

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-19

Subject: For-Profit Medical Schools or Colleges

Presented by: Jacqueline A. Bello, MD, Chair

American Medical Association (AMA) Policy D-305.954, “For-Profit Medical Schools or Colleges,” states:

That our American Medical Association study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (1) attrition rate of students, (2) financial burden of non-graduates versus graduates, (3) success of graduates in obtaining a residency position, and (4) level of support for graduate medical education, and report back at the 2019 Annual Meeting.

The Council on Medical Education recognized the importance and timeliness of this topic and agreed that appropriate resources and data collection were needed to study this issue and prepare the report. However, meaningful and constructive review of this issue and the data collection required additional time. The Council therefore is presenting this report at the 2019 Interim Meeting.

For-profit medical schools are a rare phenomenon within the United States, and the numbers of these schools have not increased substantially, with only six for-profit U.S. medical schools. That said, there are a large and growing number of for-profit medical schools located in the Caribbean that are attended by U.S. citizens. This report focuses on for-profit medical schools located in the United States, and provides available attrition rates, general financial information associated with students who attend for-profit vs. not-for-profit medical schools, and data on student transition into residency programs. Very limited data are also included on for-profit medical schools located in the Caribbean, as such data are not publicly available.

BACKGROUND

In the 19th century, the majority of medical schools were the property of the faculty and, therefore, could be considered “for-profit.” In 1906, early accreditation standards from the Council on Medical Education required that schools not be conducted for the financial benefit of the faculty. A 1996 ruling against the American Bar Association, related to restraint of trade, opened up the possibility of accreditation of for-profit law schools and set a legal precedent for the establishment of for-profit medical schools.¹⁻³ Currently, medical school accreditation bodies, including the Liaison Committee on Medical Education (LCME) and American Osteopathic Association Commission on Osteopathic College Accreditation (COCA), are responsible for reviewing the financial status of U.S. medical schools and monitoring graduation rates and student debt.

Four for-profit osteopathic medical schools are in various stages of becoming accredited by COCA. In 2007, provisional accreditation was granted to investor-owned Rocky Vista University College of Osteopathic Medicine in Colorado.¹ The College was founded to address the need for community-based primary care physicians in the Mountain West region. The Burrell College of

Osteopathic Medicine at New Mexico State University, a privately funded osteopathic medical school founded in 2013, holds pre-accreditation status from COCA, and is expected to be fully accredited when its first class graduates in 2020.⁴ In 2016, the Idaho College of Osteopathic Medicine and the California Health Sciences University College of Osteopathic Medicine were founded to help address regional physician shortages in underserved areas.⁵ Both schools have initiated the accreditation process with COCA.

The LCME, by comparison, has granted accreditation to two for-profit allopathic medical schools. In 2013, the LCME modified its standards to remove mention of “for-profit” in the accreditation of allopathic medical schools.¹ One year later, Ponce Health Sciences University School of Medicine (a 35-year-old not-for profit institution in Puerto Rico reported to be in financial distress) was acquired by Arist Medical Sciences University, a for-profit public benefit corporation, making it the first for-profit allopathic medical school accredited by the LCME.¹ In 2015, California Northstate University College of Medicine, a private, for-profit medical school focused on educating, developing, and training physicians to address the primary care physician shortage in northern California, gained preliminary accreditation from the LCME and enrolled its first class of students.⁶

FOR-PROFIT MEDICAL SCHOOLS IN THE CARIBBEAN

There is a growing number of for-profit medical schools located in the Caribbean, often referred to as “offshore medical schools.”⁷ Accreditation/approval of these schools is the purview of a variety of bodies, each with varying standards and requirements for quality and duration of education. Currently, 75 offshore medical schools are acceptable to the Educational Commission for Foreign Medical Graduates (ECFMG) for graduates to obtain ECFMG certification.⁸ Offshore schools typically engage in minimal clinical or scientific research. As a result, offshore proprietary schools have a profitable business model in that their costs are mainly related to the educational program. These schools use their tuition revenue to pay faculty to teach in the basic sciences at U.S. hospitals, and as part of their tuition third- and fourth-year medical students pay to take clinical rotations in the United States.

