

## REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports, 1-3, were presented by Lynne M. Kirk, MD, Chair.

### 1. PROMOTING AND REAFFIRMING DOMESTIC MEDICAL SCHOOL CLERKSHIP EDUCATION (RESOLUTION 308-I-16)

*Reference committee hearing: see report of Reference Committee K.*

#### **HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 308-I-16 REMAINDER OF REPORT FILED**

*See Policies H-295.988, H-295.995 and D-295.309*

#### GENESIS AND OUTLINE

Resolution 308-I-16, “Promoting and Reaffirming Domestic Medical School Clerkship Education,” introduced by the Medical Student Section, asked that the 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 among 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.

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

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.

#### BACKGROUND

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

Concerns 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 competition for placement sites from other health professions programs, such as nurse practitioner and physician assistant programs. Further, the extensive and ongoing consolidation in the health care industry has led to closure of multiple hospital facilities, with concomitant reduction in the number of sites available for clinical education. The educational experience of U.S. medical students could be compromised through competition with other learners for faculty attention and access to patients.

A final factor (which is most pertinent to this report) is the growing number of foreign medical schools that seek to place their students in clerkships in U.S. institutions—in particular, those schools that cater primarily to U.S. citizen international medical graduates (USIMGs). Many of these institutions are located in the Caribbean, and are

sometimes referred to as “offshore medical schools.” The eight largest of these institutions (by number of students certified by the Educational Commission for Foreign Medical Graduates [ECFMG] in 2013) include:

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)	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

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

Accreditation/approval of these institutions is the purview of a variety of bodies, each with varying standards and requirements for quality of education. These include seeking recognition through the Ministry of Education or Ministry of Health of the institution’s home country, or accreditation or approval from regional agencies, such as the Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP) and the Accreditation Commission on Colleges of Medicine, (a nonprofit organization in Ireland that inspects and accredits medical schools in countries that do not have a national medical accreditation body). As of 2023, the ECFMG will require that physicians applying for ECFMG Certification graduate from a medical school that has been “appropriately accredited”—that is, “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, such as those put forth by the World Federation for Medical Education (WFME).”<sup>1</sup>

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

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

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

## STATE REGULATIONS

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

*New York*

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

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

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

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

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

*Texas*

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

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

The legislation was supported by the Texas Medical Association (TMA) and the state's medical schools, which feared a diminution in the number of clinical clerkships for its medical students, due in part to the willingness of offshore medical schools to pay for clerkships for their students. With only one exception, Texas medical schools do

not pay for clerkships and are in no position financially to do so. Had the state legislation not been passed, it would have been expected that Texas medical schools would not have been able to afford to compete in paying for clerkships, thereby displacing Texas medical students from long-standing clerkships at Texas teaching hospitals. As a result, medical schools would likely have been forced to participate in bidding wars for clerkship space, and, consequently, pass on this added cost to medical students, resulting in increased tuition and likely, increased student debt. Noted one of the co-authors of the Texas legislation, “Our Texas medical students should be prioritized, and we must ensure they have access to those clinical rotations without doing anything to jeopardize that. They are our investment. [The state] invests in medical education, and we have to protect that investment.”<sup>7</sup>

The TMA’s advocacy on this issue was buttressed by policy adopted in 2013, which resulted from a report of the association’s Council on Medical Education (see Appendix B). The policy stated, in part, that the TMA “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.” In addition, the policy states, “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 [LCME- and COCA-accredited] programs.... 3. TMA 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.”<sup>8</sup>

## RELEVANT LCME STANDARDS

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

### *4.1 Sufficiency of Faculty*

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

### *5.5 Resources for Clinical Instruction*

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

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

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

### *10.8 Visiting Students*

*A medical school does all of the following:*

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

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

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

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

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

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

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

#### LIMITATIONS ON AMA ACTIONS

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

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

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

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

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

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

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

#### DISCUSSION

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

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

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

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

As to the resolve clauses of Resolution 308-I-16, the AMA can pursue or support legislative and regulatory advocacy to promote fair competition amongst medical schools vying for clerkship positions. Additionally, the AMA can focus on educational quality, to include the appropriate number of students on a given clerkship at any one time, and address such educational aspects as curriculum, supervision, and procedural experience (logbooks). The AMA can work with interested state and specialty medical associations to pursue legislation that addresses this issue and helps ensure a quality experience for all medical students.

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

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

## RECOMMENDATIONS

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

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

- 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:
  - a) infrastructure and faculty development and capacity for medical school expansion; and
  - b) delivery of clinical clerkships and other educational experiences.

- 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.
  - 3) Advocate for federal and state legislation/regulations to:
    - 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);
    - b. Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and
    - 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, curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA.
  - 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.
  - 5) Work with interested state and specialty medical associations to pursue legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students.
2. 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 financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites.
  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.
  4. 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 medicine in schools not accredited by the LCME or COCA.
  5. 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.
  6. That Policies H-255.988 (6, 23, 25), H-255.998, H-295.995 (30, 31), D-295.320, D-295.931, and D-295.937 be rescinded, as described in Appendix C to this report.

## REFERENCES

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## APPENDIX A - Offshore Medical Schools in 2013, by Number of ECFMG-Certified Students / Graduates

School	Location	Number
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.

#### 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.

#### 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.

#### 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.

## 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.

## 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.

## 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> <ol style="list-style-type: none"> <li>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)</li> </ol>
<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>	<ol style="list-style-type: none"> <li>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)</li> </ol>
<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>	<ol style="list-style-type: none"> <li>3. Advocate for federal and state legislation/regulations to           <ol style="list-style-type: none"> <li>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);</li> <li>b) Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and</li> </ol> </li> </ol>
<p>(c) advocate that any institution that accepts students for</p>	<p>(c) Require that any institution that accepts students for clinical</p>

<p>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. 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>placements ensure that all such students are trained in programs that meet requirements for educational quality, 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>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</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 financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites. (New HOD Policy)</p>

access to appropriate clinical teaching resources, can be assured. D-295.320 (3)	
(new)	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)
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)  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)	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 medicine in schools not accredited by the LCME or COCA. (New HOD Policy)
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)	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)
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 D-295.931 (2)	<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>

## 2. A NATIONAL CONTINUING MEDICAL EDUCATION REPOSITORY

*Informational report; no reference committee hearing.*

### HOUSE ACTION: FILED

It is a physician's professional responsibility to participate in continuing medical education (CME) activities in order to sustain life-long learning and improve the care provided to patients.<sup>1</sup> Often, CME credits can be used to meet the CME requirements of state medical and osteopathic boards, medical specialty societies, specialty boards, hospital medical staffs, and insurance networks. Yet the tools with which physicians track their CME vary widely by state, specialty, and institution.

