

**HOD ACTION: Council on Medical Education Report 1 adopted and the remainder of the report filed.**

REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-17)

Promoting and Reaffirming Domestic Medical School Clerkship Education (Resolution 308-I-16)  
(Reference Committee K)

EXECUTIVE SUMMARY

The catalyst for this report was Resolution 308-I-16, “Promoting and Reaffirming Domestic Medical School Clerkship Education,” from the Medical Student Section, which asked that our American Medical Association (AMA): 1) pursue legislative and/or regulatory avenues that promote the regulation of the financial compensation which medical schools can provide for clerkship positions in order to facilitate fair competition amongst medical schools and prevent unnecessary increases in domestically-trained medical student debt; 2) support the expansion of partnerships of foreign medical schools with hospitals in regions which lack local medical schools in order to maximize the cumulative clerkship experience for all students; and 3) reaffirm policies D-295.320, D-295.931, and D-295.937. Due to the complexity of the issues surrounding this topic, the resolution was referred.

This report considers concerns that have been raised about the availability of clinical clerkship training sites due to continuing increases in the enrollment of U.S. allopathic and osteopathic medical schools and in the absolute numbers of U.S. medical schools—as well as the growing number of foreign medical schools that seek to place their students in clerkships in U.S. institutions. These schools, which cater primarily to U.S. citizen international medical graduates (USIMGs), are generally located in the Caribbean, and are sometimes referred to as “offshore medical schools.” The educational experience of U.S. medical students could be compromised through competition with other learners for faculty attention and access to patients.

This report comprises:

- A review of state efforts to address this issue, in New York and Texas
- A summary of relevant medical school accreditation standards
- An analysis of potential implications for the physician workforce
- Consideration of legal and antitrust issues around this issue
- A review of past Council on Medical Education reports and AMA policy on this topic
- Proposed emendations to current AMA policy to strengthen and streamline the AMA’s position on this important topic

**HOD ACTION: Council on Medical Education Report 1 adopted and the remainder of the report filed.**

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-17

Subject: Promoting and Reaffirming Domestic Medical School Clerkship Education  
(Resolution 308-I-16)

Presented by: Lynne Kirk, MD, Chair

Referred to: Reference Committee K  
(L. Samuel Wann, MD, Chair)

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1 GENESIS AND OUTLINE

2  
3 Resolution 308-I-16, “Promoting and Reaffirming Domestic Medical School Clerkship Education,”  
4 introduced by the Medical Student Section, asked that the American Medical Association (AMA):  
5 1) pursue legislative and/or regulatory avenues that promote the regulation of the financial  
6 compensation which medical schools can provide for clerkship positions in order to facilitate fair  
7 competition among medical schools and prevent unnecessary increases in domestically-trained  
8 medical student debt; 2) support the expansion of partnerships of foreign medical schools with  
9 hospitals in regions which lack local medical schools in order to maximize the cumulative  
10 clerkship experience for all students; and 3) reaffirm policies D-295.320, D-295.931, and D-  
11 295.937.

12  
13 Testimony at Reference Committee C during the 2016 Interim Meeting was unanimous in support  
14 of referral of Resolution 308. This is a complex issue, with numerous factors, ranging from state  
15 law to physician workforce implications. It was felt that a thorough analysis by the Council on  
16 Medical Education was required to ensure an in-depth, nuanced solution to this issue—one that  
17 involves all key stakeholders and places patient care and education needs at the forefront.  
18 Accordingly, Resolution 308-I-16 was referred.

19  
20 This report comprises:

- 21 • A review of state efforts to address this issue, in New York and Texas.
- 22 • A summary of relevant medical school accreditation standards.
- 23 • An analysis of potential implications for the physician workforce.
- 24 • Consideration of legal and antitrust issues around this issue.
- 25 • A review of past Council on Medical Education reports and AMA policy on this topic.

26  
27 BACKGROUND

28  
29 Clinical clerkships are required of medical school programs accredited by the Liaison Committee  
30 on Medical Education (LCME). These clerkships are conducted, at least in part, within teaching  
31 hospitals with which the medical school has an affiliation or formal agreement for instruction of its  
32 students. The clinical phase of education traditionally takes place in years three and four in LCME-  
33 accredited medical schools.

1 Concerns have been raised about the availability of clinical clerkship training sites due to  
 2 continuing increases in the enrollment of U.S. allopathic and osteopathic medical schools and in  
 3 the absolute numbers of U.S. medical schools, as well as competition for placement sites from  
 4 other health professions programs, such as nurse practitioner and physician assistant programs.  
 5 Further, the extensive and ongoing consolidation in the health care industry has led to closure of  
 6 multiple hospital facilities, with concomitant reduction in the number of sites available for clinical  
 7 education. The educational experience of U.S. medical students could be compromised through  
 8 competition with other learners for faculty attention and access to patients.

9  
 10 A final factor (which is most pertinent to this report) is the growing number of foreign medical  
 11 schools that seek to place their students in clerkships in U.S. institutions—in particular, those  
 12 schools that cater primarily to U.S. citizen international medical graduates (USIMGs). Many of  
 13 these institutions are located in the Caribbean, and are sometimes referred to as “offshore medical  
 14 schools.” The eight largest of these institutions (by number of students certified by the Educational  
 15 Commission for Foreign Medical Graduates [ECFMG] in 2013) include:

16		
17	St George’s University School of Medicine (Grenada)	891
18	Ross University School of Medicine (Dominica)	815
19	American University of Antigua College of Medicine (Antigua and Barbuda)	347
20	American University of the Caribbean (Sint Maarten)	281
21	Saba University School of Medicine (Saba)	156
22	Windsor University School of Medicine (Saint Kitts and Nevis)	139
23	Medical University of the Americas (Saint Kitts and Nevis)	135
24	Saint Matthew’s University (Cayman Islands)	129