There are no summary data available on the enrollment of U.S. citizens in offshore medical schools. However, an estimate can be made based on the number of U.S. citizens pursuing certification by the ECFMG. Of the 9,430 ECFMG certificates issued in 2018, 2,398 (25.4 percent) were issued to U.S. citizen graduates of offshore medical schools.⁹ The students/graduates registering for certification were from medical schools located in countries in the Caribbean.

ATTRITION RATES

Not-for-profit U.S. Medical Schools

The Association of American Medical Colleges (AAMC) reports that from 1993-1994 through 2012-2013, the total national attrition rate for not-for-profit medical schools remained relatively stable at an average of 3.3 percent (Appendix A, Table 1).¹⁰ The AAMC notes that more medical students left medical school for nonacademic than for academic reasons, and that attrition rates appeared to vary by type of degree program—that is, the attrition rates of students in combined degree programs, such as MD-MPH programs, differ from those for students in MD programs.

The American Association of Colleges of Osteopathic Medicine (AACOM) calculates attrition rate by dividing the sum of students who withdrew or took a leave of absence by total enrollment. Withdrawals and dismissals are types of permanent attrition from the colleges of osteopathic

medicine (COM), while leaves of absence are types of temporary attrition that may become a withdrawal or dismissal after a period of time.¹¹ Reasons for students' withdrawals/dismissals include academic failure or school policy violation; poor academic standing; transferring to another medical school; medical or personal reasons; changes in career plans; and failure to take or pass COMLEX (per COM policy). Reasons for leaves of absence include poor academic performance/remediation; academic enrichment/research/study for another degree; medical or personal reasons; and failure to take or pass COMLEX (per COM policy). AACOM only reports on those schools with a full four-year enrollment.

Attrition rates for all COMs ranged from a low of 2.63 percent (2009-2010) to a high of 3.59 percent (2012-2013), with an average 3.03 percent attrition rate from 2009-2010 through 2018-2019 (Table 1).¹¹ AACOM reports that first- and third-year students had a higher rate of attrition than their second- and fourth-year counterparts, due largely to the struggles first-year students experience when adjusting to the rigors of medical school and to COMLEX being administered to third-year students.

For-profit Medical Schools

Ponce Health Sciences University School of Medicine reports on its website that its average attrition rate for 2016-2017 was 2.3 percent (Table 1).¹² Although actual attrition rates are not available for California Northstate University College of Medicine, the school's website notes that a total of 60 new students enrolled in fall 2015, one student left the program, and three students fell back a year, with a total attrition of one student (1.7 percent).¹³ Rocky Vista University College of Osteopathic Medicine, the only COM that has a full class (four years of students enrolled), reports on its website that 91 percent of Title IV students complete the program within four years.¹⁴ Data on attrition rates for newer U.S. medical and osteopathic schools as well as offshore medical schools are not available.

FINANCIAL BURDEN

Not-for-profit U.S. Medical Schools

In 2018-2019, the median annual tuition and fees at state medical schools were \$38,202; at private medical schools the median cost was \$61,533 (Appendix B, Table 2).¹⁵ In 2019, for students who attended state medical schools, the median debt was \$190,000; for students who attended private medical schools, the median debt was \$210,000.¹⁵ The overall mean osteopathic medical education debt reported by academic year 2017-2018 graduates is \$254,953 (\$222,972 for public schools and \$261,133 for private schools).¹⁶

For-profit Medical Schools

The four-year estimated tuition, fees, and cost of attending a for-profit U.S. medical school can range from \$209,000 to \$342,000 (Table 2). Rocky Vista University College of Osteopathic Medicine reports that four-year estimated tuition, fees, and costs is \$215,748, and its typical graduate leaves with \$294,018 debt.¹⁷ Median student loan debt accrued for attending an offshore medical school ranges from \$191,500 (Ross University School of Medicine) to \$253,072 (American University of the Caribbean School of Medicine).⁷

