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ABSTRACT

Policies on U.S. citizens studying medicine abroad are reviewed, based on visits to six foreign medical schools in the Caribbean, Mexico, and Europe, which have about 5,400 U.S. citizens studying medicine, or about half of the total estimated number. The following areas are considered: education and training provided, clinical training in U.S. hospitals provided by U.S. citizens studying in foreign medical schools, avenues available for entering the American medical system, and federal financial assistance in the form of guaranteed student loans and educational benefits provided to these students. It is found that many U.S. citizens attend foreign medical schools with the goal of returning to practice in this country; however, the education and training provided by some of these schools vary greatly and may not be comparable to that offered in U.S. schools. It is recommended that more appropriate mechanisms be developed to ensure that all students who attend foreign medical schools demonstrate that their medical knowledge and skills are comparable to those of their U.S.-trained counterparts before they are allowed to enter the mainstream of American medicine. Alternatives to be considered in accomplishing this objective are suggested, including admission with advanced standing. Recommendations concerning guaranteed student loans and educational benefits, and U.S. hospital clinical training of foreign medical school students are also offered. Appendices include information on qualifying examinations, foreign medical schools, accrediting organizations in the United States, and communications among agencies. (SW)

BY THE COMPTROLLER GENERAL

# Report To The Congress

OF THE UNITED STATES

# Policies On U.S. Citizens Studying Medicine Abroad Need Review And Reappraisal

Many U.S. citizens attend foreign medical schools with the goal of returning to practice in this country. However, the education and training provided by some of these schools, in which several thousand U.S. citizens are enrolled, vary greatly and, in GAO's opinion, are not comparable to that offered in U.S. schools.

GAO recommends that more appropriate mechanisms be developed to ensure that all students who attend foreign medical schools demonstrate that their medical knowledge and skills are comparable to those of their U.S.-trained counterparts before they are allowed to enter the mainstream of American medicine. This report suggests several alternatives to be considered in accomplishing this objective.

GAO also recommends that (1) action be taken to address the practice of foreign medical school students receiving undergraduate clinical training in U.S. hospitals, (2) the Department of Education and VA ensure that guaranteed student loans and educational benefits go only to students at foreign medical schools providing an education comparable to that provided at U.S. schools, and (3) the Government's interest in outstanding guaranteed student loans for U.S. citizens studying medicine abroad be adequately protected.



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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-200077

To the President of the Senate and the
Speaker of the House of Representatives

This report summarizes our review of U.S. citizens studying medicine abroad. It discusses the:

--Education and training provided by six foreign medical schools, in which several thousand U.S. citizens are enrolled.

--Clinical training U.S. citizen foreign medical school students receive in U.S. hospitals.

--Avenues available for entering the American medical system.

--Federal financial assistance in the form of guaranteed student loans and educational benefits provided to U.S. citizens while studying medicine abroad.

We made our review at the request of the Chairman, House Committee on Interstate and Foreign Commerce, and the Ranking Minority Member, Subcommittee on Health and the Environment. Because of the widespread congressional interest in this matter, we are issuing our report to the Congress.

We are sending copies of this report to the Chairmen of interested congressional committees and subcommittees; the Director, Office of Management and Budget; the Secretary of Health and Human Services; the Secretary of Education; the Administrator of Veterans Affairs; the Secretary of State; and those entities responsible for the education, testing, and licensure of physicians in the United States.

Comptroller General
of the United States

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COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

# POLICIES ON U.S. CITIZENS STUDYING MEDICINE ABROAD NEED REVIEW AND REAPPRAISAL

## D I G E S T

Because of the intense competition for a limited number of slots in U.S. medical schools, many U.S. citizens attend foreign schools with the goal of returning to practice medicine. Much concern has been expressed about the recent proliferation of medical schools established to attract U.S. citizens, and questions have been raised about the adequacy and appropriateness of that educational experience for practicing in the United States.

GAO believes that:

--More appropriate mechanisms are needed to ensure that all students who attend foreign medical schools demonstrate that their medical knowledge and skills are comparable to their U.S.-trained counterparts before they are allowed to enter the mainstream of American medicine.

--Action should be taken concerning the practice of foreign medical school students receiving undergraduate clinical training in U.S. hospitals.

--The Department of Education and the Veterans Administration need to ensure that guaranteed student loans and educational benefits go only to students at medical schools providing an education comparable to that provided at U.S. schools and the Department of Education needs to ensure that the Government's interest in outstanding guaranteed loans for U.S. citizens studying medicine abroad is adequately protected.

The exact number of U.S. citizens studying medicine abroad is not known; however, GAO believes that there are about 10,000 to 11,000. About 63,800 medical students were enrolled in the 125 accredited U.S. medical schools during academic year 1979-80.

GAO recognizes that there are many first-rate medical schools in foreign countries which produce excellent physicians; that many distinguished scholars from medical schools around the world are welcomed to this country as teachers and practitioners and make a valuable contribution; and that, even with limitations in a medical school's educational capabilities, some students will do well because of their own ability and willingness to study and learn.

During its review, GAO visited six foreign medical schools that were selected primarily because large numbers of U.S. citizens either had studied or were studying at these schools. Because it was generally believed that the goal of most U.S. citizens attending foreign medical schools is to return to the United States to practice medicine, GAO believed it was necessary to compare the training received in medical schools abroad to that provided in the United States. GAO's review was made in this context.

## FOREIGN MEDICAL SCHOOLS VISITED DO NOT OFFER A COMPARABLE EDUCATION

The foreign medical schools GAO visited differed considerably, and the problems of each school must be evaluated separately. However, in GAO's opinion none of them offered a medical education comparable to that available in the United States because of deficiencies in admission requirements, facilities and equipment, faculty, curriculum, or clinical training. While it is difficult to judge the adequacy of the foreign medical schools in all of these areas, a serious shortcoming at each school was the

lack of adequate clinical training facilities. None of the foreign schools had access to the same range of clinical facilities and numbers and mix of patients as a U.S. medical school. (See p. 10 and apps. II to VII.)

## CLINICAL TRAINING IN U.S. HOSPITALS

Many U.S. citizen foreign medical school students obtained part or all of their undergraduate clinical training in U.S. hospitals. However, the type, length, and extent of training received at most U.S. hospitals participating in these arrangements that GAO visited varied greatly, and generally such training was not comparable to that provided to U.S. medical school students.

Moreover, most of the hospitals participating in these arrangements that GAO visited (1) were not affiliated with U.S. medical schools and (2) had little assurance that U.S. citizens from foreign medical schools were adequately and properly prepared for clinical training.

The Liaison Committee on Medical Education approves and accredits U.S. and Canadian medical schools, including their clinical training programs. This Committee, however, is not responsible for reviewing and approving other foreign medical schools or the clinical training programs provided in U.S. hospitals for U.S. citizens attending those foreign medical schools.

State medical licensing boards in California, New York, and Florida generally had not approved clinical training programs for foreign medical school students at hospitals in their States, nor were they aware of the extent to which such programs existed in their States. However, the New Jersey licensing board had approved some but not all such programs in New Jersey. (See p. 15.)

## FOREIGN-TRAINED U.S. CITIZENS ENTER THE AMERICAN MEDICAL SYSTEM IN VARIOUS WAYS

Foreign-trained U.S. citizens can enter the American medical system four ways:

--Transfer with advanced undergraduate standing to U.S. medical schools.

--Participate in a Fifth Pathway Program.

--Enter graduate medical education in the United States.

--Obtain a license to practice medicine from a jurisdiction authorized to license physicians. (See p. 23.)

### Transfer to U.S. schools

A May 1980 report to the Congress by the Department of Health and Human [illegible] (HH stated that U.S. cit[illegible]n foreign medical school students who transferred to U.S. medical schools generally had deficiencies in the clinical and basic sciences. [illegible]e p. 24.)

### Fifth Pathway Program

The Fifth Pathway Program is an alternative route to enter U.S. graduate medical education for U.S. citizens who attend foreign medical schools in countries that require a year of internship or social service to obtain their final degree and practice medicine. It provides a year of undergraduate clinical training in the United States under the supervision of a U.S. medical school. (See p 27.)

### Graduate medical education

Those U.S. citizens at foreign medical schools who are unable to pursue either of the first two alternatives usually enter the American

medical system by participating in graduate medical education programs conducted in the United States.

The American Medical Association's Center for Health Services Research and Development reports that about 2,300 U.S. citizen foreign medical school graduates were in U.S. graduate medical education training programs in 1979.

U.S. citizen foreign medical school graduates must pass the Educational Commission for Foreign Medical Graduates examination to enter graduate medical education in this country. Less than 50 percent of the U.S. citizens taking this examination each year pass, although the pass rate is reportedly higher for first-time takers than repeaters.

Nevertheless, members of the medical profession have questioned whether this screening examination is adequate to serve the purpose for which it is being used--both as a test of the readiness for graduate medical education and as an adequate safeguard of the health and welfare of patients.

Foreign citizen foreign medical school graduates, who may have attended the same foreign medical school, must pass the Visa Qualifying Examination to obtain a visa and participate in a U.S. graduate medical education program. However, some in the medical profession consider the Visa Qualifying Examination more comprehensive and difficult to pass than the examination given to U.S. citizen foreign medical school graduates. (See p. 29.)

## Licensure

Licensure for medical practice is a legal function of the 50 States, Guam, Puerto Rico, the Virgin Islands, and the District of Columbia. Although eligibility requirements differ among and within jurisdictions for U.S. and foreign medical school graduates, all applicants must submit evidence of their

undergraduate medical education. However, State licensing authorities have no way of adequately assessing the education and training provided in foreign medical schools in deciding whether the applicant is eligible to take the State licensing examination.

Most jurisdictions require that physicians trained in foreign medical schools obtain graduate medical education in order to be licensed, whereas a similar requirement may not be imposed on U.S. medical school graduates.