In a previous report,<sup>2</sup> the American Medical Association (AMA) Council on Medical Education noted that while a central repository/online reporting system that would allow a physician to track/store CME credits would be very useful for meeting requirements for licensure, certification, and credentialing, many specialty and state medical societies and other organizations already provide such services, and a central repository was perceived as duplicative (or not warranted). Additionally, research indicated that the cost of a centralized service would almost invariably be borne by physicians. Furthermore, all CME providers would need to agree upon technical and data security proposals in order to proceed with a centralized repository, and questions about which entity(ies) would fund and maintain such a service remained unanswered. Pursuant to more recent Council on Medical Education discussions,



however, members agreed that a follow-up review was warranted, given the time elapsed since the adoption of the previous report.

## BACKGROUND

There are three major credit systems in the United States: (1) The AMA Physician Recognition Award (PRA) credit system; (2) American Academy of Family Physicians (AAFP) credit system; and (3) American Osteopathic Association (AOA) credit system. These three established credit systems facilitate physician credentialing and the renewal of licensure by providing metrics to demonstrate that a physician has maintained a commitment to study, apply, and advance scientific knowledge through participation in appropriate CME activities. There is strong communication and cooperation among the AMA, AOA, and AAFP, and although there are differences in how credits are categorized, the CME rules followed are similar in many ways. However, there is no centralized data repository to track all CME credits earned by a physician, and physicians are generally personally responsible for tracking and documenting their earned CME credits when verification is required for licensure or other credentialing purposes.

## CREDIT SYSTEMS AND ACCREDITING BODIES

### *AMA, ACCME, and State/Territory Medical Societies*

In 2016, more than 1,800 CME providers accredited by the Accreditation Council for Continuing Medical Education (ACCME) and state/territory medical societies produced almost 159,000 educational activities that were certified for *AMA PRA Category 1 Credit*.<sup>TM 3</sup> AMA PRA requirements mandate that all accredited CME providers maintain records for each physician who participates in their CME activities and verify this participation if requested by the physician. The vast majority of CME providers do not report the actual number of credits awarded to individual physicians at the participant level. An exception to this is a new partnership between the ACCME and three American Board of Medical Specialties' (ABMS) Member Boards. The American Board of Anesthesiology (ABA), American Board of Internal Medicine (ABIM), and American Board of Pediatrics (ABP) have established a relationship with the ACCME's Program and Activity Reporting System (PARS). Through this partnership, CME providers upload physician-level data to the ACCME PARS system, which then can be transmitted directly to the specialty board. However, this transmission occurs only in those instances in which the credits are accepted by the specialty boards to meet their MOC requirements.

AMA PRA policy encourages physicians to report to the AMA any accredited CME provider that fails to provide documentation to a physician of his or her earned *AMA PRA Category 1 Credits*.<sup>TM 4</sup> Additionally, physicians can choose to apply for the AMA PRA, which many state licensing boards accept as demonstrating compliance with state CME requirements.

### *AOA*

The AOA works with approximately 170 AOA-accredited sponsors that provide AOA Category 1 credit. It is the responsibility of the sponsor to report all CME credit earned by individual physicians to the AOA. For non-osteopathic-sponsored CME activities, it is the responsibility of the physician to provide documentation to the AOA. A certificate of attendance or letter of verification from the CME sponsor must be provided. The AOA tracks earned CME credits for individual physicians in a centralized online repository, the AOA "traCME" system. AOA members may view their CME profile/activity report online or contact the AOA for an electronic copy.<sup>5</sup>

### *AAFP*

AAFP members usually self-report CME credits to the AAFP. However, this is strictly voluntary. The AAFP does not require CME providers to provide certificates to CME participants; however, the AAFP encourages providers to offer certificates, since many members need them for state licensing and credentialing. CME providers are required to have a mechanism in place to document learner participation.<sup>6,7</sup>

### *Comparison of Accrediting Bodies*

Appendix A reviews the credit-related services currently offered by the three major CME credit systems.

## CME TRACKING SERVICES

### *State Medical Societies*

In preparation for the writing of this report, the Council canvassed state medical societies regarding their efforts to assist physicians with tracking CME to meet state licensure requirements. Of those who responded, four indicated that they offer related services beyond providing a transcript for their own CME activities:

- The Pennsylvania Medical Society (PMS) ([www.pamedsoc.org/Tracker](http://www.pamedsoc.org/Tracker)) allows physicians to enter their AMA *PRA Category 1 Credits™* and AMA *PRA Category 2 Credits™* into an electronic tracking system called Tracker. This system shows physicians when they have met the state's licensing requirements and the PMS's CME certificate requirements.
- The California Medical Association's Institute for Medical Quality (IMQ) CME Certification Program ([www.imq.org/continuingmedicaleducation/cmecertification.aspx](http://www.imq.org/continuingmedicaleducation/cmecertification.aspx)) records and verifies AMA *PRA Category 1 Credit™* for California-licensed physicians to meet the state medical board's requirements for licensure. CME credits can be reported using an online form and CME transcripts can be viewed and printed from the IMQ online site. Physicians who participate in this program are not required to undergo an independent audit of their CME activities by the California Medical Board.
- The Florida Medical Association (FMA) tracks all CME it provides directly in each physician's record in its membership database (<http://www.floridahealth.gov/licensing-and-regulation/ce.html>). This allows the FMA to generate a transcript with all FMA directly-provided CME that a physician (member or non-member) has completed over a specific period of time. The FMA also electronically reports its CME attendance data to CE Broker, which is the official continuing education (CE) tracking system for the state of Florida. Any educational provider that is specifically approved by a medical licensing board in Florida is statutorily required to report its attendance data to CE Broker. Although organizations accredited through the ACCME system are not statutorily required to report attendance (as their approval is from an entity other than the medical licensing board), many ACCME and FMA-accredited CME providers in Florida choose to do this.
- The South Carolina Medical Association (SCMA) receives information from its accredited CME providers on a quarterly basis that is uploaded into its database, which also contains data from SCMA's own CME activities. The SCMA provides, on a biennial basis, a report to the state Board of Medical Examiners of members who have submitted their CME for tracking and met the minimum standard for license renewal (<https://www.scmmedical.org/education>). The SCMA also tracks all South Carolina physicians who participate in its online opioid courses and reports this biennially to the Board of Medical Examiners.