25  
 26 *(Note: A full list is available in Appendix A, as adapted from Eckhert NL, van Zanten M.*  
 27 *Overview of For-Profit Schools in the Caribbean. 2014. Foundation for Advancement of*  
 28 *International Medical Education and Research.)*

29  
 30 Accreditation/approval of these institutions is the purview of a variety of bodies, each with varying  
 31 standards and requirements for quality of education. These include seeking recognition through the  
 32 Ministry of Education or Ministry of Health of the institution’s home country, or accreditation or  
 33 approval from regional agencies, such as the Caribbean Accreditation Authority for Education in  
 34 Medicine and other Health Professions (CAAM-HP) and the Accreditation Commission on  
 35 Colleges of Medicine, (a nonprofit organization in Ireland that inspects and accredits medical  
 36 schools in countries that do not have a national medical accreditation body). As of 2023, the  
 37 ECFMG will require that physicians applying for ECFMG Certification graduate from a medical  
 38 school that has been “appropriately accredited”—that is, “accredited through a formal process that  
 39 uses criteria comparable to those established for U.S. medical schools by the Liaison Committee on  
 40 Medical Education (LCME) or that uses other globally accepted criteria, such as those put forth by  
 41 the World Federation for Medical Education (WFME).”<sup>1</sup>

42  
 43 Offshore medical schools typically do not own teaching hospitals. It is common for these students  
 44 to complete their required clinical clerkships in another country, and the level of supervision and  
 45 instruction provided to the medical student can vary widely. Medical students attending these  
 46 schools tend to complete their required clinical clerkships in the U.S. Offshore medical schools are  
 47 often willing to provide significant financial remuneration to secure slots for their students’  
 48 clerkship experiences. These funds are often an attractive source of revenue, particularly for urban  
 49 hospitals/institutions in underserved areas.

1 In theory, U.S. medical schools could provide similar financial incentives to gain access to clinical  
2 sites or faculty. However, the cost would most likely be passed on to students in the same way such  
3 costs are covered for students who are attending offshore medical schools. This could result in  
4 raised tuition, and ultimately increase U.S. medical student debt (as noted in Resolve 1 of  
5 Resolution 308-I-16).

6  
7 The buying (and selling) of clerkship slots benefits the offshore medical student seeking a clerkship  
8 as well as the offshore medical school and the stateside institution providing the clerkship. Medical  
9 schools (and medical students) in the United States, however, may be negatively affected. Data  
10 compiled from the 2012-2013 LCME Annual Medical Questionnaire (Part II) showed that, of the  
11 136 medical school programs accredited at that time, 52.2 percent (71) saw increased difficulty in  
12 finding inpatient clinical placements for students in core clerkships. Of these schools, 25 attributed  
13 this increased difficulty in part to “competition for placement sites from offshore international  
14 medical schools” (along with other factors, including increase in class size and other U.S. schools  
15 in the region). Of the 15 states with the highest number of schools reporting such issues, 12 are in  
16 the northeast and mid-Atlantic regions and the upper Midwest.

## 17 18 STATE REGULATIONS

19  
20 Nine states evaluate the physician’s clinical clerkships in connection with an application for  
21 licensure.<sup>2</sup> In most states, clerkships for U.S. medical students must take place in hospitals  
22 affiliated with medical schools accredited by the LCME or with residency programs accredited by  
23 the Accreditation Council for Graduate Medical Education (ACGME). A number of states have  
24 special rules that apply to students of non-LCME-accredited medical schools in the Caribbean.

### 25 26 *New York*

27  
28 Since 1981, the New York State Board of Regents has had in place regulations on the eligibility of  
29 students enrolled in offshore medical schools for clinical clerkships in New York hospitals. In  
30 summary, only students from offshore medical schools that have been approved by the New York  
31 State Education Department are eligible to complete clinical clerkships totaling more than 12  
32 weeks in New York teaching hospitals. In addition, students wishing to participate in such  
33 clerkships must pass the United States Medical Licensing Examination (USMLE) Step 1  
34 examination, and the clerkship may only occur in a teaching hospital with which the offshore  
35 medical school has an approved affiliation agreement. In addition, the teaching hospital must have  
36 a residency program accredited by the ACGME in the clerkship discipline.

37  
38 The approval process for offshore medical schools, handled by the New York State Education  
39 Department, is based on an assessment of educational quality similar to a medical school  
40 accreditation review.<sup>3</sup> Students from medical schools that are unapproved by the department are  
41 limited to no more than 12 weeks’ clerkship experience in New York teaching hospitals.<sup>4</sup>

42  
43 In 2008, New York City Health and Hospitals Corporation signed a 10-year, \$10 million exclusive  
44 contract with a state-approved offshore medical school, through which the school pays \$400 per  
45 student per week for training slots. Several other such schools soon entered into similar agreements  
46 with other New York institutions, and a 2009 report subsequently found that “about half of the  
47 4,000 medical students doing third- and fourth-year rotations in New York State were from  
48 offshore medical schools.”<sup>5</sup> These agreements began to raise concern among U.S.-based educators  
49 as to the availability of clerkships for their own students, as well as concerns that accreditation  
50 standing might be jeopardized if the quality of clerkship experiences was negatively affected due to  
51 the sheer number of students in a given rotation.