Specifically, according to information collected by the American Medical Association, 15 States do not require U.S. medical school graduates to obtain graduate medical education to be licensed. However, 12 of these States require graduate medical education for physicians trained in foreign medical schools. The other three States (Massachusetts, New Mexico, and Texas) do not require graduates of foreign medical schools to obtain graduate medical training to secure licensure. (See p. 32.)

FEDERAL FINANCIAL ASSISTANCE

Foreign medical schools do not receive direct Federal financial assistance. However, U.S. citizens attending approved schools are eligible for guaranteed student loans from the Department of Education (ED); qualified veterans, their spouses, and their dependents may receive Veterans Administration (VA) educational benefits.

Before authorizing guaranteed loans, ED is required by law to determine that the education and training provided is comparable to that available at a U.S. medical school. The VA Administrator may deny or discontinue educational benefits if such enrollment is determined not to be in the individual's or the Government's best interest. (See p. 39.)

In GAO's opinion, the approach used by ED and VA to make this comparability determination is inadequate. Both agencies primarily based their determination on the foreign schools' listing in the World Health Organization's "World Directory of Medical Schools." This approach only provides recognition of a medical school by the country's government--it does not provide sufficient information to assure that foreign medical schools are comparable to U.S. medical schools. (See p. 41.)

ED and VA have a somewhat common objective in evaluating foreign medical schools. However, each agency developed its own comparability criteria as a result of the recent proliferation of foreign medical schools that are attracting large numbers of U.S. citizens. (See p. 42.)

However, regulations establishing procedures and criteria for making comparability determinations have not been published by either agency even though the programs were enacted years ago. (See pp. 43 to 45.)

Over the past 10 years, VA has disbursed $5.6 million to 997 veterans and their spouses and dependents attending foreign medical schools.

During the same period, ED's records show that it guaranteed about 21,500 loans for over $45 million to U.S. citizens attending foreign medical schools. Based on ED's records, GAO estimates that interest subsidies, defaults, and other expenses for U.S. citizens receiving these loans have cost the Federal Government about $12.4 million during this period.

However, because the Department's accounting system does not provide accurate and complete information on the number or amount of guaranteed student loans and defaults, GAO is unable

to state precisely the program's cost. (See p. 45.)

PHYSICIAN SUPPLY IN THE UNITED STATES

During the past several years, HHS has stated that the Nation's shortage of physicians appears to have ended and that the United States could be producing an adequate or excess number of physicians by the end of this century. As a result, the administration and the Congress have begun taking steps to remove the incentives for increasing the number of U.S.-trained physicians.

In September 1980 additional steps to reduce the supply of physicians trained in the United States were recommended to the Secretary of HHS by the Graduate Medical Education National Advisory Committee. The Committee also recommended that action be taken to reduce the number of foreign medical school graduates, including U.S. citizens, who enter this country to practice medicine. (See pp. 5 and 37.)

CONCLUSION

GAO recognizes that U.S. citizens are free to go abroad to study medicine, and many will continue to do so with the ultimate goal of returning to the United States to practice medicine. Because there are no adequate means of evaluating the education and training provided by foreign medical schools, GAO believes that the Congress, the administration, State licensing authorities, and the medical profession need to consider how the issues discussed in this report can be best addressed and how the highest quality of patient care can be assured.

RECOMMENDATION TO THE CONGRESS

The Congress should direct the Secretary of HHS to work with State licensing authorities

and representatives of the medical profession to develop and implement appropriate mechanisms that would ensure that all students who attend foreign medical schools demonstrate that their medical knowledge and skills are comparable to those of their U.S.-trained counterparts before they are allowed to enter the U.S. health care delivery system for either graduate medical education or medical practice. GAO suggests a number of alternatives that should be considered in accomplishing this objective. (See p. 56.)

RECOMMENDATION TO
THE SECRETARY OF HHS

The Secretary of HHS, in cooperation with State licensing authorities and representatives of the medical profession, should address the current practice whereby students attending foreign medical schools receive part or all of their undergraduate clinical training in U.S. hospitals. (See p. 56.)

RECOMMENDATIONS TO
THE SECRETARY OF EDUCATION

The Secretary of Education should:

--Issue regulations establishing procedures and criteria for implementing the legislative requirement that ED ensure that foreign medical schools are comparable to medical schools in the United States before authorizing guaranteed student loans for U.S. citizens attending these schools.

--Ensure that the Government's interest in outstanding guaranteed student loans at foreign medical schools is adequately protected by properly verifying the status of all U.S. citizens with outstanding loans and initiating repayment where appropriate. (See p. 56.)

## RECOMMENDATION TO THE ADMINISTRATOR OF VETERANS AFFAIRS

The Administrator should accept foreign medical schools approved by the Secretary of Education as a basis for authorizing educational benefits to qualified veterans, their spouses, and their dependents. (See p. 56.)

## COMMENTS BY FEDERAL AGENCIES, STATE LICENSING AUTHORITIES, AND THE MEDICAL PROFESSION AND UNRESOLVED ISSUES

HHS, the Federation of State Medical Boards, the Association of American Medical Colleges, and the American Hospital Association generally agreed with the findings, conclusions, and recommendations in the draft report regarding the need to ensure that all students who attend foreign medical schools demonstrate that their medical knowledge and skills are comparable to their U.S.-trained counterparts before they are allowed to enter the U.S. health care delivery system.

The American Medical Association agreed with GAO's recommendation concerning clinical training in U.S. hospitals and stated that this is a valid issue for concern. However, the Association does not believe the Federal Government should become involved in accrediting programs or in establishing prerequisites for licensure or graduate medical education in the United States. The Association contends that adequate safeguards already exist and, therefore, further Federal regulation is inappropriate.

GAO disagrees and points out that HHS, the Federation of State Medical Boards, and other members of the medical profession reached different conclusions than the Association on this issue. Moreover, GAO did not recommend that the Federal Government assume responsibility for program accreditation or licensure. The report recognizes that this responsibility rests with State licensing

bodies and the medical profession. At the same time, however, GAO believes HHS can and should actively participate in these deliberations because the judgments involved, which affect U.S. citizens as well as foreign nationals, would benefit from public participation, an open deliberative forum, and a close relationship to the public policy development process to ensure equitable solutions that are sensitive to the needs and rights of all involved parties.

The Coordinating Council on Medical Education and its Liaison Committees on Undergraduate and Graduate Medical Education chose not to comment.

ED agreed with GAO's findings and recommendation regarding the need to issue regulations for assessing comparability to determine eligibility for the Guaranteed Student Loan Program. However, ED believes there may be ways other than issuing regulations to implement the intent of this recommendation. In view of the importance of this issue and the need for such regulations, we are concerned that the Department has not set forth a specific course of action it intends to take. ED agreed with GAO's recommendation to protect the Government's interest in outstanding guaranteed student loans for U.S. citizens studying medicine abroad.

VA said it has no objection to GAO's recommendation that it accept foreign medical schools approved by the Secretary of Education as a basis for authorizing educational benefits to qualified veterans, their spouses, and their dependents. VA stated, however, that its legislation and attendant regulations would have to be considered when evaluating the adequacy of any new ED standards.

GAO was informed that the Department of State had no disagreement with the draft report and therefore did not submit written comments.

Comments by Federal agencies and the medical profession are included as appendixes and are discussed in chapter 5.

Summaries of our observations on their medical education and training programs were sent to each of the foreign medical schools we visited. Their comments have been incorporated as appropriate and recognized in appendixes II to VII.

# Contents

## ABBREVIATIONS

| | |
|---|---|
| AAMC | Association of American Medical Colleges |
| AHA | American Hospital Association |
| AMA | American Medical Association |
| COTRANS | Coordinated Transfer Application System |
| ECFMG | Educational Commission for Foreign Medical Graduates |
| ED | Department of Education |
| FLEX | Federation Licensing Examination |
| GAO | General Accounting Office |
| GMENAC | Graduate Medical Education National Advisory Committee |
| HHS | Department of Health and Human Services |
| LCME | Liaison Committee on Medical Education |
| MSKP | Medical Sciences Knowledge Profile |
| NBME | National Board of Medical Examiners |
| VA | Veterans Administration |
| VQE | Visa Qualifying Examination |
| WHO | World Health Organization |

# CHAPTER 1

## INTRODUCTION

Despite significant growth in the enrollment capacity of U.S. medical schools, many who apply are not accepted because of the intense competition for a limited number of positions. As a result, substantial numbers of U.S. citizens attend foreign medical schools with the goal of practicing medicine in the United States. The exact number of U.S. citizens studying medicine abroad is not known. However, based on the number enrolled in the schools we visited and data obtained from other sources, we estimate that about 10,000 to 11,000 U.S. citizens are studying medicine abroad.

In the past, U.S. citizens unable to gain admission to U.S. medical schools generally attended European schools. However, in recent years, newly established schools in the Western Hemisphere, particularly in the Caribbean, have begun to attract these students.

Much concern has been expressed about the recent proliferation of foreign medical schools established to attract U.S. citizens who were unable to gain admission to medical schools in this country. Questions have been raised about the quality of medical education in those medical schools most willing to accept U.S. students and the adequacy and appropriateness of that educational experience as a preparation for practicing medicine in the United States.

## MEDICAL EDUCATION IN THE UNITED STATES 1/

In the United States, medical education usually begins with 3 or 4 years of college or university studies generally followed by 4 years at a medical school. For graduates wishing to specialize, this is followed by several years of graduate medical education.

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1/Information regarding medical education in the United States was obtained primarily from publications of the American Medical Association, the Association of American Medical Colleges, and the Liaison Committee on Medical Education.

The United States had 125 accredited medical schools with about 63,800 medical students enrolled for academic year 1979-80. The average first-year class had 133 students, and the average total enrollment was about 500. Medical students are selected on the basis of multiple criteria, including performance in premedical college coursework, scores on a standardized test of academic achievement, letters from college faculty, and evaluations obtained through personal interviews.