### *Specialty Societies*

Specialty societies are more likely than state medical societies to offer CME tracking tools and capabilities to their members, and this tracking is more likely to relate to MOC requirements. Appendix B summarizes information obtained from 2013 and 2017 surveys of Council of Medical Specialty Societies (CMSS) member organizations.

### *Personal Digital Strategies*

A number of mobile apps and online services are available to track CME credit. A simple search of the phrases "continuing medical education tracker" and "CME Tracker" in Apple's App Store and Google Play generated multiple hits, including JoyCE, CEAgent, CE Vault Healthcare Edition, CME Tracker, eeds Mobile, My CE, and DocIt, among others. Online membership groups, such as Doximity, and products, such as UpToDate, also offer some level of CME tracking. However, the ability of these products to interface with accrediting bodies is unclear, and the product in many cases seems to be more reflective of a transcript, rather than of a comprehensive tracking system.

### *Institutional Tracking Systems*

Some hospital systems and institutions also offer a type of CME tracking through their credentialing offices or other similar bodies, although this credit tracking may apply only to credit granted for the health system's own

events/CME offerings, and there does not appear to be aggregated information regarding which systems offer these services at the national level. The Association of American Medical Colleges (AAMC) does not officially track which of its member institutions offer CME tracking as a physician employee benefit.<sup>8</sup> However, the Alliance for Continuing Education in the Health Professions (ACEHP) notes that at least one of its major hospital system members, the Cleveland Clinic, offers its employed physicians a free database tool for tracking CME (although it is the responsibility of individual physicians to manage their CME).<sup>9</sup>

## DISCUSSION

### *Perceived Need for a National Repository*

As noted in a previous report, the AMA recognizes that a centralized repository and online reporting system for CME credit would be very useful to today's physicians. However, in addition to the duplicative nature of such a service, some CME providers might resist requirements to report information to an additional central repository as they already provide this service to their members. Furthermore, as noted, some specialty societies already have developed working relationships with their certifying boards as a member service. In addition, each CME provider is required to keep records of the credits it issues to meet the requirements of the AMA PRA Credit System, and this could create additional administrative work for their staff.

The 2013 survey of CME directors from CMSS member organizations found that the majority of specialty societies that manage a database of CME credits earned by their physician members would not prefer a centralized credit database in lieu of their services, as they considered their own CME tracking services to be a valuable member benefit. At that time, specialty societies also were concerned about the potential data integrity/ownership/security issues that could arise with the development of a centralized database.

A 2017 survey of CMSS member societies reinforced this group's lack of support for the creation of centralized repository; respondents cited multiple reasons for their opinions. "Creating a centralized database would only create additional work for us to copy the records we have to keep into an outside system and answer member questions when the centralized system has errors or the information we provide doesn't upload correctly," wrote one respondent. Another noted, "We want to incentivize physicians to see our learning center as their digital home for medical education. Centralizing CME credits elsewhere would fracture that experience." Others noted the difficulties inherent in creating and maintaining such a system: "This could potentially be a real benefit for physicians. However, it will only be beneficial if there is 100% participation by CME providers, and 100% adoption by the organizations who require CME or coordinate MOC and other elements with CME. The amount of coordination and resources it would take on the part of all organizations involved should not be underestimated." Another responded, "We understand the AMA's desire for greater centralization of the data. We request that a large organization like the AMA take into consideration the butterfly effect. One phrase mandating change may seem like a small improvement for the CME enterprise, but will most certainly have a significant impact on the budget for each CME provider."

### *Barriers*

Additional barriers to the implementation of a centralized tracking system include funding, staffing, and technical and security requirements. In order to create a central repository, all CME providers would need to agree upon technical and data security proposals to ensure interoperability and determine who would pay for database development and maintenance. On several previous occasions, the AMA has considered development of a central repository, but in-depth analysis indicated that such a repository would be impractical due to complexity and cost. A system that includes AAFP and AOA credit would be more complex still.

### *Opportunities*

Suggestions have been made that a remedy could be achieved through the creation of a single web link, which, when followed, directs users to a page with additional links to all specialty society, state medical society, AAFP, AMA, and AOA CME pages (and their vendors that handle CME reporting services). This potentially could reduce the amount of time and frustration physicians currently experience when attempting to access multiple sites. However, this solution would place responsibility on these groups to ensure all links are accurate and up-to-date. Furthermore,

simply creating a page of links to reporting sites does not ensure that all credits a physician reports to these sites are automatically shared with licensing bodies.

The AMA is currently developing its Education Center, which aims to improve health and health care and enhance professional competency and satisfaction through trusted, innovative educational resources. The Education Center will deliver education that is based on user needs and focuses on user experience. Today, the Education Center includes routine transcript functionality. In the near term, it will be developing and testing features that support improved and expanded CME tracking and reporting.