1 One challenge in evaluating these concerns is that the literature is silent with respect to the  
 2 appropriate number of medical students in a clerkship or the resources needed to assure that a  
 3 rotation is “adequate,” and indeed, the “adequate” number of students may change based on patient  
 4 population and geographic location. To attempt to better ascertain these data, the Association of  
 5 Medical Schools of New York (AMSNY) fielded a survey of clerkship directors in 2009. A second  
 6 iteration of that survey is scheduled soon. The survey, which included questions on the availability  
 7 of an adequate number of faculty/residents/staff and patients, as well as physical and IT resources,  
 8 concluded that:

- 9
- 10 • LCME and COCA standards control the educational behaviors of accredited schools,  
 11 but have no influence on hospitals seeking to enhance revenue streams through the sale  
 12 of clerkship “slots” to unaccredited bidders.
- 13 • The establishment of quantitative benchmarks may help schools in negotiations with  
 14 their traditional academic affiliates.
- 15 • Legislative action may be needed to assure quality training and patient safety in state-  
 16 or federal-regulated care delivery-sites.
- 17

#### 18 *Texas*

19

20 In April 2013, the Texas legislature passed legislation to address growing concerns that affiliation  
 21 agreements between offshore medical schools and Texas hospitals and other health care facilities  
 22 would limit Texas medical students’ options for clinical training. Through the enacted legislation,  
 23 the following subsection was added to the state’s Education Code:

24

25 (c) The board may not issue a certificate of authority for a private postsecondary institution to  
 26 grant a professional degree or to represent that credits earned in this state are applicable toward  
 27 a degree if the institution is chartered in a foreign country or has its principal office or primary  
 28 educational program in a foreign country. In this subsection, “professional degree” includes a  
 29 Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.),  
 30 Doctor of Veterinary Medicine (D.V.M.), Juris Doctor (J.D.), and Bachelor of Laws (LL.B.)<sup>6</sup>

31

32 The legislation was supported by the Texas Medical Association (TMA) and the state’s medical  
 33 schools, which feared a diminution in the number of clinical clerkships for its medical students, due  
 34 in part to the willingness of offshore medical schools to pay for clerkships for their students. With  
 35 only one exception, Texas medical schools do not pay for clerkships and are in no position  
 36 financially to do so. Had the state legislation not been passed, it would have been expected that  
 37 Texas medical schools would not have been able to afford to compete in paying for clerkships,  
 38 thereby displacing Texas medical students from long-standing clerkships at Texas teaching  
 39 hospitals. As a result, medical schools would likely have been forced to participate in bidding wars  
 40 for clerkship space, and, consequently, pass on this added cost to medical students, resulting in  
 41 increased tuition and likely, increased student debt. Noted one of the co-authors of the Texas  
 42 legislation, “Our Texas medical students should be prioritized, and we must ensure they have  
 43 access to those clinical rotations without doing anything to jeopardize that. They are our  
 44 investment. [The state] invests in medical education, and we have to protect that investment.”<sup>7</sup>  
 45 The TMA’s advocacy on this issue was buttressed by policy adopted in 2013, which resulted from  
 46 a report of the association’s Council on Medical Education (see Appendix B). The policy stated, in  
 47 part, that the TMA “strongly objects to the practice of substituting clinical experiences provided by  
 48 U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, our association  
 49 strongly disapproves of the placement of any medical school undergraduate students in hospitals  
 50 and other medical care delivery facilities that lack sufficient educational resources for the  
 51 supervised teaching of clinical medicine.” In addition, the policy states, “2. Institutions that accept

1 students for clinical placements should ensure that all such students are trained in programs that  
2 meet requirements for curriculum, clinical experiences, and attending supervision as expected for  
3 [LCME- and COCA-accredited] programs.... 3. TMA opposes extraordinary payments by any  
4 medical school for access to clinical rotations. 4. Foreign medical students should not displace  
5 Texas medical students in clinical training positions at Texas health care facilities. Priority should  
6 be given to Texas medical students and other health care professionals for clinical training.”<sup>8</sup>

## 8 RELEVANT LCME STANDARDS

9  
10 A number of LCME standards<sup>9</sup> are relevant to the topic of this report, including:

### 11 *4.1 Sufficiency of Faculty*

12 *A medical school has in place a sufficient cohort of faculty members with the qualifications*  
13 *and time required to deliver the medical curriculum and to meet the other needs and fulfill the*  
14 *other missions of the institution.*

### 15 *5.5 Resources for Clinical Instruction*

16 *A medical school has, or is assured the use of, appropriate resources for the clinical*  
17 *instruction of its medical students in ambulatory and inpatient settings and has adequate*  
18 *numbers and types of patients (e.g., acuity, case mix, age, gender).*

### 19 *5.10 Resources Used by Transfer/Visiting Students*

20 *The resources used by a medical school to accommodate any visiting and transfer medical*  
21 *students in its medical education program do not significantly diminish the resources available*  
22 *to already enrolled medical students.*

### 23 *10.8 Visiting Students*

24 *A medical school does all of the following:*

- 25 • *Verifies the credentials of each visiting medical student*
- 26 • *Ensures that each visiting medical student demonstrates qualifications comparable to*  
27 *those of the medical students he or she would join in educational experiences*
- 28 • *Maintains a complete roster of visiting medical students*
- 29 • *Approves each visiting medical student’s assignments*
- 30 • *Provides a performance assessment for each visiting medical student*
- 31 • *Establishes health-related protocols for such visiting medical students*
- 32 • *Identifies the administrative office that fulfills these responsibilities*

33  
34  
35  
36  
37  
38 LCME requirements also provide guidance as to faculty serving as supervisors for medical students  
39 from more than one institution. For example, a 2014 LCME white paper<sup>10</sup> notes the following, in  
40 part:

41  
42 *4. A given medical school must evaluate the quality of its education across sites, including at*  
43 *the site(s) that serve(s) students from multiple schools, and must ensure and document that*  
44 *comparability exists in the curricular core, including in required clinical encounters.*

45  
46 *5. There must be sufficient patient resources and faculty numbers so that medical students from*  
47 *each medical education program are able to meet their defined objectives and required clinical*  
48 *encounters and have appropriate levels of supervision and assessment.*