Despite increased enrollments at U.S. medical schools, many applicants cannot be accommodated. For example, first-year enrollments in U.S. medical schools increased by 89 percent (8,964 to 16,930) from 1966-67 to 1979-80. However, the number of applicants increased by 98 percent (18,250 to 36,137) during the same period, although it decreased somewhat in 1978-79.

Accreditation of U.S. medical schools

All U.S. medical schools are evaluated and expected to have adequate full-time faculties and facilities and to maintain standards of education that assure society and the medical profession that graduates are competent to practice medicine.

The responsibility for evaluating the soundness of the schools' education programs leading to the M.D. degree rests with the Liaison Committee on Medical Education (LCME), which is recognized as the official accrediting body for U.S. medical schools. LCME is a joint committee consisting of representatives from the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC). LCME also includes representatives from the Government and the public. Because Canadian medical schools are also evaluated and accredited by LCME and the Association of Canadian Medical Colleges, they are not viewed as "foreign" medical schools for the purposes of this report.

LCME has only general guidelines for accrediting medical schools. These guidelines--which deal with curriculum, administration, faculty, and facilities--are intended to assure that graduates of accredited schools meet appropriate national standards of medical education.

Upon a medical school's request, a formal survey is made 1 year before entrance of its first class. Favorable action in this survey results in "provisional accreditation," which assures students, the school, other organizations, and the public that the school is capable of providing a nationally acceptable education. During the school's fourth year of operation, a definitive formal survey is made. Favorable action at this time means that the school has met minimum standards for its entire 4-year period of training and the school is given "full accreditation."

LCME plans to survey each school at least every 10 years. Special consideration is given to particular institutional needs as identified by the school itself or by previous LCME accrediting action. Site visits, usually lasting 3 to 4 days, are conducted at the school. During these visits, the curriculum for the M.D. degree, teaching and evaluation methods, staff, facilities, and the resources available to meet the school's objectives are evaluated. Assessments are also made of the medical services, research, and graduate education.

Curriculum

The faculty at each medical school determines the curriculum. The medical school curriculum traditionally covers 4 years--the first 2 years are predominately devoted to basic sciences, and the last 2 to clinical training.

Basic science instruction, generally involving lectures, seminars, and laboratory work, is conducted in facilities often clustered in the immediate vicinity of the school's research laboratories and faculty offices.

During clinical training, students deal directly, under the supervision of the medical school faculty, with patients in a teaching hospital. Students are exposed to a variety of cases which become increasingly complex as they progress through medical school and into graduate medical education.

The number and mix of patients needed to carry out a school's program of clinical instruction varies, depending on the number of students, the curriculum, the institution's goals, and the involvement of other health professions' education programs.

To have access to enough patients suitable for teaching, medical schools generally depend on arrangements with several teaching hospitals and with other health service facilities, such as ambulatory clinics. Through these arrangements, the average medical school has access to about 3,100 beds, or an average of 6 beds per student.

The clinical educational periods, commonly referred to as clinical clerkships, are a large part of the medical school curriculum. They vary in length (from less than 1 week to as many as 14 weeks per clerkship, depending on the specialty and on the school). However, an average of seven clerkships are required lasting 4 to 12 weeks; they most frequently include internal medicine, obstetrics/gynecology, pediatrics, psychiatry, and surgery.

In addition to the broad study of physical and mental diseases, the school curriculum allows for the particular interests of each student by providing time for elective subjects. In most schools, the last year of the curriculum is essentially elective.

Facilities and equipment

Medical schools operate in physical facilities that vary in size, composition, configuration, age, and type of ownership. The facilities generally include classrooms, teaching and research laboratories, faculty and administrative offices, libraries, and specialized buildings.

Faculty

U.S. medical school faculties include physicians, biomedical scientists, behavioral scientists, and other scholars. They can be full-time salaried employees of the institution, part-time employees, or volunteers.

The medical school faculty serve several roles. They are involved in direct patient care activities, teaching, research, and other responsibilities. For academic year 1978-79, there were 46,598 full-time faculty members, or 1 for each 1.3 medical students. The full-time clinical faculty is about 2-1/2 to 3 times as large as the full-time basic science faculty. Additionally, there were 95,787 part-time and volunteer medical school faculty.

## Teaching hospitals and clinics

To acquaint students with a sufficient number and variety of cases, medical schools depend on affiliations with teaching hospitals and ambulatory care centers and on agreements with practicing physicians. Relatively few teaching hospitals are owned by the medical schools or by their parent universities. Most participate in the teaching programs of the schools through individually negotiated agreements that vary considerably even for a single school. However, agreements are based on medical school control and supervision of the teaching programs.

Each school generally has affiliation agreements with several hospitals, depending on the size of its student body and on the number and mix of patients needed. Not all patients are suitable subjects for teaching, and few hospitals offer the full range of specialties to which students must be exposed. Affiliations may be "major" or "limited," depending on the extent to which the clinical specialties and services of the hospital or ambulatory unit participate in the school's programs.

## PHYSICIAN SUPPLY IN THE UNITED STATES

During the past several years, the Department of Health and Human Services (HHS) has stated that the Nation's shortage of physicians appears to have ended and that the United States could be producing an adequate or an excess supply of physicians by the end of this century. As a result, the administration and the Congress have sought to remove the incentives for growth in the supply of physicians being trained in the United States.

Under the Health Professions Educational Assistance Act of 1976, HHS is required to report to the President and the Congress on the status of health personnel in the United States. The Department has prepared two reports, in August 1978 and in December 1979.

In its earlier report, the Department concluded that by 1990 the supply of physicians may exceed requirements. HHS' position was reaffirmed in an October 1978 speech by the Secretary before AAMC. He announced that the first tenet in a National Policy for Health Professions is that the Nation

faces an oversupply of doctors in the next decade. Unless we change direction, he warned, we will seriously aggravate the oversupply problem by the end of the century.

The December 1979 report, "A Report to the President and Congress on the Status of Health Professions Personnel in the United States," also concluded that the total physician supply will be greater than requirements in the years ahead. HHS projected that by 1990 there would be a requirement for 553,000 to 596,000 physicians, as compared with an anticipated supply of nearly 600,000. 1/ This is equivalent to about 245 physicians for each 100,000 people. Furthermore, the Department concluded that there was adequate training capacity to meet current and future U.S. needs.

As a result of these projections, HHS believes that Federal incentives to increase the enrollments at U.S. medical schools should be terminated. Since fiscal year 1979, the Department has taken steps to reduce incentives. For example, for fiscal years 1980 and 1981 HHS requested that capitation grants to U.S. medical schools be eliminated in order to remove incentives for unwarranted growth in the number of physicians being trained.

In its September 30, 1980, report to the Secretary of HHS, 2/ the Graduate Medical Education National Advisory Committee (GMENAC) estimated there would be a surplus of 70,000 3/ physicians by 1990. GMENAC attributed more than half of this estimated surplus to the influx of foreign medical school graduates. GMENAC was established in 1976 to advise the Secretary on the number of physicians needed

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1/HHS' supply projections assumed a net increase of about 2,300 foreign medical school graduates. HHS officials said this figure included only about 200 U.S. citizen foreign medical school graduates because they had little information on the number who return to practice medicine.

2/"Report of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services," September 1980.

3/GMENAC said, however, that the mathematical models used have a certain range of error and therefore caution should be used in viewing the magnitude of the surplus.

to bring supply and requirements into balance with the Nation's needs. Accordingly, GMENAC made a number of recommendations designed to reduce the number of U.S. medical school students. It further recommended that the number of foreign medical school graduates entering the United States be severely restricted.

GMENAC was particularly concerned about U.S. citizens who study medicine abroad and return to the United States to practice medicine. This concern was stimulated by the recent establishment of many new medical schools outside the United States. Therefore, GMENAC urged that the Federal Government adopt measures to substantially reduce this inflow. (See p. 37.)

## ORGANIZATIONS INVOLVED IN THE EDUCATION, TESTING, AND LICENSURE OF PHYSICIANS IN THE UNITED STATES

A number of organizations are involved in the education, testing, and licensure of physicians in the United States. Some of these organizations and their roles are briefly discussed in appendix I.

## OBJECTIVES, SCOPE, AND METHODOLOGY

This review was made at the request of the Chairman, House Committee on Interstate and Foreign Commerce, and the Ranking Minority Member, Subcommittee on Health and the Environment. It was conducted at the headquarters offices of HHS, 1/ the Department of Education (ED), 1/ the Department of State, and the Veterans Administration (VA).

We also visited six foreign medical schools in the Caribbean, Mexico, and Europe, which had about 5,400 U.S. citizens studying medicine--about half of the total number we estimate are studying medicine abroad. At these schools, we met with school administrators and faculty; obtained information on admission standards, curriculum content, and faculty credentials; and observed facilities and equipment. We also talked with U.S. citizens about their experiences at the schools and their future plans. The schools we visited, their locations, and dates of our visits are as follows:

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1/On May 4, 1980, the Department of Health, Education, and Welfare was replaced with two departments--HHS and ED.

| School and location | Date visited |
|---|---|
| Universidad Central del Este, San Pedro de Macoris, Dominican Republic | July 1979 |
| Universidad Nordestana, San Francisco de Macoris, Dominican Republic | July 1979 |
| St. George's University School of Medicine, Grenada, West Indies | Aug. 1979 |
| Universidad Autonoma De Guadalajara, Guadalajara, Mexico | Oct. 1979 |
| Universita Degli Studi Di Bologna, Bologna, Italy | Nov. 1979 |
| Universite de Bordeaux II, Bordeaux, France | Nov. 1979 |

These foreign medical schools were selected primarily because they either have or had a large enrollment of U.S. citizens.

We also met with foreign government health and education officials as well as representatives of each country's medical society to discuss the country's (1) requirements for establishing a medical school, (2) medical school evaluation procedures, and (3) supply of physicians.