#### RELEVANT AMA POLICY

The AMA Code of Medical Ethics (Opinions on Professional Self-Regulation, E-9.2.6 “Continuing Medical Education”) and existing AMA policy support lifelong learning. Related policies include the following:

- The AMA Principles of Medical Ethics state, V.) A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- Policy D-300.999, “Registration of Accredited CME Sponsors,” states that our AMA will: (1) continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician’s Recognition Award (PRA) policy when designating AMA PRA credit; and (2) remind all accredited CME providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the credit awarded at the request of the physician.
- Policy H-300.980, “Focused Continuing Education Programs for Enhanced Clinical Competence,” states that the AMA: (1) encourages state and, where appropriate, local medical societies to respond to the needs of physicians who have been identified as requiring focused continuing medical education; (2) encourages state and county medical societies to cooperate with organizations and agencies concerned with physician competence, such as state licensing boards, and to assist in providing opportunities for physicians to participate in focused continuing education programs; (3) supports the collection and dissemination of information on focused continuing medical education programs that have been developed or are in the process of development; and (4) recommends that organizations with responsibilities for patient care and patient safety request physicians to engage in content-specific educational activities only when there is a reasonable expectation that the CME intervention will be appropriate for the physician and effective in improving patient care or increasing patient safety in the context of the physicians’ practice.
- Policy H-300.958, “Support for Continuing Medical Education,” states that the AMA: (1) Supports the concept of lifelong learning by recognizing the importance of continuing medical education as an integral part of medical education, along with undergraduate and graduate medical education; (2) Encourages physicians to maintain and advance their clinical competence and keep up with changes in health care delivery brought about by health system reform; (3) Assists and supports the expansion and enhancement of funding resources for continuing medical education on a local, regional, and national basis through foundations, private industry, health care organizations and appropriate government agencies; (4) Encourages U.S. medical schools to integrate continuing medical education into the continuum of undergraduate and graduate medical education; (5) Supports and assists medical schools, teaching institutions, and other health-related organizations in developing and facilitating implementation of health policy that supports research in continuing medical education, relevant to the needs of practicing physicians; and (6) Supports efforts to facilitate and speed development of computer-based interactive and distance learning technologies to support learning needs of practicing physicians regardless of their geographic location.
- Policy H-275.924, “Maintenance of Certification,” states in part that: (10) In relation to MOC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

## CONCLUSION AND AREAS FOR FURTHER STUDY

CME credit is currently tracked and monitored to a varying degree by a wide variety of organizations at the state, specialty society, and institutional level, but as a result, physicians lack a single tool to track all types of earned CME credit, including credit earned from multiple CME providers or CME earned from one provider that is applied for multiple purposes (such as state licensing renewal and MOC). Because the nature of tracking and monitoring CME credit can be so specialized, the creation and maintenance of a centralized repository—while helpful for physicians—may not be feasible at this time due to a myriad of factors. Despite these challenges, however, appropriate departments within the AMA should continue to monitor advancements in technology and changes in the CME environment that may inform future deliberations on this topic, and the AMA should continue to actively work with the ABMS, ACCME, the CME provider community including state medical and professional societies, and other CME stakeholders to address these and related issues.

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8. Personal communication, Stacia Gueriguian, Director of Meetings, Association of American Medical Colleges. July 12, 2017.
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## APPENDIX A: Credit-Related Services Offered by the Three Major Credit Systems

	Is tracking provided for participants of credit system activities?		Which types of activities are tracked for inclusion in the transcript/CME report?			Is there a fee for tracking?	
	Members	Non-members	Credit system's own activities as a CME provider	All credit system activities (including those offered by others)	Other activities (including other types of credit)	Members	Non-Members
AAFP <sup>1</sup>	Yes	No	Yes	If entered by the CME provider or self-reported by the member	Members can self-report and it will be included in transcript	Member benefit	N/A
AMA <sup>2</sup>	Yes	Yes	Yes	No	Anyone can self-report and it will be included in transcript	No	No
AOA <sup>3</sup>	Yes	No	Yes	Yes	Members can self-report and it will be included in transcript	Member benefit	N/A

1. The AAFP directly certifies CME activities offering AAFP credit; these activities are listed on the AAFP website. Activity providers can report activity completion, including credits earned by members. This is optional, and not all activity providers do this; however, if done, the credits are automatically entered into the members' AAFP transcripts. Individual physician members can also report activity completion and credits earned, and the information is entered into their AAFP transcript. For activities for which the AAFP is the accredited CME provider, the credit is automatically included in the transcript. Non-members receive a letter of participation for each activity, but not a transcript.

2. AMA transcripts include credit for CME activities for which the AMA is the accredited CME provider. However, AMA *PRA Category 1 Credits*<sup>TM</sup> awarded by the AMA for credit conversions through international agreements, international conference recognition program conferences, and direct credit categories are not included in the transcript at this time. Anyone can self-report AMA *PRA Category 1 Credit*<sup>TM</sup> activities from other accredited CME providers and activities for other types of credit.

3. The AOA tracks AOA credits for DO members and non-members, but only DO members are provided access to their CME report, which reflects the credits. AOA credits are reported by the AOA sponsors and posted to the CME activity report. DO members also self-report AMA *PRA Category 1 Credits*<sup>TM</sup> and AAFP credits, and these are included on the CME activity report.

## APPENDIX B: Survey of CMSS Member Societies Regarding CME Tracking

	2013 (N = 17)	2017 (N = 14)
	Number of respondents (%)*	Number of respondents (%)*
<i>Does your society maintain a database of CME credits earned annually for any of the following? Please check all that apply.</i>		
Member physicians, for CME offered by your society	15 (93.8)	14 (100.0)
Non-member physicians in your specialty, for CME offered by your society	11 (68.8)	12 (92.3)
Member physicians, for CME offered by any CME provider	6 (37.5)	6 (50.0)
Non-member physicians in your specialty, for CME offered by any CME provider	3 (18.8)	3 (25.0)
<i>If your membership organization offers this service, is there an additional fee associated with tracking the CME?</i>		
	2013	2017
	Yes 0 (0.0)	No 16 (100.0)
	Yes 0 (0.0)	No 12 (100.0)
<i>Would you prefer a centralized database of CME credits earned by all physicians in lieu of managing such a database through your society?</i>		
	2013	2017
	Yes 2 (12.5)	No 9 (56.3)
	Unsure 5 (31.2)	Yes 0 (0.0)
		No 6 (60.0)
		Unsure 4 (40.0)

\*Percentages calculated based on the number of respondents answering the individual question.