SUCCESS OF U.S. GRADUATES IN OBTAINING A RESIDENCY POSITION

Not-for-profit U.S. Medical Schools

The National Resident Matching Program (NRMP) defines a successful match into a residency program as “one that is measured not just by volume, but also by how well it matches the preferences of applicants and program directors.”¹⁸ In 2019, U.S. allopathic medical school senior students comprised 18,925 of the active applicants, and the first-year post-graduate (PGY-1) Match rate for U.S. seniors was 93.9 percent.¹⁸

In 2019, the transition to a single accreditation system resulted in higher participation among students and graduates of U.S. osteopathic medical schools. An all-time high of 6,001 DO candidates submitted NRMP rank and order lists of programs, and the 84.6 percent PGY-1 match rate was the highest in history.¹⁸

Earlier Match data reflected NRMP and AOA National Matching Service (NMS) systems. Data reported by the COMs show that 98.7 percent of spring 2018 graduates seeking GME successfully placed into GME as of April 12, 2018.¹⁹ This represents 6,224 new physicians beginning their graduate medical education in July 2018.¹⁹ This compares to the 2017 match/placement process, when 5,898 new physicians entered GME (99.3 percent of graduates seeking GME) and 2016, when 5,356 graduates were successfully matched/placed—99.6 percent of graduates seeking to enter GME.¹⁹

The 2020 Match will be the first single match system administered by the NRMP, to include both allopathic and osteopathic residency programs. This single system will simplify the matching process for osteopathic medical school students. A result of the new process will be a shift in the way the Match rate percentage is reported.

For-profit Medical Schools

The California Northstate University College of Medicine class of 2019 had a 96.3 percent overall Match rate.²⁰ Rocky Vista University College of Osteopathic Medicine reported that the majority of students (79 percent) found a residency placement through the 2019 NRMP match, while other students matched into their top choices through the AOA Intern/Resident Registration Program (12 percent) or into military-specific residency programs (nine percent).²¹

However, fewer students matched into U.S. residency programs at some of the other for-profit schools. For example, Ponce Health Sciences University School of Medicine reported that its 2016-2017 initial residency Match rate (aside from the Supplemental Offer and Acceptance Program, or SOAP) was 89.4 percent, vs. 84.4 percent in 2017-2018.¹² In 2019, 5,080 U.S. IMGs (primarily graduates of offshore medical schools) participated in the NRMP, and 59 percent (n=2,997) successfully matched.¹⁸

LEVEL OF SUPPORT FOR GRADUATE MEDICAL EDUCATION

All U.S. allopathic and osteopathic medical schools are required to prepare their students to successfully transition into Accreditation Council for Graduate Medical Education (ACGME)-accredited GME programs. Two new for-profit osteopathic medical schools are in the process of developing their GME programs. Burrell College of Osteopathic Medicine at New Mexico State University has facilitated the ongoing development of new residency programs in family medicine, internal medicine, orthopaedic surgery, and osteopathic neuromusculoskeletal medicine, and

1 additional new GME programs are under development.²² The leadership at the Idaho College of
2 Osteopathic Medicine body is also focused on being able to provide its students with a high-quality
3 academic and clinical clerkship experience and facilitating their placement into ACGME-
4 accredited residency programs.²³

5
6 Concern has been raised about the paucity of academic teaching hospitals associated with some
7 for-profit medical schools. For example, students who attend Rocky Vista University College of
8 Osteopathic Medicine complete clinical rotations at various hospitals throughout the state of
9 Colorado and the mountain west region.²⁴ Third- and fourth-year medical students in their
10 clerkships could be sent for rotations to nonacademic community hospitals without a strong
11 background in education and research.²⁴ Although the college was established on the premise that
12 physicians practice in locations close to their residency or fellowship programs, many of the
13 graduates have had to leave the state to complete residency training requirements.²⁴

14
15 Offshore for-profit medical schools, including those in the Caribbean, continue to provide a large
16 number of medical school graduates who return to the United States for GME.²⁴ However, the
17 accreditation standards these schools are held to, if any, vary widely and may not require that the
18 schools provide career counseling or support for the transition of their students into ACGME-
19 accredited programs.²⁵

20 21 RELEVANT AMA POLICY

22
23 The AMA has extensive policy related to the cost and financing of medical education.