During our visits to these foreign schools, we learned that many U.S. citizen foreign medical students obtained part or all of their undergraduate clinical training in U.S. hospitals under arrangements made by either the foreign medical schools or the students themselves. Therefore, to gain insight into such training provided in the United States, we reviewed clinical training programs offered U.S. citizen foreign medical school students at nine hospitals in three States--California, New York, and Florida. We also met with officials of these States' medical licensing boards to determine whether they were aware of the clinical training programs. Additionally, we discussed with New Jersey officials similar clinical training programs for foreign-trained U.S. citizens conducted in their State.

We also attempted to visit the American University of the Caribbean, which was located in Cincinnati, Ohio. We wanted to visit this school because it had the unique distinction of being a "foreign medical school" located in the

United States; however, we were refused access. At that time the school was in litigation with the State of Ohio about its right to operate without certification. The school later moved to the Caribbean island of Montserrat.

We also met with representatives of the Coordinating Council on Medical Education, LCME, the Liaison Committee on Graduate Medical Education, AAMC, the American Hospital Association (AHA), AMA, the National Board of Medical Examiners (NBME), and the Educational Commission for Foreign Medical Graduates (ECFMG).

Throughout this assignment, our audit staff was assisted by GAO's Chief Medical Advisor. This physician accompanied the staff on visits to the foreign medical schools, host country health and education organizations, U.S. hospitals, State medical licensing boards, and U.S. medical organizations.

## CHAPTER 2

## MANY U.S. CITIZENS ATTEND FOREIGN SCHOOLS WHICH DO NOT PROVIDE A MEDICAL EDUCATION COMPARABLE TO THAT AVAILABLE IN U.S. SCHOOLS

In our opinion, none of the foreign medical schools we visited offered a medical education comparable to that available in the United States because of deficiencies in one or more of the following areas--admission requirements, facilities, equipment, faculty, curriculum, or clinical training. While it is difficult to generalize about the adequacy of the foreign medical schools in all of these areas, a serious shortcoming we observed at each school was the lack of adequate clinical training facilities. None of the foreign schools had access to the range of clinical facilities and numbers and mix of patients as a U.S. school.

To supplement the inadequate clinical training opportunities at the foreign medical schools we visited, many U.S. citizens obtained part or all of their undergraduate clinical training in U.S. hospitals under arrangements made by either the foreign medical schools or themselves. However, the extent, length, and type of training they received at most of the U.S. hospitals we visited participating in these arrangements varied greatly and generally was not comparable to that available to U.S. medical school students. Further, for the most part, three of the four State medical licensing boards we contacted had not approved these clinical training programs for foreign medical schools, nor were they aware of the extent to which such programs existed in their States.

We recognize that there are many first-rate medical schools in foreign countries which produce excellent physicians; that many distinguished scholars from medical schools around the world are welcomed to this country as teachers and practitioners and make a valuable contribution; and that, even with limitations in a medical school's educational capabilities, some medical students will do well because of their own ability and willingness to study and learn.

It should be emphasized that we visited only six foreign medical schools and they were selected primarily because large numbers of U.S. citizens either had studied or were studying at these schools. Because it was generally believed that the goal of the U.S. citizens attending foreign medical schools is to return to the United States to practice medicine, we believed it was necessary to compare the training U.S. citizens received in medical schools abroad to that provided in the United States. Our review was made in this context.

## VISITS TO FOREIGN MEDICAL SCHOOLS

A great deal has been written about some foreign medical schools in recent years. Some schools have been criticized for their locations; their lack of faculty, facilities, and equipment; and their profit motives.

Some of the schools we visited had existed for hundreds of years and had only a few U.S. citizens. Other recently established schools apparently existed primarily because of the U.S. citizen enrollment. For example, three of the six schools we visited, with a combined enrollment of about 3,100 U.S. citizens, did not exist 10 years ago, and two of these were established in the past 4 years. It was obvious that some of the schools had made sizable investments in facilities and equipment, faculty, and curriculum with the intent of providing a quality medical education. It was not possible to determine what role financial gain played in the establishment of these schools, especially those that have existed for a long time.

Health officials in the countries we visited did not expect U.S. students to remain and practice medicine. The U.S. citizens we spoke with confirmed that they intended to return to the United States and practice medicine. Further, except in Grenada, we were told that each country had an adequate or in some instances an oversupply of physicians.

In every case, the administration and faculty of the schools we visited, as well as the country's health and education officials, were cooperative, helpful, and open during our discussions.

Students from the United States had many cultural and language adjustments to make in these countries. Foreign medical schools are quite different from U.S. schools. For example, at all except one school, lectures, laboratory sessions, and examinations were conducted in a foreign language. Moreover, because of different admission requirements, U.S. citizens often found themselves in classes with students who had not attended college.

The admission requirements, adequacy of facilities and equipment, size of student enrollment and faculty, and availability of clinical facilities varied considerably, and most were very different from what would be found at a U.S. medical school. Because of these differences, it is difficult to generalize about these foreign medical schools. However, a serious shortcoming at each foreign school was the lack of adequate clinical training facilities. None of them had access to the same amount of clinical facilities or patients as a U.S. medical school.

A summary of our overall observations on each of these areas follows. Detailed information on each school is contained in appendixes II to VII.

## Admission requirements

None of the foreign medical schools had admission requirements as stringent as those of U.S. medical schools. Most of the foreign schools we visited had "open" admissions policies for residents of the country whereby all applicants were qualified. However, admission requirements for U.S. citizens differed greatly. In this regard, only one of the schools we visited had an open admissions policy for foreign applicants, while some required only that foreign applicants have a high school degree and have completed certain basic premedical courses. Two of the schools specified that U.S. applicants should be able to meet the requirements for admission to a U.S. medical school. However, according to officials of these universities, exceptions were made.

## Curriculum

The foreign medical schools' curricula were similar to those of U.S. schools. However, at some of the schools, the lack of facilities, equipment, faculty, or clinical opportunities made the content of the curriculum less than what would be provided in a U.S. medical school.

The foreign medical schools we visited had on-campus programs of study lasting anywhere from 2 to 7 years. Graduation requirements at the schools included studies in the basic and clinical sciences, usually a 1-year internship program, and either a thesis or final exam. In addition, Mexico and the Dominican Republic required students to do a period of social service before receiving a final medical degree. During this period, students are expected to participate in patient care services in the surrounding communities.

Attendance at lectures and class demonstrations, as well as participation in clinical training, to the extent it was available, was not required at some of the foreign medical schools visited. This was due to the large number of students compared to the limited number of available facilities. Laboratory sessions at some of the medical schools were crowded and/or few in number.

Facilities and equipment

The foreign medical schools we visited differed greatly with regard to the adequacy and quality of facilities and equipment. Facilities at these schools ranged from old and dirty to modern and highly sophisticated. For example, one medical school was located in an old warehouse-type building, another in a renovated motel complex, and a third in a sprawling modern university with numerous campuses.

Basic science classrooms and laboratories were generally inadequate or insufficient to meet the needs of the large number of students enrolled at many of these medical schools. However, one school's basic science facilities were generally very good, although it did not have pharmacology, physiology, and biochemistry laboratories. One school had laboratories only for microbiology, histology, and hematology. At two schools, basic science laboratories were good, but most were devoted primarily to research and few were available for teaching.

Materials and equipment used in basic science laboratories were sufficient at some of the medical schools, but two schools had virtually no equipment. Students at these schools apparently learned the basic sciences from textbooks and lectures. The availability of cadavers varied greatly. Two of the foreign medical schools had no cadavers, two had only a few (at one of these schools, the cadavers were so old that clear identification of nerves, arteries, veins, and other tissues was difficult), and two had an adequate supply.

## Faculty

During our visits to foreign medical schools we had access to limited faculty vitae. Nevertheless, through discussions with students and numerous faculty members and a review of a limited number of faculty vitae, as well as a review of faculty hiring practices, it appears that most of the faculty at the foreign medical schools we visited were adequately trained to teach medical subjects.

The ratio of students to faculty was quite high at the two European medical schools we visited, and some faculty members indicated that this made effective teaching difficult. Faculty members at these two schools seemed to place higher priority on their research than on teaching. Research played a lesser role with faculty members at the medical schools in Mexico and the Caribbean. Officials at one university stated that research was not required of their faculty so that more emphasis could be placed on teaching.

At one foreign medical school in the Caribbean, some of the students with whom we spoke said that faculty members frequently missed class or arrived late. At another school, portions of the clinical training were supervised by students who were satisfying their social service requirements. At the schools we visited, however, it appeared that most lectures and laboratory demonstrations were taught by professors trained in their field.

## Clinical training

A major shortcoming we observed at each foreign medical school was the lack of adequate clinical training facilities. None of the schools had access to the same amount of clinical facilities or patients as would a U.S. medical school. The average U.S. medical school has access to about six beds per medical student; the schools we visited had an exceptionally large number of students compared to their available clinical facilities. For example, the largest foreign medical school we visited, the University of Bologna, had almost 13,000 medical students--almost 10 times the enrollment of the largest U.S. medical school--but it had access to only about 2,300 beds.

The foreign hospitals affiliated with the foreign medical schools we visited ranged from ill-equipped, primitive non-air-conditioned facilities to modern complexes equipped with sophisticated, up-to-date equipment. The equipment at the hospitals used by three of the schools was very limited, outdated, and in poor condition.

According to officials at the European medical schools we visited, opportunities for clinical training were severely limited because of the large enrollments. Students at one school were chosen for clinical training by a lottery or alphabetic selection process. Some faculty members at another school said U.S. citizens rarely participated in available clinical training opportunities at the university because they were motivated only to receive a degree and not to learn medicine. As a result, some U.S. citizens obtaining a medical education at those schools may complete medical school without having been exposed to a clinical patient in some of the important medical disciplines. For example, one student said he will not see a pediatric or obstetric patient before graduation.

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A recent report to the Congress by the Secretary of HHS identified similar deficiencies in the clinical and basic sciences education of U.S. citizens who attended foreign medical schools and later transferred to U.S. medical schools. (See p. 25.)