1 *The presence of students from another school must not diminish the access to resources needed*  
2 *by students from a given medical school to meet the objectives of the specific course/clerkship,*  
3 *including appropriate patients/procedures and faculty.*

4  
5 *6. If two or more LCME-accredited medical schools share faculty at a given instructional site,*  
6 *there should be coordination between the schools, for example, an agreement that each*  
7 *medical school will have appropriate access to needed resources to support its medical*  
8 *education program.*

9  
10 *Resources include: 1) faculty with sufficient time to teach each cohort of students and to*  
11 *participate in relevant faculty development, 2) patients sufficient to meet the required clinical*  
12 *conditions specified by each medical school, and 3) appropriate facilities for the total numbers*  
13 *of students at the site at any given time.*

#### 14 15 LIMITATIONS ON AMA ACTIONS

16  
17 The types of actions that the AMA can take are limited by antitrust considerations. That is, the  
18 AMA as a private entity cannot act in concert with others to limit competition by attempting to  
19 deny or restrict access of medical students from offshore medical schools to U.S. teaching  
20 hospitals. The AMA can, however, advocate to governmental entities for such limitations as a  
21 means to assure the ongoing quality of the U.S. medical education system. The AMA can also  
22 develop model state legislation that would reflect best practices for financial remuneration of  
23 clerkships.

#### 24 25 PAST COUNCIL ON MEDICAL EDUCATION REPORTS AND RELEVANT AMA POLICY

26  
27 The availability of clerkships for medical students has been the topic of three recent Council on  
28 Medical Education reports:

- 29  
30 1. Report 1-1-13, "Update on Expanding Access to Clinical Training Sites for Medical  
31 Students" (<http://bit.ly/2uvGikn>)  
32 2. Report 4-I-09, "Factors Affecting the Availability of Clinical Training Sites for Medical  
33 Student Education" (<http://bit.ly/2tmi4ds>)  
34 3. Report 2-I-08, "Update on Availability of Clinical Training Sites for Medical Student  
35 Education" (<http://bit.ly/2tmsJ7W>)  
36

37 As a result of these and other reports and resolutions, the AMA has a number of policies on this  
38 topic:

- 39  
40 1. H-255.988 (6, 23, 25), "AMA Principles on International Medical Graduates"  
41 2. H-255.998, "Foreign Medical Graduates"  
42 3. H-295.995 (30, 31), "Recommendations for Future Directions for Medical Education"  
43 4. D-295.320, "Factors Affecting the Availability of Clinical Training Sites for Medical  
44 Student Education"  
45 5. D-295.931, "Update on the Availability of Clinical Training Sites for Medical Student  
46 Education"  
47 6. D-295.937, "Competition for Clinical Training Sites"  
48

49 This report includes recommendations for revisions to consolidate and streamline these policies, as  
50 shown in Appendix C.

## 1 DISCUSSION

2  
3 The issue of adequate availability of clerkships for U.S. medical students can be seen in the context  
4 of larger issues—in particular, the quality and quantity of the future physician workforce. That  
5 workforce comprises both U.S. medical school graduates as well as a significant number of IMGs  
6 (both U.S. citizens and noncitizens). To clarify thinking in this regard, several questions may be  
7 posed. For example, is the quality of education/training for U.S. medical students imperiled by  
8 competition for clerkships by students from offshore medical schools? Also, are USIMGs receiving  
9 an adequate education to prepare them for residency and practice in the U.S.?

10  
11 Recent literature on this topic urges increased scrutiny of offshore medical schools and their  
12 graduates. Eckhart<sup>11</sup> writes, “Just as the Flexner Report strengthened medical education by raising  
13 standards, recommending quality improvements, and suggesting closure of weaker schools, a  
14 present-day review of the schools [in other countries] whose purpose is to train physicians for the  
15 United States could lead to recommendations for improvement and/or accreditation, educational  
16 innovations, or sanctions against poorly performing medical schools.” She argues that the U.S.  
17 must “look beyond our borders to ensure that physicians around the world obtain the best possible  
18 education. To begin this effort close to home—in the Caribbean Basin—makes good sense,  
19 because the growing number of graduates from the [offshore medical schools] there will be part of  
20 the next generation of physicians caring for the U.S. public and practicing alongside U.S.-trained  
21 physicians.”

22  
23 Likewise, note Halperin and Goldberg,<sup>12</sup> “U.S. medical education today faces a threat similar to  
24 that leading up to the Flexner Report, although this time the schools that do not meet the training  
25 standards necessary to ensure public health are outside U.S. borders. A dire emergency is  
26 approaching that could compromise American medical education.” They call for a number of  
27 potential solutions; most pertinent to this report, these include that state higher education boards  
28 “deny students of proprietary offshore schools access to clinical education in U.S. teaching  
29 hospitals unless these schools meet accreditation standards equivalent to those expected of U.S.  
30 medical schools.” In addition, they urge additional legislation at the state level, similar to that  
31 passed in Texas in 2013, described above.

32  
33 Related to the second question posed above, the educational standards of offshore medical schools  
34 are a topic of some concern—particularly as students at these institutions are able to obtain federal  
35 funding. Attrition (and tuition) rates are high, and educational resources often lack in comparison  
36 to those at LCME-accredited medical school programs. Norcini et al. raised concerns about  
37 “striking” gaps in clinical performance among practicing USIMGs versus their non-citizen IMG  
38 and U.S. medical school graduate counterparts, and proposed further research “to clarify whether  
39 [USIMG] performance is a result of their medical education experiences or their ability. To the  
40 degree that it is the former, U.S. citizens will need information about international medical schools  
41 on which to base their application decisions. To the degree that it is the latter, and as additional  
42 training opportunities become available for U.S. citizens, medical schools and residency programs  
43 will need to be more vigilant in their selection procedures and not accept students who lack the  
44 ability to perform as physicians.”<sup>13</sup>

45  
46 As to the resolve clauses of Resolution 308-I-16, the AMA can pursue or support legislative and  
47 regulatory advocacy to promote fair competition amongst medical schools vying for clerkship  
48 positions. Additionally, the AMA can focus on educational quality, to include the appropriate  
49 number of students on a given clerkship at any one time, and address such educational aspects as  
50 curriculum, supervision, and procedural experience (logbooks). The AMA can work with interested



1 state and specialty medical associations to pursue legislation that addresses this issue and helps  
2 ensure a quality experience for all medical students.