### 3. IMPACT OF IMMIGRATION BARRIERS ON THE NATION'S HEALTH

*Informational report; no reference committee hearing.*

#### **HOUSE ACTION: FILED**

American Medical Association (AMA) Policy D-255.980, "Impact of Immigration Barriers on the Nation's Health," was adopted by the AMA House of Delegates (HOD) at its 2017 Annual Meeting. It states the following:

1. Our American Medical Association (AMA) recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce.

During the HOD meeting, Reference Committee C heard universal support for the timely and salient resolutions that were introduced regarding these topics, which sought to address and rectify the multiple implications of restricting U.S. travel for foreign-born physicians, trainees, and researchers. Testimony also noted that any travel restrictions could negatively affect patient access to care, especially in areas of need. These same implications hold true for patients served by other foreign-born clinicians and trainees employed in this country.

Restricting travel on the basis of country of origin or religion goes against the principles and policy of our AMA, which has worked to enhance physician diversity and to address the quality of care received and experienced by diverse patients and populations. Additionally, many communities, including rural and low-income areas, face challenges attracting physicians to meet their health care needs. International medical graduates (IMGs) often fill these openings. Currently, one out of every four physicians practicing in the United States is an IMG. In certain specialties, that number is even higher. These physicians are trained and licensed by the same stringent requirements applied to U.S. medical school graduates. They are more likely to practice in underserved and poor communities, and in primary care and other specialties that face significant workforce shortages.

Concerns related to additional limitations on immigration also have been voiced by the biomedical research community. Restriction of travel can constrain the free flow of ideas and hamper the international cooperation that has historically led to advancements in the delivery of care.

AMA delegates collectively introduced seven related resolutions to the HOD for the 2017 Annual Meeting; an umbrella resolution, which incorporated elements of all seven resolutions, was subsequently adopted. This report addresses Resolves 6 and 7 of that umbrella resolution. The issue of physician immigration also was highlighted by the Council on Medical Education during the Annual Meeting—with support from the Council on Science and Public Health, Academic Physicians Section, International Medical Graduates Section, Integrated Physician Practice

Section, and Medical Student Section—through development of an educational session that called attention to and addressed these important concerns.

Individuals eligible for Deferred Action for Childhood Arrivals (DACA) status face related, but not entirely similar, concerns. Council on Medical Education Report 4-A-17, “Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages,” offers a comprehensive review of DACA-eligible individuals, their prospects, and their potential impact on the U.S. workforce. This report was submitted to and adopted by the HOD (see D-350.986), and interested parties are encouraged to review the report and its findings. The Council on Medical Education continues to monitor DACA and will report back to the HOD as needed.

## INTRODUCTION

The executive order issued by President Donald J. Trump on January 27, 2017—“Protecting the Nation from Foreign Terrorist Entry into the United States”—introduced great uncertainty into the lives of physicians in training, physician scientists, other medical researchers, and hospital administrators. Many in the health care community expressed immediate concern regarding the impacts of the proposed order on physicians, institutions, researchers, and patients on multiple levels, especially during a time when physician shortages are predicted and the number of patients with multiple chronic conditions is growing.

A recent article published in *JAMA* effectively frames these legitimate concerns. The article notes, “At least 1 in 4 physicians [in the U.S.] are foreign born. Research demonstrates that foreign-born physicians offer high-quality care, with low mortality rates among their patients. Due to critical health worker shortages, special visas are offered to foreign physicians who practice for 3 years in rural, underserved communities. More than 13,000 physicians from the 6 Muslim-majority countries with suspended entry practice in the United States, including 9,000 from Iran and 3,500 from Syria. In 2015 alone, 453 foreign nationals from these countries were admitted to residency programs. If this group of physicians were not replaced, given the size of the average primary care patient panel (2,500 patients), the ban could affect more than 1 million patients nationally.”<sup>1</sup>

Understanding the Orders: “Protecting the Nation from Foreign Terrorist Entry into the United States”

- On January 27, 2017, President Donald J. Trump signed the executive order titled “Protecting the Nation from Foreign Terrorist Entry into the United States.”<sup>2</sup> The order barred entry to the United States to all individuals with immigrant and non-immigrant visas from Iraq, Iran, Libya, Somalia, Sudan, Syria, and Yemen for a period of 90 days. Refugees worldwide were subject to an entry ban for 120 days, and refugees from Syria were indefinitely banned. In subsequent days, federal lawsuits were filed in New York, Massachusetts, Virginia, and Washington on behalf of travelers denied entry into the U.S. from one of the seven affected countries.
- On February 3, a Federal District Court halted the implementation of the executive order with a temporary restraining order; also that day, the state of Hawaii filed a lawsuit asking the court to block the order’s implementation.
- On February 4, the Department of Justice appealed the February 3 restraining order to the Ninth Circuit Court of Appeals.
- On February 9, the Ninth Circuit Court of Appeals unanimously ruled to deny the Justice Department’s request for a stay.
- On March 6, rather than continue to litigate the first executive order, President Trump withdrew the first executive order and signed a revised order, which was intended to go into effect on March 16.<sup>3</sup> The revised order removed Iraq from the list of countries facing the 90-day travel ban. Additionally, the order removed the indefinite ban on Syrian refugees and clarified that individuals with a valid visa to enter the U.S. would be permitted to do so, regardless of their country of origin.
- On March 8, Hawaii filed another legal challenge to this revised ban.
- On March 15, a U.S. District Judge issued a temporary restraining order, blocking the executive order from taking effect on March 16.<sup>4</sup> On March 16, a second judge issued a preliminary injunction related to the order.<sup>5</sup>
- On March 29, a federal judge in Hawaii extended an order that blocked the ban from nationwide implementation until Hawaii’s lawsuit was decided.<sup>6</sup>
- On June 12, the Ninth Circuit Court largely upheld the injunction on the revised travel ban.
- On June 26, the U.S. Supreme Court allowed parts of the revised order to go into effect; oral arguments are scheduled to be heard in October 2017 (after drafting of this report). The Supreme Court’s decision upholds the revised order with the exception of those with “any bona fide relationship with a person or entity in the United



States,”<sup>7</sup> which is being defined as those with certain family connections in the U.S. (guidance from the State Department indicated that only parents, step-parents, spouses, children, step-children, adult sons/daughters, sons-/daughters-in-law, and siblings apply, but later added fiancées and grandparents as well<sup>8</sup>); students accepted by a U.S. university; individuals with job offers at U.S. companies; and lecturers invited to address an American audience.