## CLINICAL TRAINING FOR U.S. CITIZEN FOREIGN MEDICAL SCHOOL STUDENTS IN U.S. HOSPITALS

Many U.S. citizen foreign medical school students obtained part or all of their undergraduate clinical training in a U.S. hospital through arrangements either they or the foreign medical school made. However, State medical licensing boards we contacted generally had not approved these clinical training programs for foreign medical schools, nor were they aware of the extent to which such programs existed in their States. Most of the hospitals we visited that were participating in these arrangements (1) were not teaching hospitals affiliated with U.S. medical schools, (2) did not offer clinical training opportunities comparable to those available to U.S. medical school students, and (3) had no assurance that U.S.

citizens from foreign medical schools were properly prepared for clinical training. Also, these clinical training programs were inadequately monitored by the foreign medical schools. In U.S. teaching hospitals these programs were often separate from the clinical training programs for students from U.S. medical schools.

LCME accredits U.S. medical schools, including their clinical training programs that are conducted in hospitals approved for teaching purposes. However, no such organization has responsibility for overseeing all undergraduate clinical training that U.S. citizen foreign medical school students receive in U.S. hospitals.

## State medical boards are generally not aware of clinical training programs for foreign medical school students

State medical licensing boards in California, New York, and Florida had generally not approved clinical training programs for foreign medical school students at hospitals in their States, nor were they aware of the extent to which such programs existed in their States. However, the New Jersey licensing board has approved a number of seventh and eighth semester clinical training programs.

Medical board officials in California, New York, and New Jersey said they require hospitals that provide clinical training programs for foreign medical school students to submit their programs for approval.

However, we found few instances in which the foreign medical schools or the U.S. hospitals that offered clinical training programs had submitted their programs to the State medical licensing board for approval. Specifically, officials and students at some of the foreign medical schools we visited told us of 19 California hospitals that offered clinical training programs for foreign medical school students. However, only nine of these hospitals had requested approval of their programs. Four of these hospitals requested approval after we advised them of the requirement. On the other hand, board officials in Florida said they have no such requirement.

The New York and New Jersey licensing boards recently expressed concern about the quality of such clinical training programs and the students from foreign medical schools. In

April 1980, the New Jersey Hospital Association was advised by the licensing board that only certain seventh and eighth semester clinical training programs for foreign medical school students had been reviewed and approved by the board. A New Jersey licensing board official told us the board had questioned the quality of training provided in fifth and sixth semester programs for foreign medical school students and, therefore, has not approved these programs. Accordingly, all hospitals in New Jersey were advised in February 1980 that fifth and sixth semester clinical training programs were illegal. In addition, one of the medical schools in the State advised its affiliated hospitals in December 1979 to stop offering clinical training programs to foreign medical students because their presence might jeopardize training provided U.S. medical school students at the hospitals.

In February 1980, New York State officials advised hospitals that only medical students enrolled in a medical education program that meets standards specified by the State may participate in a clinical training program at New York hospitals.

Clinical training arrangements with U.S. hospitals

According to officials and students at the foreign medical schools we visited, most hospitals that offer clinical training programs to U.S. citizen foreign medical school students are in large metropolitan areas in New York, New Jersey, Texas, Florida, and California. We were also told that:

--Some U.S. citizens enrolled at Central del Este, Bologna, and Bordeaux medical schools make their own arrangements for clinical training at U.S. hospitals.

--U.S. citizens at St. George's, Guadalajara, and Nordestana participate in clinical training programs under formal arrangements made by the foreign medical schools.

Clinical training received by students at U.S. hospitals is accepted toward degree requirements at four of the foreign medical schools we visited--Central del Este, St. George's, Guadalajara, and Nordestana. Students from Bologna and Bordeaux said they sought clinical training to satisfy a personal need rather than to meet the schools' degree requirements.

## Differences exist among U.S. hospitals visited

LCME evaluates and approves clinical training programs as part of its accreditation of U.S. and Canadian medical schools. Consequently, none of the clinical training programs for U.S. citizens attending foreign medical schools that we visited were approved by LCME.

U.S. medical schools have formal affiliation agreements with teaching hospitals for their clinical training programs. The agreements are based on medical school control and supervision of the training program. However, foreign medical schools exercised little control or supervision over the clinical training programs at the U.S. hospitals we visited.

Six of the nine clinical training programs we reviewed were at hospitals not affiliated with U.S. medical schools. Officials at two of the three hospitals that were affiliated with a U.S. medical school said the U.S. schools were not directly involved with the clinical training program offered foreign medical school students. Furthermore, the U.S. medical schools were not pleased with the presence of students from foreign medical schools at their affiliated hospitals.

The hospitals varied in size--six of the nine hospitals had fewer than 300 beds, and the other three had over 500 beds. Two of these larger hospitals were affiliated with U.S. medical schools and had a complete array of services, including medicine, surgery, obstetrics/gynecology, pediatrics, and psychiatry. At hospitals that were unable to provide training in one or more of these areas, we were advised that they sent students who requested the training to nearby hospitals which could provide the training.

Eight of the nine hospitals accepted U.S. citizen foreign medical school students based on a review of information provided by their foreign medical school, even though a recent study found that most of these students are not adequately prepared when they begin clinical training. One of the nine hospitals required students to pass either Part I of the National Board of Medical Examiners examination or the ECFMG examination before being accepted into clinical training.

U.S. citizen foreign medical school students we spoke with at one hospital said they began their foreign medical education without graduating from college. One U.S. citizen who was to begin his clinical training in the United States had completed only 1 year of college before attending a foreign medical school.

Eight of the nine hospitals did not charge U.S. citizen foreign medical school students tuition for their clinical training. The other hospital charged tuition--$2,000 per year per student--which, according to the hospital administrator, was to offset costs associated with the training program.

U.S. citizens at the four foreign medical schools we visited in Mexico and the Caribbean continue to pay tuition to the foreign medical school while participating in clinical training programs at U.S. hospitals. However, only two of the four schools pay some of the participating U.S. hospitals for such clinical training. For example, one of these foreign medical schools, St. George's, pays U.S. hospitals $1,000 per semester per student to defray the expenses of the hospitals' clinical training programs.

Administrators and medical directors at the U.S. hospitals we visited gave various reasons for having clinical training programs for U.S. foreign medical school students. Among these are:

--The medical staff's desire to do something to help students who are eventually going to practice medicine in the United States.

--The possibility that some students will return as residents and ultimately practice in the area.

--The desire on the part of the medical staff to improve themselves.

--The fact that the medical staff enjoys teaching.

--The prestige for the hospital and medical staff.

Other factors also seemed to influence hospitals' decisions to provide clinical training programs to U.S. citizens attending foreign medical schools. For example, a staff physician at

a U.S. hospital we visited said that his daughter, his son-in-law, and five other relatives attended a foreign medical school which used that hospital as part of its clinical training program.

## Clinical training programs differ, and most are not comparable to those of U.S. medical schools

The length, type, and extent of clinical training received by U.S. citizen foreign medical school students at the U.S. hospitals we visited varied greatly and, in most cases, was not comparable to what students in a U.S. medical school receive.

### Curriculum

The curricula of U.S. medical schools vary, but generally include 2 years of clinical training. An average of seven clerkships are required, lasting 4 to 12 weeks and usually including internal medicine, obstetrics/gynecology, pediatrics, psychiatry, and surgery. The U.S. medical school students are in direct contact with patients during their clinical clerkship. Further, they are exposed to a variety of cases in teaching hospitals and frequently, under supervision, perform surgical and medical procedures on patients.

However, most of the U.S. citizen foreign medical school students at the hospitals we visited could only rotate through a maximum of five basic clinical areas--general medicine, surgery, obstetrics/gynecology, pediatrics, and psychiatry. Furthermore, the extent, type, and length of training in these clinical areas varied.

In some instances, students did not receive training in all five areas. For example, one of the hospitals we visited permitted U.S. citizen foreign medical school students to take clinical electives only after they completed a basic course in physical diagnosis and appropriate basic clinical clerkship in the area of the elective. These students were limited to 12 weeks during an academic year. U.S. citizen foreign medical school students at another hospital were permitted to do a rotating externship consisting of 3 months each in medicine, surgery, obstetrics/gynecology, and pediatrics but not psychiatry.

Additionally, some of the clinical rotations for U.S. citizen foreign medical school students at the hospitals we visited were insufficient to provide a thorough understanding in the subject matter. For example, several of the hospitals had limited facilities for obstetrics and/or pediatrics.

For the most part, the U.S. citizen foreign medical school student was an observer during his or her period of U.S. clinical training, and the student did little in terms of "hands on" procedures. The student was generally assigned two patients each day. In most cases, he or she accompanied a physician, took a history, and did the physical examination. Although the history and physical examination performed by the student was generally countersigned by a physician, it was not made a part of the patient's record.

The students were generally allowed to attend lectures and conferences given by the medical staff and guest lecturers. Some hospitals offered many lectures, whereas others offered few. Some hospitals provided special lectures for students, while others provided lectures only as part of the hospital's continuing medical education program.

Faculty

U.S. medical school faculty play various roles. In addition to education and research, three-quarters of the clinical faculty are involved in direct patient care activities. A large but undetermined number of faculty participate in other activities, such as continuing medical education, professional standards review, and maintenance of ethical norms.

However, at the six hospitals we visited, which were not affiliated with U.S. medical schools, physicians without medical school teaching appointments generally taught U.S. citizen foreign medical school students.

Inadequate supervision and monitoring

According to university officials at St. George's and Guadalajara, representatives from their medical schools monitor the clinical training programs at U.S. hospitals to ensure adequacy and completeness. However, our visits to some of the hospitals used by students raised questions about the extent of such monitoring. For example, the clinical training coordinator at one hospital advised us that no faculty member from Guadalajara had visited the hospital since the affiliation began over 3 years earlier.

Officials at one U.S. hospital, affiliated with Nordestana, said they exposed students to clinical subjects that the students said they would be tested on when they returned to the foreign school.