3  
4 Related to Resolve 2 of Resolution 308-I-16, fostering partnerships with hospitals that are not  
5 currently used for clinical teaching may benefit both students from offshore schools as well as U.S.  
6 students; this possibility also aligns with AMA policy on addressing geographic disparities in  
7 access to care. In fact, it may be appropriate that clerkship training slots be treated as public  
8 resources to help expand the physician workforce—particularly in underserved areas—versus  
9 being seen as the “property” of academic medical centers and teaching hospitals.

10  
11 Finally, Resolve 3, which asks for reaffirmation of AMA policy, is obviated through the  
12 recommendations below, which incorporate changes to consolidate and streamline existing policy.

### 13 RECOMMENDATIONS

14  
15  
16 The Council on Medical Education recommends that the following recommendations be adopted in  
17 lieu of Resolution 308-I-16, and the remainder of the report be filed.

#### 18 19 1. That our American Medical Association (AMA):

- 20  
21 1) Work with the Association of American Medical Colleges, American Association of  
22 Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local  
23 and state governments and the federal government, as well as private sector  
24 philanthropies, to provide additional funding to support: a) infrastructure and faculty  
25 development and capacity for medical school expansion; and b) delivery of clinical  
26 clerkships and other educational experiences. (Directive to Take Action)  
27
- 28 2) Encourage clinical clerkship sites for medical education (to include medical schools  
29 and teaching hospitals) to collaborate with local, state, and regional partners to create  
30 additional clinical education sites and resources for students. (Directive to Take  
31 Action)  
32
- 33 3) Advocate for federal and state legislation/regulations to:  
34
  - 35 a. Oppose any extraordinary compensation granted to clinical clerkship sites that  
36 would displace or otherwise limit the education/training opportunities for medical  
37 students in clinical rotations enrolled in medical school programs accredited by  
38 the Liaison Committee on Medical Education (LCME) or Commission on  
39 Osteopathic College Accreditation (COCA);  
40
  - 41 b. Ensure that priority for clinical clerkship slots be given first to students of LCME-  
42 or COCA-accredited medical school programs; and  
43
  - 44 c. Require that any institution that accepts students for clinical placements ensure  
45 that all such students are trained in programs that meet requirements for  
46 educational quality, curriculum, clinical experiences and attending supervision  
47 that are equivalent to those of programs accredited by the LCME and COCA.  
48 (Directive to Take Action)  
49
- 50 4) Encourage relevant stakeholders to study whether the “public service community  
51 benefit” commitment and corporate purposes of not for profit, tax exempt hospitals

- 1 impose any legal and/or ethical obligations for granting priority access for teaching  
2 purposes to medical students from medical schools in their service area communities  
3 and, if so, advocate for the development of appropriate regulations at the state level.  
4 (Directive to Take Action)  
5
- 6 5) Work with interested state and specialty medical associations to pursue legislation that  
7 ensures the quality and availability of medical student clerkship positions for U.S.  
8 medical students. (Directive to Take Action)  
9
- 10 2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools  
11 entering into appropriate relationships directed toward providing clinical educational  
12 experiences for advanced medical students who have completed the equivalent of U.S. core  
13 clinical clerkships. Policies governing the accreditation of U.S. medical education  
14 programs specify that core clinical training be provided by the parent medical school;  
15 consequently, the AMA strongly objects to the practice of substituting clinical experiences  
16 provided by U.S. institutions for core clinical curriculum of foreign medical schools.  
17 Moreover, it strongly disapproves of the placement of medical students in teaching  
18 hospitals and other clinical sites that lack appropriate educational resources and experience  
19 for supervised teaching of clinical medicine, especially when the presence of visiting  
20 students would disadvantage the institution's own students educationally and/or financially  
21 and negatively affect the quality of the educational program and/or safety of patients  
22 receiving care at these sites. (New HOD Policy)  
23
- 24 3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen  
25 international medical students between foreign medical schools and teaching hospitals in  
26 regions that are medically underserved and/or that lack medical schools and clinical sites  
27 for training medical students, to maximize the cumulative clerkship experience for all  
28 students and to expose these students to the possibility of medical practice in these areas.  
29 (New HOD Policy)  
30
- 31 4. U.S. citizens should have access to factual information on the requirements for licensure  
32 and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for  
33 entry into graduate medical education programs, and other relevant factors that should be  
34 considered before deciding to undertake the study of medicine in schools not accredited by  
35 the LCME or COCA. (New HOD Policy)  
36
- 37 5. Existing requirements for foreign medical schools seeking Title IV Funding should be  
38 applied to those schools that are currently exempt from these requirements, thus creating  
39 equal standards for all foreign medical schools seeking Title IV Funding. (New HOD  
40 Policy)  
41
- 42 6. That Policies H-255.988 (6, 23, 25), H-255.998, H-295.995 (30, 31), D-295.320, D-  
43 295.931, and D-295.937 be rescinded, as described in Appendix C to this report. (Rescind  
44 HOD Policy)