- The partial ban went into effect the evening of Thursday, June 29, and expired on September 24. A new ban was then instituted, scheduled to take effect on October 18, which struck the country of Sudan from the list but added Chad, North Korea, and Venezuela (limited to government officials and their families).
- On October 10, the U.S. Supreme Court dismissed one of two pending lawsuits related to the travel ban based on the argument that the ban in question had expired.
- On October 17, a federal judge in Hawaii blocked the revised travel ban, scheduled to go into effect on October 18. As of the writing of this report, restrictions on North Korea and Venezuela will be permitted to go into effect.

## REACTION TO THE ORDER

The U.S. medical and scientific community responded immediately and forcefully to both executive orders. Leading national medical groups, including the AMA,<sup>9,10</sup> Accreditation Council for Graduate Medical Education (ACGME),<sup>11</sup> American Association of Colleges of Osteopathic Medicine (AACOM),<sup>12</sup> Association of American Medical Colleges (AAMC),<sup>13,14</sup> American Hospital Association (AHA),<sup>15,16</sup> American Medical Student Association (AMSA),<sup>17</sup> American Osteopathic Organization (AOA),<sup>18</sup> Committee of Interns and Residents (CIR),<sup>19</sup> and National Medical Association (NMA)<sup>20</sup> all registered their serious concerns, often multiple times, over the following months. The Educational Commission for Foreign Medical Graduates (ECFMG), the body that evaluates and certifies qualified graduates of foreign medical schools prior to their entry into the U.S. graduate medical education system, dedicated an entire page of resources on its website related to the executive order.<sup>21</sup>

Individual specialty societies also spoke out. The American College of Cardiology (ACC),<sup>22</sup> American College of Physicians (ACP),<sup>23</sup> American Society for Clinical Oncology (ASCO),<sup>24</sup> American Academy of Family Physicians (AAFP),<sup>25</sup> and American Academy of Pediatrics (AAP),<sup>26,27</sup> among others, all expressed unease with the content and implications of the executive orders.

On June 12, the AAMC filed an amicus brief with the Supreme Court in opposition to the government’s petition for a stay against lower court injunctions against the executive order. Twenty-one organizations joined the brief: the AAFP; AAP; American Association of Colleges of Nursing (AACN); American Association of Colleges of Pharmacy (AACP); American College of Healthcare Executives (ACHE); American College of Obstetricians and Gynecologists (ACOG); ACP; American Dental Education Association (ADEA); American Nurses Association (ANA); American Psychiatric Association (APA); American Public Health Association (APHA); Association of Academic Health Centers (AAHC); Association of Schools and Programs of Public Health (ASPPH); Association of Schools of Allied Health Professions (ASAHP); Association of University Programs in Health Administration (AUPHA); Greater New York Hospital Association; Hispanic-Serving Health Professions Schools, Inc. (HSHPS); NMA; National Resident Matching Program (NRMP); Physician Assistant Education Association (PAEA); and Society of General Internal Medicine (SGIM).

As the brief noted, “Individuals from outside the United States play a critical role in the delivery of healthcare in America...Non-U.S. health professionals hail from around the world, including from the six countries subject to the Executive order’s suspension of entry. Economists estimate that more than seven thousand physicians currently working in the United States received training in the six countries, and that those doctors collectively provide fourteen million patient visits each year...Physicians from outside the United States ‘situate [themselves] on the front lines of medical need,’ including rural and other underserved communities, Native American communities, and U.S. Department of Veterans Affairs hospitals. In Alabama, for example, ‘Syria ranks fourth as a source of doctors for medically-needy areas . . . behind India, Pakistan and the Philippines’.”<sup>28</sup>

The brief goes on to describe additional implications: “Collaborative international efforts, especially strengthening the capacity of national health systems, are essential to prevent and prepare for an array of threats, from infectious disease pandemics to the silent killers of chronic non-communicable diseases. Any constraint on the participation of recognized experts in the free exchange of scientific research and collaboration impairs the collective knowledge of our healthcare community and jeopardizes American lives.”<sup>29</sup>

Innovation and medical research were also highlighted in the brief: “The Executive order also has the potential to adversely affect patient care by constraining medical research and innovation. In 2016, all six American winners of the Nobel Prize in economics and scientific fields were immigrants. Moreover, since 2000, immigrants have been awarded 40%—or 31 of 78—of the Nobel Prizes won by Americans in chemistry, medicine, and physics. An analysis of the U.S. Patent and Trademark Office’s online database shows that 76% of patents awarded to the top ten patent-producing U.S. universities in 2011 listed at least one inventor who had been born in another country. During that same period, 56% of all patents were awarded to inventors who were students, postdoctoral fellows, or staff researchers from another country. Because non-U.S. post-doctorate students are increasingly relied upon to counter a decrease in U.S. students pursuing biomedical research in this nation, chilling their participation could adversely affect biomedical research and our health security.”<sup>30</sup>

## VISA IMPLICATIONS

As noted in Council on Medical Education Report 11-A-09, “Rationalize Visa and Licensure Process for IMG Residents,” the two most commonly used temporary, nonimmigrant classifications by IMGs are the J-1 Exchange Visitor program and the H-1B Temporary Worker classification.

Most IMGs in graduate medical education (GME) programs arrive under the J-1 Exchange Visitor Program, although the H-1B Temporary Worker category has been increasingly utilized. Data collected via the AMA’s National GME Census reflect changes in the ease or difficulty of obtaining different visas. Between 2001 and 2008, there was an increase in IMGs in residency programs under H status from 1,474 to 4,777. Meanwhile, IMGs under J status declined over the same period from 5,473 to 4,152.<sup>31</sup> Since then, however, more IMGs have been training with J-1 visas. In 2012 there were 4,059 residents with H visas, and 5,200 with J visas; by 2015 there were 2,889 IMG residents with H visas and 6,394 with J visas.<sup>32</sup>

Additional analysis of the AMA’s National GME Census reveals that during the 2016/2017 academic year, 2,477 physicians who were born in the seven countries affected by the original executive order were participating in GME in the U.S. Of those, 615 (24.8 percent) were training here with a visa.<sup>33</sup>

The J-1 visa is a temporary, non-immigrant visa, meant to enhance educational and cultural exchange and promote mutual understanding between the U.S. and other countries. The ECFMG is the only authorized J-1 visa sponsor of foreign national physicians in U.S. clinical training programs. In 2016/2017, the ECFMG sponsored more than 10,000 individuals who are training in U.S. GME programs in 48 states plus the District of Columbia and Puerto Rico. The majority of these physician trainees were in primary care programs: 50 percent in internal medicine, 10 percent in pediatrics, and 7 percent in family medicine.<sup>34</sup> The ECFMG also reports that in the 2017 NRMP Match, while the overall match rate of non-U.S. citizen IMGs increased slightly, fewer IMGs participated in the Match process.