U.S. citizens from foreign medical schools who made their own arrangements for training in U.S. hospitals were not supervised or monitored by their medical schools. Therefore, the foreign medical schools may be unaware of the extent, type, or length of clinical training many of their students actually receive at U.S. hospitals.

## CHAPTER 3

## ALTERNATIVE ROUTES FOR ENTERING THE AMERICAN MEDICAL SYSTEM

The goal of U.S. citizens studying at foreign medical schools with whom we spoke is to return and practice medicine in the United States. Four routes are available to such persons to enter the American medical system.

--Transfer with advanced undergraduate standing to U.S. medical schools.

--Participate in a Fifth Pathway Program.

--Enter graduate medical education in the United States.

--Obtain a license to practice medicine from a jurisdiction authorized to license physicians.

All four routes require passing a standardized examination, which is generally designed to measure the individual's medical knowledge and proficiency. The examination may be the NBME examination, the ECFMG examination, or the Federation Licensing Examination (FLEX).

A recent study submitted to the Congress by HHS found that U.S. citizen foreign medical school students generally had deficiencies in the clinical and basic sciences when they transferred to U.S. medical schools. In addition, we observed that:

--Requirements for entering graduate medical education differ for U.S. medical school graduates, U.S. citizen foreign medical school graduates, and foreign citizen foreign medical school graduates.

--Concerns have been raised that the present examination (ECFMG) used to screen U.S. citizen foreign medical school students for graduate medical education is no longer being used for its original purpose and is not sufficiently rigorous for testing an individual's readiness to pursue graduate medical education or as an adequate safeguard of the health and welfare of patients.

--Foreign-trained graduates who are not U.S. citizens and are seeking a visa to come to the United States for graduate medical education now take an examination (VQE) that some in the medical profession consider more comprehensive and difficult to pass than the examination (ECFMG) taken by U.S. citizen foreign medical school graduates even though they may have attended the same foreign medical school.

Moreover, some State licensing boards have become increasingly concerned about the difficulty in assessing the quality of applicants' foreign medical education. Therefore, the Federation of State Medical Boards recently established a commission to evaluate foreign medical schools as an interim measure to help licensing boards determine whether a candidate for licensure has an adequate medical education.

ADMISSION WITH ADVANCED STANDING

One alternative for the U.S. citizen foreign medical school students is to transfer with advanced standing to a U.S. medical school. To assist such students, AAMC and NBME in 1970 established the Coordinated Transfer Application System (COTRANS). Under this system, sponsored by AAMC, eligibility for taking the NBME Part I examination for evaluation purposes was established; selected U.S. citizen foreign medical school students were sponsored for the examination; and test scores were disseminated to interested medical schools. Beginning in 1980, the COTRANS program was replaced by the Medical Sciences Knowledge Profile (MSKP) Program, sponsored by AAMC. The MSKP examination has been developed for this purpose. (See app. X for a description of the NBME Part I examination and app. XIV for a description of the MSKP examination, which was administered for the first time in June 1980.)

The number of U.S. citizen foreign medical school students who transferred to U.S. medical schools increased from 162 in academic year 1971-72 to 401 in 1977-78. In 1978-79, 858 U.S. citizen foreign medical school students transferred. The large 1-year increase occurred as a result of the provisions of the Public Health Service Act, as amended by Public Law 95-215. To remain eligible for Federal capitation funds, U.S. medical schools were required to accept as transfer students enough U.S. citizens studying abroad or in other advanced degree programs to increase enrollment by 5 percent of their first- or third-year full-time enrollment, whichever

was less. Because the legislation was applicable to one academic year, the number of students transferring in 1979-80 dropped to 318.

Most students who succeeded in transferring to U.S. medical schools cannot be considered representative of the total group of U.S. citizens studying medicine in foreign countries. The criteria for transfer were quite restrictive, including passing the NBME Part I examination during the period 1970 through 1979, and beginning in 1980, presenting a score on the MSKP examination in addition to meeting the U.S. medical school's standards. Accordingly, the transfer students can be considered the "cream of the crop" of U.S. citizens studying medicine abroad.

Section 782 of the Public Health Service Act, as amended by the Health Professions Educational Assistance Act of 1976 (Public Law 94-484), authorized grants to U.S. medical schools to conduct training programs for U.S. citizens who transfer from foreign medical schools with advanced standing. This training was intended to assist these U.S. citizen foreign medical school students to overcome their educational deficiencies.

Schools receiving grants were required to submit to the Secretary of HHS a report of any deficiencies the school identified in the foreign medical education of its transferees. The law further required the Secretary to compile the reports submitted by the schools and submit an evaluation of the information contained therein to the Congress.

This study, 1/ provided to the Congress on May 13, 1980, found that U.S. citizen foreign medical school students who transferred to U.S. medical schools had major deficiencies in the clinical sciences but relatively modest deficiencies in the basic sciences. The study was based primarily on analysis of student transcripts and anecdotal comments of about 200 transfer students, including U.S. citizens from four of the six medical schools we visited.

An analysis of student transcripts revealed that they received relatively limited training in clinical skills in the first 2 years of medical school. Training in physical

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1/"Analysis of Deficiencies in the Foreign Medical Education of U.S. Foreign Medical Student Transferees."

examination, medical history taking, physical diagnosis, case presentation and report writing, and the use of instruments was reported deficient by many of the transfer students.

The study commented that the presence of a course in a school's curriculum did not assure that the required material was adequately taught. It cited student views on weakness in the basic science curriculum, including (1) obsolesence and fragmentation of material, (2) absence or inadequacy of laboratory experience, (3) lack of clinical correlation, and (4) abbreviated nature of courses.

Specifically, the report said that

"* * * a review of USFMS (United States Foreign Medical Students) transcripts revealed that the great majority of required basic science courses were present in foreign medical school curricula. Behavioral science was the only course with an absence rate greater than 11 percent. However, anecdotal comments supplied by the transfer students and grantee faculty pointed to less obvious deficiencies in basic scie curricula, teaching methods, faculty, and facilities. For example many students noted the absence or limited emphasis on laboratory work in such courses as anatomy, physiology, microbiology, and pathology. Instruction in dissection was considered weak; the difficulty of obtaining satisfactory cadavers was noted. Further, laboratory equipment and facilities, audiovisual equipment, and teaching aids used in support of basic science instruction were considered deficient by many students. Some students complained about the emphasis on lectures and "rote" learning as opposed to problem-oriented approaches, practical experience, and student-faculty interaction. Although the extent of deficiencies (as noted by USFMS) varied somewhat between Mexican and European medical schools, there are enough common items to suggest that foreign medical education in the basic sciences would not meet the standards of many U.S. medical schools."

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"* * * An analysis of student transcripts revealed that the USFMS received relatively limited training in clinical skills in the first two years of medical school. Training in physical examination, medical history taking, physical diagnosis, case presentation and report writing, and the use of instruments was reported deficient by many of the transfer students. Unlike the basic sciences, these deficiencies were corroborated by clinical examinations that many grantees (U.S. medical schools) gave the USFMS upon their entry into the remedial programs."

The study suggested, however, that the U.S. medical schools were successful in remedying student deficiencies, based upon a comparison of pre- and post-course scores that transfer students received on clinical examinations administered by the grantees. U.S. medical school grantees indicated that the great majority of the students were functioning at the level required by their respective schools at the conclusion of the remedial program. In addition, students who later took an official NBME Part I examination improved significantly in six of the eight subjects tested. Their post-course scores were comparable to the mean of U.S. medical students.

FIFTH PATHWAY

Certain foreign countries require medical students to do a year of internship and/or social service before the final medical degree and license to practice medicine can be granted. In response to appeals from U.S. citizen foreign medical school students and other concerned parties, the AMA Council on Medical Education issued a policy statement in June 1971 recognizing the Fifth Pathway Program as an alternate route to enter graduate medical education for U.S. citizens who attend foreign medical schools in countries that require a period of internship and/or social service. According to AMA, "The fifth pathway program is considered to provide an undergraduate experience analogous to the third year core clinical curriculum of a U.S. medical school and is considered to provide a remedial supervised and evaluated clinical experience."

About a third of U.S. medical schools offer Fifth Pathway Programs to U.S. citizens who attended foreign medical schools. To be eligible these students must have completed their premedical education in the United States 1/ and completed all but the internship or social service requirements of the foreign medical school. A U.S. citizen at the Autonomous University of Guadalajara, for example, who is unwilling to perform the years of internship and social service required to receive his or her final medical degree completes 4 years of formal medical training, passes a screening examination, and then completes a Fifth Pathway Program (an additional year of clinical training supervised by a U.S. medical school) in order to enter graduate medical education.

The Fifth Pathway Program provides for a year of clinical training in the United States under the supervision of a U.S. medical school. Fifth Pathway students are required to pass a screening examination satisfactory to the U.S. medical school sponsoring the program. The ECFMG examination is generally used for this purpose. (See app. VIII for a description of the ECFMG examination.) U.S. medical schools may also require that applicants undergo a personal interview and present transcripts of their premedical undergraduate and foreign medical studies. In some instances, Fifth Pathway Programs are open only to students who are residents of the State when they began their medical study abroad. Candidates who successfully complete this year of clinical training are eligible for graduate medical education whether or not they have their final medical degree and/or ECFMG certification. Moreover, according to the March 7, 1980, Journal of the American Medical Association, some States, upon the student's meeting other eligibility requirements, including passing the State licensing examination, will grant a license to Fifth Pathway Program graduates and permit them to use the title "Doctor of Medicine."

The program has grown considerably from the 1973-74 academic year, when U.S. medical schools received 197 applications and admitted 126 students. For academic year 1978-79, U.S. medical schools received about 2,854 applications for a Fifth Pathway clerkship from U.S. students in foreign medical

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1/However, U.S. citizenship is not required for participation in a Fifth Pathway Program.

schools. The schools enrolled 515 students, of whom 461 successfully completed the program and presumably entered graduate medical education.