24
25 Policy H-305.925 (20f), “Principles of and Actions to Address Medical Education Costs and
26 Student Debt,” states that the costs of medical education should never be a barrier to the pursuit of
27 a career in medicine nor to the decision to practice in a given specialty. To help address this issue
28 related to the Public Service Loan Forgiveness (PSLF) Program, the AMA will advocate that the
29 profit status of a trainee’s institution not be a factor for PSLF eligibility.

30
31 Policy H-200.949 (3), “Principles of and Actions to Address Primary Care Workforce,” directs the
32 AMA, through its work with stakeholders, to encourage development and dissemination of
33 innovative models to recruit medical students interested in primary care, train primary care
34 physicians, and enhance both the perception and the reality of primary care practice, to encompass
35 the following components: a) Changes to medical school admissions and recruitment of medical
36 students to primary care specialties, including counseling of medical students as they develop their
37 career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded
38 financial aid and debt relief options; d) Financial and logistical support for primary care practice,
39 including adequate reimbursement, and enhancements to the practice environment to ensure
40 professional satisfaction and practice sustainability; and e) Support for research and advocacy
41 related to primary care.

42
43 Policy D-295.309, “Promoting and Reaffirming Domestic Medical School Clerkship Education,”
44 directs the AMA to support agreements for clerkship rotations, where permissible, for U.S. citizen
45 international medical students between foreign medical schools and teaching hospitals in regions
46 that are medically underserved and/or that lack medical schools and clinical sites for training
47 medical students, to maximize the cumulative clerkship experience for all students and to expose
48 these students to the possibility of medical practice in these areas.

49
50 Additional related policies are provided in Appendix C.

SUMMARY

Stigma and reputational challenges associated with for-profit medical schools can be traced back to the 1910 Flexner Report on Medical Education in the United States and Canada, which called for quality education that linked medical schools with universities and teaching hospitals.³ The report criticized for-profit schools, and the subsequent linkage between accreditation and licensure requirements led to the collapse of many proprietary medical schools. However, for-profit medical education has reemerged in the United States and has expanded in the Caribbean and elsewhere around the world.^{7, 24} The Ponce Health Sciences University School of Medicine was recently incorporated to facilitate the retention of public benefit.¹

For-profit schools are based on a tuition-dependent business model. For example, at Rocky Vista University College of Medicine approximately 80 percent of revenue, as with the other private osteopathic medical schools, comes from tuition and fees. In contrast, tuition and fees constitute only 14 percent of public osteopathic medical schools' revenues.²⁴

As with any medical school, for-profit medical schools may have a positive impact on the physician workforce. For example, the mission of California Northstate University College of Medicine is to train primary care physicians to serve the needs in underserved areas in northern California. As with other medical schools, however, the graduates of U.S. for-profit medical schools are subject to competition for residency placements. Graduates from for-profit medical schools in the Caribbean need to complete the requirements for ECFMG certification before they can apply for residency training in the United States.

Through its Council on Medical Education, the AMA will continue to monitor the development of for-profit medical schools, both allopathic and osteopathic, and report back to the House of Delegates as needed.

APPENDIX A

TABLE 1. ATTRITION RATE OF STUDENTS ATTENDING U.S. MEDICAL SCHOOLS

<i>Not-for-profit</i>	<i>Attrition Rate:</i>
U.S. allopathic medical schools	From 1993-1994 through 2012-2013, the total national attrition rate remained relatively stable at an average of 3.3%. ¹
U.S. osteopathic medical schools	From a low of 2.63% (2009-10) to a high of 3.59% (2012-13), with an average of 3.03% attrition rate from 2009-10 through 2018-19. ²
<i>For-profit*</i>	<i>Attrition Rate:</i>
Ponce Health Sciences University School of Medicine	Average attrition rate is 2.3%; retention rate is 97.7% (2016-2017) ³
California Northstate University College of Medicine**	Total of 60 new students enrolled in the Fall of 2015; one student left the program and three students fell back a year; the total attrition of 1 student (1.7%). ⁴
Rocky Vista University College of Osteopathic Medicine**	91% of Title IV students complete the program within 4 years with an attrition rate of 9%. ⁵
Burrell College of Osteopathic Medicine at New Mexico State University**	Matriculated 162 students in 2018; retained 154 (95.06%) with an attrition rate of 4.94%. ⁶
Idaho College of Osteopathic Medicine***	Matriculated its inaugural class in August 2018. This class of 2022 is composed of graduates from 97 U.S. colleges and universities, with above average composite medical board (MCAT) scores and highly competitive undergraduate grade point averages. ⁷
California Health Sciences University College of Osteopathic Medicine***	Campus construction underway with targeted completion date of Spring 2020.