The ECFMG further reports that the number of J-1 visa applications it has received for the 2017/2018 year has declined 33 percent from Iran and 60 percent from Syria, while remaining flat in Libya and Yemen.<sup>35</sup> As of August 15, 2017, 97.8% of the 2,766 physicians initially sponsored by ECFMG for J-1 visa status had successfully secured this status and arrived at their U.S. training programs. Of the 57 initially-sponsored J-1 physicians who are nationals of the countries identified in Executive Order 13780, 50 (87.7%) have successfully secured J-1 status and reported to their training program. Of the 7 (12.3%) who have not yet reported to their programs in J-1 status, 5 already are in the United States in another visa status and awaiting a change of status through U.S. Citizenship and Immigration Services.<sup>36</sup>

A program known as the Conrad 30 Waiver program, which is intended to lessen physician shortages in medically underserved areas, allows physicians with J-1 status to apply for a waiver for the two-year residence requirement upon completion of the J-1 program (individuals with J-1 status are otherwise required to return to their country of last permanent residence for two consecutive years prior to being permitted to apply for permanent resident status in the U.S.). Participants in the Conrad 30 Waiver program are required to practice medicine for a minimum of three years in an area designated by the U.S. Department of Health and Human Services (HHS) as a health professional shortage area (HPSA), medically underserved area (MUA), or medically underserved population (MUP). At the conclusion of that three-year period, waiver recipients can apply for an immigrant visa and permanent resident status.<sup>37</sup>

The Conrad State 30 and Physician Access Act (S. 898 and H.R. 2141) is intended to address the most recent extension of the Conrad State 30 Program, which was scheduled to expire on April 28. The AMA strongly supports adoption of the Act, writing that “J-1 visa waivers play a significant role in placing physicians in communities that face healthcare access challenges. Many communities, including rural and low-income urban areas, struggle to attract physicians to meet their patient needs. This legislation will help ensure continued access to care in medically underserved communities across the U.S.”<sup>38</sup> As of the writing of this report, these bills had been referred to both the Senate and House Committees on the Judiciary.

#### *J-1 Visas and the 2017 Match*

The timing of the executive order was extremely disruptive to IMGs applying for residency training programs through the NRMP match, as well as for institutions and program directors seeking to fill their slots. The NRMP was concerned enough to issue a February 3 statement: “We ask the medical education community to support all international medical graduates and their families during these difficult times. Please be assured that NRMP will do all it can to address the uncertainties the order has created. As for the current Match cycle, we hope that applicants and programs will continue to rank each other in the order of true preference, based on the qualifications and qualities each seeks in the other.”<sup>39</sup> Although no data exist to support this claim, the Council on Medical Education has heard anecdotally that some GME programs struggled to justify ranking qualified applicants from the list of countries affected by the executive order because of concerns about filling their programs and having enough resident staff on hand to fully serve their local patient populations.

#### *H-1B Visas*

In March, U.S. Citizenship and Immigration Services (USCIS) reported that it would temporarily suspend premium processing of H-1B visas beginning on April 3.<sup>40</sup> H-1B visas grant temporary work status for immigrants who work for a specific employer. A recent *JAMA* article<sup>41</sup> noted that physicians practicing in the U.S. with H-1B status accounted for 1.4% of all physicians actively delivering patient care nationwide in 2016 (more than 10,000 physicians). Physicians with this visa status, however, make up much larger percentages of the practicing physician workforce in certain states. For example, of practicing physicians in the following states, 4.7 percent in North Dakota are authorized to work through the H-1B visa program, 4 percent in Rhode Island, 3.9 percent in Michigan, and 3.6 percent in Delaware. It is worth noting, however, that USCIS typically suspends premium processing annually. The primary difference in this suspension, and likely the reason why it garnered more attention, is that this year’s suspension period was longer (potentially up to six months).

On June 23, USCIS announced that the department would resume the expedited processing of H-1B visas for physicians seeking such status under the Conrad 30 waiver program.<sup>42</sup> As of the writing of this report, premium processing remains suspended for other categories of H-1B petitions.

### IMPLICATIONS FOR RESEARCHERS AND GLOBAL DATA SHARING

Physician scientists and researchers were quick to note the obstacles the executive order would introduce into the heretofore collaborative nature of scientific research, which has led to life-saving medical advancements at home and abroad.<sup>43-49</sup> There were concerns that existing research partnerships might be threatened or terminated,<sup>50,51,52</sup> and that the next generation of U.S. researchers and biomedical engineers might be depleted as talented individuals from other countries choose to settle and work outside of the U.S.<sup>53</sup>

A group of almost 200 organizations, ranging from professional scientific, engineering, and education societies, as well as leading research universities, signed a letter to President Trump vocalizing their concerns regarding the January executive order. The letter notes, “Scientific progress depends on openness, transparency, and the free flow of ideas and people, and these principles have helped the United States attract and richly benefit from international scientific talent...The Executive order will discourage many of the best and brightest international students, scholars, engineers and scientists from studying and working, attending academic and scientific conferences, or seeking to build new businesses in the United States. Implementation of this policy will compromise the United States’ ability to attract international scientific talent and maintain scientific and economic leadership.”<sup>54</sup>

Furthermore, since the first order was signed in January, more than 41,000 academics and researchers from a variety of fields, including 62 Nobel Laureates, have signed a statement attesting that “The EO [Executive order]

significantly damages American leadership in higher education and research...The proposed EO limits collaborations with researchers from these nations by restricting entry of these researchers to the US and can potentially lead to departure of many talented individuals who are current and future researchers and entrepreneurs in the US. We strongly believe the immediate and long term consequences of this EO do not serve our national interests.”<sup>55</sup>