## ENTRY INTO GRADUATE MEDICAL EDUCATION

U.S. citizens at foreign medical schools who are unable to transfer with advanced standing to a U.S. medical school or participate in a Fifth Pathway Program usually enter the American medical system by participating in U.S. graduate medical education, which is required for licensure in most States. Specifically, all but 3 of the 54 licensing jurisdictions require graduates of foreign medical schools to have some U.S. graduate medical education in order to be licensed. AMA's Center for Health Services Research and Development reported that about 2,300 U.S. citizen foreign medical school graduates were in U.S. graduate medical training programs in 1979.

### Admission requirements differ

The admission requirements for graduate medical education differ for U.S. medical school graduates, U.S. citizen foreign medical school graduates, and foreign citizen foreign medical school graduates.

Before entering graduate medical education, U.S. medical school graduates must have graduated from accredited medical schools. Moreover, by the time they enter graduate medical education, most U.S. medical school graduates have taken NBME Parts I and II examinations either by choice for obtaining National Board certification leading to licensure or in order to meet stated requirements of their medical schools.

However, because U.S. citizen foreign medical school graduates have not attended accredited U.S. medical schools, the Liaison Committee on Graduate Medical Education requires them to pass the ECFMG examination and obtain certification before they are allowed to begin graduate medical education. To become certified by ECFMG, the U.S. citizen foreign medical school graduate must, among other things, have attended a school listed in the World Directory of Medical Schools and completed all educational requirements to practice medicine in the country of their school. However, listing in this publication does not constitute accreditation, recognition, or approval of the World Health Organization (WHO), as discussed in chapter 4.

The foreign citizen medical school graduate must now take and pass the Visa Qualifying Examination (VQE) to obtain a visa and participate in a U.S. graduate medical education program. 1/ The Health Professions Educational Assistanc Act of 1976 (Public Law 94-484) amended the Immigration and Naturalization Act to require that foreign citizen foreign medical school graduates pass the NBME Parts I and II examinations or an examination determined to be equivalent by the Secretary of HHS. The VQE is considered, for purposes of the law, equivalent to the NBME Parts I and II examinations. Before the 1976 act, foreign citizen foreign medical school graduates were required to pass the ECFMG examination.

Examinations for graduate medical education

NBME developed a series of standardized medical examinations that are used to measure medical proficiency of U.S. and foreign medical school graduates. The screening examinations for graduate medical education include the ECFMG examination given to U.S. citizen foreign medical school students and the VQE given to foreign citizen foreign medical graduates. These examinations are derived from a common universe of subject matter and questions. Each examination is, however, custom designed to serve the particular purposes for which it was developed. (These examinations are described in apps. VIII and IX.)

Educational Commission for Foreign Medical Graduates examination

In 1973, NBME's Committee on Goals and Priorities stated that

> "* * * there is increasing concern that the examination [ECFMG examination] is inadequate to serve the purpose for which it is being used. Although the examination assesses cognitive information to a reasonable degree, it was not designed to assess capacity for problem solving, attitudes, behavior, or clinical skills." 2/

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1/According to AMA, the ECFMG examination is also given to alien foreign medical school graduates who are in the United States under special immigration circumstances.

2/"Evaluation in the Continuum of Medical Education."

A June 21, 1974, AAMC task force report 1/ on foreign medical school graduates stated that the ECFMG examination was inadequate to measure competency for undertaking graduate medical education. The ECFMG examination was originally intended to determine if foreign medical school graduates would benefit from graduate medical education in the United States. However, the task force implied that the examination could not substitute for rigorous competitive admission standards and the preclinical and clinical training process required of U.S. medical school graduates. Similar views have been expressed by others in the medical profession.

A review of the test performance of U.S. citizens at foreign medical schools on the ECFMG examination showed that less than 50 percent pass. 2/ Over the past 5 years (1975-79), the pass rate for all U.S. citizens ranged from 34 to 41 percent, according to data published by ECFMG. 3/ However, according to NBME, the pass rate is higher for first-takers than repeaters. Many of those who passed the examination repeated it one or more times. NBME estimated that, based on U.S. medical school students' performance on NBME Parts I and II of the examinations, about 95 percent of these students would pass the ECFMG examination if they took it near the end of medical school.

Visa Qualifying Examination

The VQE is taken by foreign citizens who graduated from foreign medical schools and are seeking a visa to come to the United States for graduate medical education. This

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1/"Graduates of Foreign Medical Schools in the United States: A Challenge to Medical Education."

2/Information regarding the ECFMG examination and pass rates was obtained from data published annually by ECFMG.

3/In commenting on a draft of this report, ECFMG and NBME suggested different pass rates for this period. In subsequent discussions with NBME officials, however, we were informed that their figures included only mainland, non-Puerto Rican U.S. citizens with at least 2 years undergraduate studies in the United States. These officials stated that such persons most closely resembled the background of U.S. medical school students for comparison purposes.

examination has been accepted by the Secretary of HHS as equivalent to NBME Parts I and II for this purpose. The VQE was given for the first time in 1977. Over the past 3 years, the pass rate of foreign citizen foreign medical school graduates ranged from about 25 to 30 percent. 1/

Some in the medical profession consider the VQE more comprehensive and difficult to pass than the ECFMG examination. In contrast to the ECFMG examination, both the VQE and NBME Parts I and II examinations have an equal number of questions from the basic and clinical sciences. Further, the test performance of foreign citizen foreign medical school graduates indicates that the ECFMG examination may be easier to pass than the VQE. For example, 37 percent of the foreign citizen foreign medical school students or graduates who took the ECFMG examination in 1979 passed, while only about 30 percent who took the VQE passed. Furthermore, according to NBME, "* * * all VQE examiners had passed an English language requirement prior to taking the test whereas a number of the ECFMG examinees had not passed such a requirement." AMA pointed out that the ECFMG examination could be taken at an earlier stage of medical education than the VQE and that this may explain, at least partially, the higher failure rate on the ECFMG examination.

MEDICAL LICENSURE

Licensure for medical practice is a legal function of the 50 States, Guam, Puerto Rico, the Virgin Islands, and the District of Columbia. Although eligibility requirements differ among and within jurisdictions for U.S. and foreign medical school graduates, all 54 jurisdictions require completion of medical school and successful passage through the FLEX or endorsement of NBME examinations before an individual may begin independent medical practice. All jurisdictions consider Canadian citizens who graduated from approved Canadian medical schools on the same basis for licensure as graduates of U.S. medical schools. Further, 39 of the jurisdictions require 1 or 2 years of graduate medical training

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1/Information regarding pass rates on the VQE was obtained from ECFMG and NBME.

in an accredited program before licensure. Other qualifications are also usually required. 1/

All States and the District of Columbia have adopted the FLEX as their State medical licensing examination. Eligibility to take the examination is determined by the various State medical licensing boards. About 80 to 85 percent of U.S. medical school graduates are now licensed by endorsement of their NBME certification. Those who are not licensed by endorsement must pass the FLEX. However, graduates of foreign medical schools are not eligible to take the NBME certifying examinations and, therefore, must pass the FLEX.

The NBME examinations are divided into three parts. A candidate who has received the M.D. degree from an accredited U.S. or Canadian medical school, who has passed all three examinations, and who has also satisfactorily completed 1 year of approved graduate medical education, is eligible for NBME certification. Only students or graduates of accredited U.S. or Canadian medical schools may take the three National Board examinations. (See apps. X to XII for a description of these examinations.)

U.S. citizen foreign medical school students who took the NBME Part I examination under the COTRANS program in order to apply for transfer to a U.S. medical school did not perform as well as their U.S. medical school counterparts on the Part I examination. For example, 946 (or 51 percent) of the 1,855 U.S. citizen foreign medical school students who took the examination under COTRANS in 1978 passed, compared to 11,607 (or 84 percent) of the 13,797 U.S. medical school students who took Part I.

Over the past 9 years (1970-78), the pass rate for U.S. medical school students on the Part II examination has been over 96 percent. During the same period, the pass rate for U.S. medical school graduates on the Part III examination has been over 97 percent.

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1/Physician Distribution and Medical Licensure in the U.S., 1978. Center for Health Services Research and Development, AMA.

Foreign medical school graduates (including U.S. and foreign citizens) have not performed as well as their U.S.-trained counterparts on the FLEX. For examinations given between June 1968 and June 1979, only 47 percent of the foreign medical school graduates passed, compared to 87 percent of the U.S. medical school graduates. 1/ A Federation of State Medical Boards' official said data were not available to differentiate between the test results of foreign and U.S. citizen graduates of foreign medical schools.

According to information collected by AMA, 2/ 15 States do not require U.S. medical school graduates to obtain graduate medical education to be licensed. However, 12 of these States require graduate medical education for foreign-trained physicians. The other three States (Massachusetts, New Mexico, and Texas) do not require graduates of foreign medical schools to obtain graduate medical training.

To be licensed, graduates of U.S. and Canadian medical schools must have attended a medical school accredited by LCME. Although LCME does not evaluate or accredit other foreign medical schools, their graduates are eligible for licensure in the United States. Paradoxically, a graduate of an unaccredited U.S. medical school would not be eligible for licensure, whereas a graduate of a foreign medical school would be. For example, had the American University of the Caribbean remained in Cincinnati, Ohio, its graduates would have been ineligible for licensure in the United States because its graduates would have graduated from an unaccredited U.S. medical school. However, now that it has moved to the Island of Montserrat, its graduates will presumably be eligible for licensure in the United States.

State medical licensing boards cannot adequately evaluate foreign medical education

State licensing boards require foreign medical school graduates to submit evidence of their undergraduate medical education. However, State licensing officials have no adequate way of assessing the quality of foreign medical

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1/Information regarding FLEX pass rates was provided by the Federation of State Medical Boards.

2/Physician Distribution and Medical Licensure in the U.S., 1978.

education. In contrast to accredited U.S. medical schools, there is generally no accrediting body for foreign medical schools. Therefore, State licensing authorities must rely on documents provided by the students and their ability to pass the FLEX. For example, the executive director of one State medical board we visited said they do not evaluate credentials from foreign medical schools and know nothing about specific foreign schools.