Fiscal Note: \$1,000 for staff time

APPENDIX A: OFFSHORE MEDICAL SCHOOLS IN 2013, BY NUMBER OF ECFMG-CERTIFIED STUDENTS/GRADUATES

<b>School</b>	<b>Location</b>	<b>Number</b>
St George's University School of Medicine	Grenada	891
Ross University School of Medicine	Dominica	815
American University of Antigua College of Medicine	Antigua and Barbuda	347
American University of the Caribbean	Sint Maarten	281
Saba University School of Medicine	Saba (Special Municipality of the Netherlands)	156
Windsor University School of Medicine	Saint Kitts and Nevis	139
Medical University of the Americas	Saint Kitts and Nevis	135
Saint Matthew's University	Cayman Islands	129
American University of Integrative Sciences	Sint Maarten	86
University of Medicine and Health Sciences	Saint Kitts and Nevis	56
Saint James School of Medicine	Saint Vincent and the Grenadines	49
Xavier University School of Medicine	Aruba	38
Avalon University School of Medicine	Curacao	24
Spartan Health Sciences University	Saint Lucia	23
Trinity School of Medicine	Saint Vincent and the Grenadines	16
Aureus University School of Medicine	Aruba	12
23 additional institutions	varies	Fewer than 10

*Source:* Eckhert NL, van Zanten M. Overview of For-Profit Schools in the Caribbean. 2014. Foundation for Advancement of International Medical Education and Research. Available at: <http://www.faimer.org/research/faimer-short-report-caribbean.pdf>. Accessed July 7, 2017.

APPENDIX B: REPORT 3-A-12 OF THE TEXAS MEDICAL ASSOCIATION COUNCIL ON MEDICAL EDUCATION

Subject: Clinical Training Resources for Texas Medical Students  
Presented by: Cynthia A. Jumper, MD, Chair  
Referred to: Reference Committee on Public Health, Science, and Education

A medical school in the Caribbean is seeking to establish affiliation agreements with Texas hospitals and other health care facilities to provide clinical training for its third- and fourth-year medical students to complete their core clinical clerkships in Texas. Our council has grave concerns about the potential damaging effects of a proposal that has the risk of displacing Texas medical students from the already limited clinical training capacity in our state. Our educational institutions already have commitments to Texas students to provide reasonable access to training opportunities. Diminishing our own students' access to clinical training in the state would negatively affect the quality and affordability of education for Texas medical students, resident physicians, and other health professionals — all who need and deserve priority access to clinical training in the state.

*Economic Impact*

State support for educating medical students, resident physicians, and other health professionals was severely reduced in the 2012-13 state budget. At the same time, in response to increasing physician demand, Texas medical schools plan an increase of 30 percent in enrollments by 2015. This will result in an estimated total of 3,300 third- and fourth-year medical students each year — the highest numbers ever for our state. There is also a strong potential for a new four-year medical school in South Texas. This vigorous growth in enrollments clearly dictates a need for more hospital clinical training space for our own students in the very near future.

Adding foreign medical students simultaneously with the large Texas enrollment growth will only exacerbate the shortage of clinical training space. The limited supply could result in a considerable increase in the cost of clerkships for medical schools, as is occurring in northeastern states, that could force increases in medical school tuition and related student debt as well as the displacement of our own medical students, and threaten the accreditation status of our own schools.

*Benefit to the State*

Recognizing that the state has only limited training capacity and the potential financial impact on Texas medical schools and students, thoughtful consideration must be given to the potential benefit to the state. Texas ranks second in the nation, behind California, in the retention of our medical school graduates in the state, at 59 percent.<sup>i</sup>

In contrast, it is not known how many students enrolled in foreign medical schools would even have an interest in practicing in Texas. Substituting foreign students for Texas medical students would not benefit the state's escalating physician workforce needs. It makes little sense for the state to invest at least \$170,000 per year for each Texas medical student yet not provide for their reasonable access to core clinical clerkships in the state.

Further, as reported by the American Medical Association Medical Student Section in November 2011,

U.S. medical school accreditation standards require both a broad and significant portfolio of undergraduate experiences as well as a rigorous and specifically defined standard of preclinical education in the first two years of medical school before admitted, visiting, or transfer American medical students are allowed to participate in third year clerkships, yet for-profit offshore medical schools do not provide any standardized or equivalent system of evaluation before they participate in third year clerkships in American hospitals.

### *Availability of Clinical Faculty and Student Supervision Rules*

Given the increases in our own medical school enrollment, it is unclear whether there are sufficient numbers of qualified clinical faculty to oversee the training of our own medical students in addition to foreign medical students. The Texas Medical Board has regulations that delineate specific requirements for physicians eligible to supervise medical students.<sup>ii</sup> The board's rules also must be considered to ensure that medical students who complete clerkships in Texas would ultimately be eligible for medical licensure in the state.

### *Policy Proposals*

Our council believes it is in the best interest of the state ... for quality, education, workforce, as well as economic considerations ... to ensure that Texas medical school students are provided first access to core clinical clerkships in the state. The council proposes adoption of the following principles as Texas Medical Association policy, including relevant policies of AMA, with their adaptation for Texas.

1. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the Texas Medical Association strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, our association strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities that lack sufficient educational resources for the supervised teaching of clinical medicine.
2. Institutions that accept students for clinical placements should ensure that all such students are trained in programs that meet requirements for curriculum, clinical experiences, and attending supervision as expected for programs accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation.
3. The Texas Medical Association opposes extraordinary payments by any medical school for access to clinical rotations.
4. Foreign medical students should not displace Texas medical students in clinical training positions at Texas health care facilities. Priority should be given to Texas medical students and other health care professionals for clinical training.

**Recommendation: Approval as TMA policy.**

i. 2011 State Physician Workforce Data Book, Association of American Medical Colleges, 2011.

ii. Texas Medical Board Program Rule, §162.1. Supervision of Medical Students.

