restrict access of international medical schools to US teaching hospitals.
29 The AMA can, however, advocate to governmental entities for such limitations in support of
30 specific actions to assure the ongoing quality of the US medical education system.

31
32 SUMMARY AND RECOMMENDATIONS

33
34 The ongoing availability of clinical teaching sites and faculty to support the education of US
35 medical students is a matter of serious concern. Medical schools in some regions of the country
36 already are experiencing difficulties gaining access to appropriate clinical teaching sites, and
37 since there are little national data, it is uncertain how extensive the problem is or will become.
38 The educational experience of US medical students could be compromised by their having to
39 compete for faculty attention and access to patients with visiting students. Also, if US medical
40 schools are forced to provide financial incentives to gain access to clinical sites or faculty, the
41 costs likely will be passed on to students.

42
43 Therefore, the Council on Medical Education recommends that the following be adopted and that
44 the remainder of this report be filed.

- 45 1. That our American Medical Association work with organizations such as the Association
46 of American Medical Colleges and the American Association of Colleges of Osteopathic
47 Medicine to study and report the current and projected availability of and need for
48 clinical clerkship placements for US medical students. (Directive to Take Action)

- 1 2. That our AMA work with appropriate collaborators to study how to build additional
2 institutional and faculty capacity in the US for delivering clinical education.
3 (Directive to Take Action)
4
- 5 3. That our AMA, in collaboration with interested stakeholders:
6 (a) study options to require that students from international medical schools who
7 desire to take clerkships in US hospitals come from medical schools that are
8 approved by an independent public or private organization, such as the Liaison
9 Committee on Medical Education, using principles consistent with those used to
10 accredit US medical schools; and
11 (b) advocate for regulations that will assure that international students taking clinical
12 clerkships in US medical schools come from approved medical schools that
13 assure educational quality that promotes patient safety. (Directive to Take
14 Action)
15 (c) advocate that any institution that accepts students for clinical placements be
16 required to assure that all such students are trained in programs that meet
17 requirements for curriculum, clinical experiences and attending supervision as
18 expected for Liaison Committee on Medical Education and American
19 Osteopathic Association accredited programs.
20
- 21 4. That our AMA study whether the “public service community benefit” commitment and
22 corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical
23 obligations for granting priority access for teaching purposes to medical students from
24 medical schools in their service area communities and, if so, advocate for the
25 development of appropriate regulations at the state level. (Directive to Take Action)
26
- 27 5. That our AMA oppose any arrangements of US medical schools or their affiliated
28 hospitals that allow the presence of visiting students to disadvantage their own students
29 educationally or financially. (New HOD Policy)

Fiscal Note: \$2500 for carrying out studies as detailed in the recommendations.

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