* Similar quality data are not available from offshore medical schools

** Attrition rate is extrapolated from the retention rate posted on the medical school's website.

*** Data on attrition rates for newer U.S. medical schools are not yet available.

1. AAMC Data Snapshot. Association of American Medical Colleges. Available at: <https://www.aamc.org/download/492842/data/graduationratesandattritionratesofu.s.medicalstudents.pdf> (Accessed April 9, 2019).
2. 2019-2020 Student Guide to Osteopathic Medical Colleges. American Association of Colleges of Osteopathic Medicine. 2019. Available at: https://www.aacom.org/docs/default-source/presentations/student-guide-for-web-5-28-19.pdf?sfvrsn=4aab3d97_2 (Accessed July 2, 2019).
3. Consumer Information and Student Achievement Guide 2017-2018. Ponce Health Sciences University. Available at: <https://www.psm.edu/wp-content/uploads/2016/09/Ponce-Health-Sciences-University-Consumer-Information-and-Student-Achievement-Guide.pdf> (Accessed July 2, 2019).
4. California Northstate University Fact Book, 2017-2018. California Northstate University. Available at: <https://www.cnsu.edu/shareddocs/Fact-Book-2017-2018.pdf> (Accessed July 2, 2019).
5. RVU At A Glance. Rocky Vista University. Available at: <http://www.rvu.edu/about/rvu-at-a-glance/> (Accessed July 2, 2019).
6. Burrell College of Osteopathic Medicine Institutional Snapshot. Burrell College of Osteopathic Medicine. Available at: <https://bcomnm.org/wp-content/uploads/2019/05/Institutional-Snapshot.pdf> (Accessed July 2, 2019).
7. Idaho College of Osteopathic Medicine. About ICOM. Available at: <https://www.idahocom.org/> (Accessed July 2, 2019).

APPENDIX B

TABLE 2. FINANCIAL BURDEN OF NON-GRADUATES VERSUS GRADUATES OF U.S. MEDICAL SCHOOLS

<i>Not-for-profit</i>	<i>Financial Burden</i>
U.S. allopathic medical schools	In 2018-2019, the median annual tuition and fees at state medical schools were \$38,202; at private medical schools the median cost was \$61,533. ⁶ In 2019, for students who attended state medical schools the median debt was \$190,000; for students who attended private medical schools the median debt was \$210,000. ¹
U.S. osteopathic medical schools	The overall mean osteopathic medical education debt reported for academic year 2017-2018 graduates is \$254,953 (\$222,972 for public schools and \$261,133 for private schools). ²
<i>For-profit*</i>	<i>Financial Burden</i>
Ponce Health Sciences University School of Medicine	4-year estimated tuition, fees and costs range from \$233,456 to \$342,069. ³
California Northstate University College of Medicine	4-year estimated tuition, fees, and costs range from \$240,000 to \$255,000. ⁴
Rocky Vista University College of Osteopathic Medicine	4-year estimated tuition, fees, and cost are \$215,748; typical graduate leaves with \$294,018 in debt. ⁵
Burrell College of Osteopathic Medicine at New Mexico State University**	2018-2019 annual cost of attendance is \$80,165. ⁶
Idaho College of Osteopathic Medicine**	2018-2019 academic year annual tuition is \$49,750 plus \$2,500 in fees. ⁷
California Health Sciences University College of Osteopathic Medicine**	Fall 2020 enrollment annual cost of tuition is \$53,500. ⁸