(a) In order to supervise a medical student who is enrolled at a Texas medical school as a full-time student or visiting student the physician must have an active and unrestricted Texas license.

(b) In order to supervise a medical student who does not meet the criteria in subsection (a) of this section the physician must:

- (1) have an active and unrestricted Texas license;
- (2) hold a faculty position in the graduate medical education program in the same specialty in which the student will receive undergraduate medical education;
- (3) supervise the student during the educational period; and
- (4) supervise the student's medical education in either a Texas hospital or teaching institution, which sponsors or participates in a program of graduate medical education accredited by the Accrediting Council for Graduate Medical Education, the American Osteopathic Association, or the Texas Medical Board in the same subject as the medical or osteopathic medical education in which the hospital or teaching institution has an agreement with the applicant's school.

(c) If the physician is not licensed in Texas as required in subsection (a) or (b) of this section, the physician must be employed by the federal government and maintain an active and unrestricted license.

(d) Physician applicants who receive medical education in the United States in settings that do not comply with statutory requirements set forth in Texas Occupations Code §155.003(b) - (c) may be ineligible for licensure.

APPENDIX C: RECOMMENDED ACTIONS ON HOUSE OF DELEGATES' POLICIES  
RELATED TO CLERKSHIPS

**H-255.988, "AMA Principles on International Medical Graduates"**

*Delete 6, 23, and 25, for incorporation into the proposed new policy. These three items are more relevant to the topic of availability of clinical clerkships than to principles on international medical graduates.*

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. The core clinical curriculum of a foreign medical school should be provided by that school; U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school.
7. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
8. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
9. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
10. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
11. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
12. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
13. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
14. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
15. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state,

county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

16. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

17. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

18. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

19. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

20. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

21. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

22. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

23. Providing U.S. students who are considering attendance at an international medical school with information enabling them to assess the difficulties and consequences associated with matriculation in a foreign medical school.

24. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

25. Our AMA supports the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.

(BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17)



### **H-255.998, “Foreign Medical Graduates”**

*Rescind and incorporate into the proposed new policy.*

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)

### **H-295.995, “Recommendations for Future Directions for Medical Education”**

*Delete 30 and 31, for insertion into the proposed new policy.*

Our AMA supports the following recommendations relating to the future directions for medical education:

- (1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
- (2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
- (3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.
- (4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.
- (5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
- (6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
- (7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
- (8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
- (9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one

of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.

(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.

(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.

(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.

(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.

(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.

(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.

(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.

(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be

assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.

(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.

(25) Specialty boards should consider having members of the public participate in appropriate board activities.

(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.

(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.

(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.

(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.

(30) U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry into graduate medical education programs, and other factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME.

(31) 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.

(32) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.

(33) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.

(34) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.

(35) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.

(36) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.

(37) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.

(CME Rep. B, A-82 Amended: CLRPD Rep. A, I-92 Res. 331, I-95 Reaffirmed by Res. 322, A-97 Reaffirmation I-03 Modified: CME Rep. 7, A-05 Modified: CME Rep. 2, I-05 Appended: CME Rep. 5, A-11 Reaffirmed: CME Rep. 3, A-11)

#### **D-295.320, "Factors Affecting the Availability of Clinical Training Sites for Medical Student Education"**

*Rescind and incorporate into the proposed new policy.*

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.

(CME Rep. 4, I-09 Appended: Sub. Res. 302, A-12 Modified: Res. 903, I-12 Modified: CME Rep. 1, I-13)

**D-295.931, “Update on the Availability of Clinical Training Sites for Medical Student Education”**

*Rescind and incorporate into new proposed policy.*

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 Reaffirmed: CME Rep. 1, I-13)

**D-295.937, “Competition for Clinical Training Sites”**

*Rescind; this analysis was completed through Council on Medical Education Report 2-I-08, “Update on Availability of Clinical Training Sites for Medical Student Education.”*

Our AMA will, through the Council of Medical Education, conduct an analysis of the adequacy of clinical training sites to accommodate the increasing number of medical students in the US accredited medical schools and study the impact of growing pressure, including political and financial, to accommodate clinical training in US hospitals for US citizen international medical students.

(Res. 324, A-08)

APPENDIX D: SUMMARY OF PROPOSED POLICY CHANGES

<p>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. D-295.320 (1)</p> <p>Our AMA will work with appropriate collaborators to study how to build additional institutional and faculty capacity in the US for delivering clinical education. D-295.931 (1)</p>	<p>Our American Medical Association (AMA) will:</p> <p>1. Work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders 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 and capacity for medical school expansion and delivery of clinical education. (Directive to Take Action)</p>
<p>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. D-295.320 (2)</p>	<p>2. Encourage clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students. (Directive to Take Action)</p>
<p>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. D-295.320 (5)</p> <p>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. D-295.320 (4)</p> <p>(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</p>	<p>3. Advocate for federal and state legislation/regulations to</p> <p>a) Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA);</p> <p>b) Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and</p> <p>(c) Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality,</p>

<p>curriculum, clinical experiences and attending supervision as expected for Liaison Committee on Medical Education and American Osteopathic Association accredited programs. D-295.931 (2)</p> <p>(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 D-295.931 (2)</p>	<p>curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA. (Directive to Take Action)</p>
<p>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. D-295.931 (3)</p>	<p>4. Encourage relevant stakeholders to 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. (Directive to Take Action)</p>
<p>(new)</p>	<p>5. Develop and disseminate to interested states model legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students. (Directive to Take Action)</p>
<p>Our AMA supports the following principles, based on recommendations of the Ad Hoc Committee on Foreign Medical Graduates (FMGs):</p> <p>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. H-255.998</p>	<p>Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools 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 medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially when the presence of visiting students would disadvantage the institution’s own students educationally and/or</p>