As noted in a recent article in the *New England Journal of Medicine*, “Whether we are concerned about the competence of the physicians who will care for us when we are ill, the biomedical enterprise that represents one sixth of our economy, the jobs created by academic medical centers, or our global leadership position in health and health care, immigration policy that blocks the best from coming to train and work in the United States and blocks our trainees and faculty from safely traveling to other countries is a step backward, one that will harm our patients, colleagues, and America’s position as a world leader in health care and innovation.”<sup>56</sup>

## INSTITUTIONAL IMPLICATIONS AND PATIENT ACCESS TO CARE

According to research generated by The Immigrant Doctors Project, physicians from Iran, Libya, Somalia, Sudan, Syria and Yemen provide 14 million doctors’ appointments each year,<sup>57</sup> and almost all Americans (94%) reside in a community that hosts at least one doctor from one of the countries specified in the executive order.<sup>58</sup> As previously noted, concerns have been voiced that regardless of country of origin, qualified non-US citizen IMGs will in the future pursue training and employment in other countries.<sup>59</sup> Yet we know that higher proportions of IMGs, compared to U.S. medical school graduates, provide care to socioeconomically disadvantaged patients,<sup>60,61,62</sup> and health care systems and patients rely heavily on foreign-born physicians. According to a recent article in the *New York Times*, “in Coudersport, Pa., a town in a mountainous region an hour’s drive from the nearest Walmart, Cole Memorial Hospital counts on two Jordanian physicians to keep its obstetrics unit open and is actively recruiting foreign specialists. In Fargo, N.D., a gastroenterologist from Lebanon — who is among hundreds of foreign physicians in the state — has risen to become vice president of the North Dakota Medical Association. In Great Falls, Mont., 60 percent of the doctors who specialize in hospital care at Benefis Health System, which serves about 230,000 people in 15 counties, are foreign doctors on work visas.”<sup>63</sup> Findings from a recent survey from a physician recruiting agency further highlight this country’s need for foreign-born physicians, noting that just over eight percent of practicing physicians and less than three percent of trainees believe that practicing in a rural area is desirable.<sup>64</sup>

Some specialties rely more heavily on IMGs. According to data from the 2017 NRMP Match, primary care continues to depend on foreign-born physicians. Of 7,233 positions offered in internal medicine, 2,003 were filled by non-U.S. IMGs. Of 3,356 positions offered in family medicine, 337 were filled by non-U.S. IMGs, and of 2,738 positions offered in pediatrics, 253 were filled by non-U.S. IMGs.<sup>65</sup> Certain subspecialties also depend heavily on non-U.S. citizen graduates of international medical schools. The NRMP notes that in 2017, these individuals filled 45.1% of nephrology fellowship positions, 41.6% of vascular neurology positions, 39.3% of endocrinology/diabetes/metabolism positions, 37% of interventional pulmonology positions, and 35.3% of abdominal transplant surgery positions.<sup>66</sup>

## RELEVANT AMA POLICY

Policy D-255.991, “Visa Complications for IMGs in GME,” directs our AMA to work with the ECFMG to minimize delays in the visa process for international medical graduates applying for visas to enter the U.S. for GME and/or medical practice; promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for international medical graduates; and work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants and reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position. It also calls on our AMA to study, in collaboration with the ECFMG and the ACGME, the frequency of such J-1 Visa reentry denials and their impact on patient care and residency training, and, with other stakeholders, to advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Policy D-255.985, “Conrad 30 - J-1 Visa Waivers,” directs our AMA to advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the U.S. in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad administrators, IMGs, US Citizenship and Immigration Services and the State Department; and continue to communicate with the Conrad 30 administrators and IMG members to share information and best practices in order to fully utilize and expand the Conrad 30 program.

## CONCLUSIONS AND AREAS FOR FURTHER STUDY

Ultimately, the real impact of the executive order will not be known until it becomes clear how the language of the revised ban is interpreted and applied at U.S. points of entry both at home and in consular offices abroad. The Supreme Court’s ruling would seem to imply that practicing physicians and resident physicians with a job offer from a U.S. institution will indeed be permitted to travel to and from the United States. However, anecdotal evidence indicates that several incoming resident trainees have either not been able to obtain a visa or have experienced significant delays, preventing them from starting residency on July 1; also, an Iranian researcher with a valid J-1 visa and job offer as a visiting scholar was prevented from entering the country on July 11.<sup>67,68</sup>

As noted previously, even the specter of immigration limitations can have an effect on individuals seeking to enter the United States. As a recent article observes, “Even with the travel restrictions on hold, admissions from the six nations fell dramatically in March and April, government data show. Compared with a year earlier, the number of people admitted from Iran, Libya, Somalia, Sudan, Syria and Yemen was down by about half year over year. It was unclear whether that was primarily due to fewer people seeking to travel to the U.S. or to the administration rejecting more applications.”<sup>69</sup>

Although not the focus of this report, what is less clear at this time is how the ruling will apply to foreign students seeking to apply to U.S. medical schools. As a parallel, we might look to the immigration environment immediately following the 2001 terrorist attacks. As one recent article notes, “Student visa applications dropped by 25 percent between 2001 and 2002, and the number of rejections rose from 25 to 34 percent between 2001 and 2003; and perhaps as a result of those post-9/11 policies, the number of international students enrolled at universities dropped for several years, says the 2009 report by the Council on Foreign Relations. ‘Overall, the number of foreign students attending American universities would have been about 25 percent higher if the pre-9/11 growth rates had continued,’ the report says. During that same time period, the report continues, international enrollment in the United Kingdom, France, Australia, Japan, and Germany surged as students went elsewhere.”<sup>70</sup> The effects of the executive order on medical school enrollment bear monitoring, as a diverse body of medical students is critical to the creation and retention of a diverse physician workforce.

If there is a bright side to the executive orders, it is this: extensive and very public discussions are taking place in multiple venues, all of which provide an excellent opportunity to educate the American people regarding the crucial, life-saving role played in this country by foreign-born physicians. Additional dialogue regarding the importance of collaborative, international research is also valuable and necessary. The Council on Medical Education therefore will continue to follow this issue and report back to the House of Delegates as necessary.

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