*Data not available from offshore medical schools

**Data on student debt for newer U.S. medical schools are not yet available

1. Medical Student Education: Debt, Costs, and Loan Repayment Fact Card. Association of American Medical Colleges. Available at: https://store.aamc.org/downloadable/download/sample/sample_id/240/ (Accessed July 2, 2019).
2. 2017-2018 Academic Year Survey of Graduating Seniors Summary. American Association of Colleges of Osteopathic Medicine. Available at: https://www.aacom.org/docs/default-source/data-and-trends/aacom-2017-2018-academic-year-graduating-seniors-survey-summary-report.pdf?sfvrsn=e14d2197_6 (Accessed July 2, 2019).
3. Ponce Health Sciences University Educational Budget Academic Year 2019-2020 Doctor in Medicine Program (4 years). Ponce Health Sciences University. Available at: <https://www.psm.edu/coa/EDUC%20BUDGETS%20MD%204%20YRS.pdf> (Accessed July 23, 2019).
4. Cost of Attendance and Tuition and Fees. California Northstate University College of Medicine. Available at: <https://www.cnsu.edu/shareddocs/StudentFA/TuitionandFeesCOM2.pdf> (Accessed July 23, 2019).
5. Rocky Vista University. Available at: <http://www.rvu.edu/gedt/gedt.html> (Accessed July 16, 2019).
6. BCOM Estimated Cost of Attendance (COA). Burrell College of Osteopathic Medicine. Available at: <https://bcomnm.org/budgeting-your-education/> (Accessed July 23, 2019).
7. Idaho College of Osteopathic Medicine. Tuition, Fees & Financial Aid. Available at: <https://choosedo.org/idaho-college-of-osteopathic-medicine-icom/> (Accessed July 23, 2019).
8. California Health Sciences University College of Osteopathic Medicine. Tuition, Fees & Financial Aid. Available at: <https://choosedo.org/california-health-sciences-university-college-of-osteopathic-medicine-chsu-com/> (Accessed July 23, 2019).

APPENDIX C
AMA POLICY

D-305.954, “For-Profit Medical Schools or Colleges”

Our AMA will study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (a) attrition rate of students; (b) financial burden of non-graduates versus graduates; (c) success of graduates in obtaining a residency position; and (d) level of support for graduate medical education; and report back at the 2019 Annual Meeting.
(Res. 302, A-18)

H-305.988, “Cost and Financing of Medical Education and Availability of First-Year Residency Positions”

Our AMA:

1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
 2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
 3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
 4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
 5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
 6. supports continued study of the relationship between medical student indebtedness and career choice;
 7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
 8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
 9. encourages for-profit hospitals to participate in medical education and training;
 10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
 11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
 12. will advocate that resident and fellow trainees should not be financially responsible for their training.
- (CME Rep. A, I-83 Reaffirmed: CLRPD Rep. 1, I-93 Res. 313, I-95 Reaffirmed by CME Rep. 13, A-97 Modified: CME Rep. 7, A-05 Modified: CME Rep. 13, A-06 Appended: Res. 321, A-15 Reaffirmed: CME Rep. 05, A-16 Modified: CME Rep. 04, A-16)

H-305.925, “Principles of and Actions to Address Medical Education Costs and Student Debt”

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the 20/220 pathway, and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the cost of attendance; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to lock in a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

(CME Report 05, I-18 Appended: Res. 953, I-18 Reaffirmation: A-19)

H-200.949, "Principles of and Actions to Address Primary Care Workforce"

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.

2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).

3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and

enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and
e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice

in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

(CME Rep. 04, I-18)

D-295.309, "Promoting and Reaffirming Domestic Medical School Clerkship Education"

1. Our American Medical Association:

A. Will 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: (1) infrastructure and faculty development and capacity for medical school expansion; and (2) delivery of clinical clerkships and other educational experiences.

B. Encourages 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.

C. Advocates for federal and state legislation/regulations to: (1) 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); (2) Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and (3) 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.

D. Encourages 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.

E. Will 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. AMA policy is that 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. AMA policy is that 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.

(CME Rep. 01, I-17)

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