<p>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. (31)</p> <p>The core clinical curriculum of a foreign medical school should be provided by that school; U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school. H-255.988 (6)</p> <p>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. D-295.931 (4)</p> <p>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. D-295.320 (3)</p>	<p>financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites. (New HOD Policy)</p>
<p>(new)</p>	<p>3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas. (New HOD Policy)</p>
<p>Providing U.S. students who are considering attendance at an international medical school with information enabling them to assess the difficulties and consequences associated with matriculation in a foreign medical school. H-255.988 (23)</p>	<p>U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of</p>



<p>U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry into graduate medical education programs, and other factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME. H-295.995 (30)</p>	<p>medicine in schools not accredited by the LCME or COCA. (New HOD Policy)</p>
<p>Our AMA supports the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding. H-255.988 (25)</p>	<p>Existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding. (New HOD Policy)</p>
<p>2. Our AMA, in collaboration with interested stakeholders, will:</p> <p>(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 D-295.931 (2)</p>	<p><i>Note: This is not needed in the new policy; as of 2023, the Educational Commission for Foreign Medical Graduates has announced that physicians applying for ECFMG certification will be required to graduate from a medical school that has been appropriately accredited. To satisfy this requirement, the physician's medical school must be accredited through a formal process that uses criteria comparable to those established for U.S. medical schools by the Liaison Committee on Medical Education (LCME) or that uses other globally accepted criteria. The World Federation of Medical Education Recognition Programme will allow medical schools accredited by recognized agencies, and their graduates, to meet ECFMG's accreditation requirement..</i></p>

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<sup>1</sup> Medical School Accreditation Requirement for ECFMG Certification. Educational Commission for Foreign Medical Graduates. Available at: <http://www.ecfmg.org/about/initiatives-accreditation-requirement.html>. Accessed July 10, 2017.

<sup>2</sup> State Medical Licensure Requirements and Statistics, 2014. American Medical Association. Chicago.

<sup>3</sup> Standards and process for the approval of international medical schools to place students in long-term clinical clerkships in New York State. New York Codes, Rules and Regulations. 8 CRR-NY 60.10; NY-CRR. Available at: <http://bit.ly/2sy9y8x>. Accessed July 7, 2017

<sup>4</sup> Regulations of the Commissioner: Part 60 Medicine, Physician Assistant, Specialist Assistant and Acupuncture. New York State Department of Education, Office of the Professions. Available at: [www.op.nysed.gov/prof/med/part60.htm](http://www.op.nysed.gov/prof/med/part60.htm). Accessed July 7, 2017.

<sup>5</sup> Sorel AL. Legislature Preserves Training Spots for Texans. *Tex Med.* 2013;109(10):49-53. Available at: <https://www.texmed.org/Template.aspx?id=29254>. Accessed July 7, 2017.

<sup>6</sup> Texas S.B. No. 301. Available at: [www.legis.state.tx.us/tlodocs/83R/billtext/html/SB00301S.HTM](http://www.legis.state.tx.us/tlodocs/83R/billtext/html/SB00301S.HTM). Accessed July 7, 2017.

<sup>7</sup> Sorel AL. Legislature Preserves Training Spots for Texans. *Tex Med.* 2013;109(10):49-53. Available at: <https://www.texmed.org/Template.aspx?id=29254>. Accessed July 7, 2017.

<sup>8</sup> Policy 200.047 Clinical Training Resources for Texas Medical Students. Texas Medical Association. Available at: <https://www.texmed.org/Template.aspx?id=43095>. Accessed July 7, 2017.

<sup>9</sup> Functions and Structure of a Medical School (2018-19 academic year). Liaison Committee on Medical Education. Available at: <http://lcme.org/publications/#Standards>. Accessed July 10, 2017.

<sup>10</sup> Principles for LCME-Accredited Medical Schools Sharing Faculty at an Instructional Site. Liaison Committee on Medical Education. Available at: [https://view.officeapps.live.com/op/view.aspx?src=http://lcme.org/wp-content/uploads/filebase/white\\_papers/principles-for-shared-instructional-sites-aug2014.doc](https://view.officeapps.live.com/op/view.aspx?src=http://lcme.org/wp-content/uploads/filebase/white_papers/principles-for-shared-instructional-sites-aug2014.doc). Accessed July 10, 2017.

<sup>11</sup> Eckhert NL. Private Schools of the Caribbean: Outsourcing Medical Education. *Academic Medicine* 2010; 85:622-630. Available at: [http://journals.lww.com/academicmedicine/Fulltext/2010/04000/Perspective\\_Private\\_Schools\\_of\\_the\\_Caribbean\\_.21.aspx](http://journals.lww.com/academicmedicine/Fulltext/2010/04000/Perspective_Private_Schools_of_the_Caribbean_.21.aspx). Accessed July 10, 2017.

<sup>12</sup> Halperin EC, Goldberg RB. Offshore Medical Schools Are Buying Clinical Clerkships in U.S. Hospitals: The Problem and Potential Solutions. *Academic Medicine*: May 2016;91:639-644. Available at: [http://journals.lww.com/academicmedicine/Fulltext/2016/05000/Offshore\\_Medical\\_Schools\\_Are\\_Buying\\_Clinical.17.aspx](http://journals.lww.com/academicmedicine/Fulltext/2016/05000/Offshore_Medical_Schools_Are_Buying_Clinical.17.aspx). Accessed July 10, 2017.

<sup>13</sup> Norcini JJ, Boulet JR, Dale Dauphinee W, Opalek A, et al. Evaluating the Quality of Care Provided by Graduates of International Medical Schools. *Health Affairs*. August 2010;29(8):1461-1468. Available at: <http://content.healthaffairs.org/content/29/8/1461.full.pdf+html>. Accessed July 10, 2017.