Some State licensing boards are becoming increasingly concerned about the difficulty in assessing the quality of applicants' foreign medical education before issuing licenses. As a result, the Federation of State Medical Boards recently established a commission to evaluate foreign medical schools as an interim measure to help licensing boards determine whether a candidate for licensure has an adequate medical education. (See p. 61.)

## EMERGING DEVELOPMENTS

During our review we learned that NBME was working on a new medical examination--the Comprehensive Qualifying Examination--which could affect the routes by which graduates of foreign medical schools enter the U.S. medical system. Additionally, the Federation of State Medical Boards is considering a new concept to achieve a uniform assessment procedure for licensure. Moreover, GMENAC made a number of recommendations to the Secretary of HHS which, if implemented, could also affect how graduates of foreign medical schools enter the U.S. medical system.

### Comprehensive Qualifying Examination

In June 1973, 1/ NBME's Committee on Goals and Priorities recommended that an examination be developed to evaluate the performance characteristics required to provide patient care in a supervised setting. The committee believed that it should be acknowledged that both U.S. and foreign medical school graduates in graduate medical training and practice have the same responsibility for patient care and that identical standards should be applied. However, the committee recognized that all physicians, during the course of graduate medical training, are engaged in providing professional services to the public, and that the responsibility for assuring

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1/"Evaluation in the Continuum of Medical Education."

the public of the physician's competence to provide such services resides with the State. The committee indicated that it was particularly important that the foreign-trained graduate be assessed through a comparable process to U.S.-trained graduates because the foreign medical schools were not subject to the LCME accreditation process which assures quality medical education in U.S. medical schools.

Assuming that such an evaluation process is recognized or adopted by authorized agencies, such as the individual State medical boards, the examination would be offered to both U.S. and foreign medical school students at or near the end of undergraduate medical training. A passing score would be required for entry into graduate medical education. The examination's primary purpose is to assure the public and the profession that the physician who is providing patient care during graduate medical education has demonstrated the requisite and measurable knowledge and skills to do so. The Comprehensive Qualifying Examination would assess cognitive competencies, such as knowledge, understanding, problem solving, and clinical judgment associated with such tasks as understanding basic sciences, taking a medical history, performing a physical examination, making appropriate use of the clinical laboratory, establishing a problem list or differential diagnosis, treating the patient, educating the patient, providing psychological support to the patient and family, monitoring the patient's health status, and providing a health maintenance program. The examination would also assess the cognitive aspects of interpersonal skills as well as the cognitive aspects of technical skills, such as conducting a physical examination and performing special diagnostic and therapeutic procedures.

The Comprehensive Qualifying Examination is expected to be a 2-day examination consisting of multiple-choice items and patient management problems.

NBME has developed a prototype of the examination and is field testing it. According to NBME officials, the Comprehensive Qualifying Examination could be implemented within 3 to 5 years.

Federation Licensing Examinations I and II

The Federation of State Medical Boards is considering a proposal for a uniform licensure process which involves developing two examinations--FLEX I and FLEX II.

FLEX I would be administered to all U.S. and foreign medical school graduates before they begin graduate medical education. Since NBME is developing a similar examination--the Comprehensive Qualifying Examination--the Federation would adopt this as its FLEX I.

FLEX II, a 2-day examination, would be clinically oriented. It would be designed to measure the fitness of the examinee to practice medicine independently. FLEX II would be offered to all medical school graduates, United States and foreign trained. A passing score would be required to obtain a license to practice medicine.

The Federation is expected to recommend that FLEX II be given near the end of the second year of graduate medical education; however, recognizing the rights of States to establish their own requirements, the timing of FLEX II would be at the discretion of the individual State licensing boards.

Recommendations to HHS by the Graduate Medical Education National Advisory Committee

As discussed in chapter 1, GMENAC's September 30, 1980, report to the Secretary of HHS raised concern about, and suggested that action be taken to reduce, the number of foreign medical school graduates, including U.S. citizens, who return to practice medicine in the United States. In this regard, GMENAC recommended to HHS that foreign medical school graduates entering the United States, which it estimates will be 4,100 annually by 1983, should be severely restricted. GMENAC added that "If this cannot be accomplished, the undesirable alternative is to decrease further the number of entrants to U.S. medical schools." GMENAC had a number of supporting recommendations, including that:

--The transfer of U.S. citizens enrolled in foreign schools into advanced undergraduate standing in U.S. medical schools should be eliminated.

--The Fifth Pathway Program for entrance to approved graduate medical education programs should be eliminated.

--All Federal and State assistance given through loans and scholarships to U.S. medical students initiating study abroad after the 1980-81 academic year should be terminated.

--Current efforts in the private sector to develop and implement a uniform qualifying examination for U.S. citizens and aliens graduating from medical schools other than those approved by LCME as a condition for entry into approved graduate training programs should be supported. Such an examination must assure a standard of quality equivalent to the standard applied to graduates of LCME-accredited medical schools. These U.S. citizens and aliens must be required to complete successfully Parts I and II of the NBME's examination or a comparable examination. The ECFMG examination should not be used as the basis for measuring the competence of U.S. or alien foreign medical school graduates.

--The Federation of State Medical Boards should recommend and the States should require that all applicants successfully complete at least 1 year of an approved graduate medical education program and pass an examination before obtaining unrestricted licensure. The examination should assure a standard of quality in the ability to take medical histories, do physical examinations, carry out procedures, and develop diagnostic and treatment plans for patients. The standard of quality should be equivalent to graduates of U.S. medical schools.

It is too early to determine what action the Secretary of HHS may take in regard to GMENAC's recommendations.

## CHAPTER 4

## FEDERAL FINANCIAL ASSISTANCE TO U.S. CITIZENS STUDYING MEDICINE ABROAD

Foreign medical schools do not receive direct Federal financial assistance. However, U.S. citizens attending approved schools are eligible for guaranteed student loans from the Department of Education, and qualified veterans, their spouses, and their dependents may receive Veterans Administration educational benefits. In order for U.S. citizens to receive guaranteed student loans, ED must first determine that the education and training provided by the foreign medical school is comparable to that available at a U.S. medical school. The VA Administrator may deny or discontinue educational benefits upon finding that such enrollment is not in the best interests of the individual or the Government.

ED and VA authorized financial assistance to several thousand U.S. citizens studying medicine abroad primarily on the basis of the foreign schools' listing in WHO's "World Directory of Medical Schools." However, inclusion in the directory only provides recognition of a medical school by the country's government; it does not provide sufficient information to assure that the education and training offered is comparable to that provided by a U.S. medical school.

It should be noted that regulations establishing procedures and criteria for making these determinations had not been published by either agency even though the programs were authorized years ago. ED, however, issued proposed rules in April 1979 but had not finalized them. VA lost a court suit in March 1980 because it had not followed appropriate procedures for promulgating regulations when it discontinued educational benefits to U.S. citizens attending a previously approved foreign medical school.

ED does not have the information needed to effectively manage its guaranteed student loan program for U.S. citizens attending foreign medical schools.

Title IV of the Higher Education Act of 1965 (Public Law 89-329) established a national program of guaranteed student loans and emphasized the need to establish guarantee agencies to insure student loans. The Federal Government was directed to (1) reinsure guarantee agency loans or (2) directly

insure loans for student borrowers who do not have access to a guarantee agency program. A guarantee agency is a State agency or private, nonprofit institution or organization administering a student loan insurance program. As of July 1980, all but three States had guarantee agencies.

Undergraduate students may now borrow up to $2,500 per academic year for educational costs, and graduate and professional students (such as those attending medical schools) may borrow up to $5,000. Total loans outstanding may not exceed $7,500 for undergraduate students and $15,000 for graduate and professional students.

Students are eligible for a Federal interest subsidy whereby the Federal Government, rather than the student, pays the interest on the student's outstanding loan directly to the lender before the repayment period and during any authorized deferment periods. In addition to the payment of an interest subsidy, a special allowance is paid to lenders on outstanding loans to provide an equitable yield and to encourage their participation in the program.

Claims against the Federal Government may arise from the death, disability, bankruptcy, or default of the student borrower. The Federal Government pays 100 percent of all lender losses on death, disability, and bankruptcy claims. On default claims, the Federal Government pays 100 percent of losses for federally insured loans and reimburses guarantee agencies for at least 80 percent of their payments to lenders.

Based upon ED's information, about 21,500 loans for over $45 million were guaranteed during the past 10 years for U.S. citizens at foreign medical schools. Based on ED's records, we estimate that interest subsidies, defaults, and other expenses on these loans have cost the Federal Government about $12.4 million. However, as discussed beginning on page 45, because ED's accounting system does not provide accurate and complete information on U.S. citizens attending foreign medical schools, we are unable to state precisely the program's cost. During the same period, VA disbursed $5.6 million to 997 veterans and their spouses and dependents to attend foreign medical schools.

## THE DEPARTMENT OF EDUCATION AND THE VETERANS ADMINISTRATION HAVE NOT ADEQUATELY EVALUATED FOREIGN MEDICAL SCHOOLS

The International Education Act of 1966 (Public Law 89-698) provided that the Guaranteed Student Loan Program would be available to U.S. citizens studying abroad. However, before ED could insure or reinsure student loans, section 204 of the act requires it to determine that the foreign school was comparable to an institution of higher learning or to a vocational school in the United States.

Loans to U.S. citizens attending foreign medical schools are a relatively small part of the total Guaranteed Student Loan Program. ED estimated that, during fiscal year 1980, over 1 million students will receive loans and $2.5 billion will be disbursed. By comparison, ED records indicate that, during fiscal year 1979, the Department guaranteed about 2,600 loans for $6 million to U.S. citizens at foreign medical schools.

Under VA's educational assistance programs (38 U.S.C. chapters 34 and 35), eligible veterans and their spouses and dependents may receive educational benefits while attending approved foreign schools. However, the VA Administrator may deny or discontinue educational assistance upon finding that such enrollment is not in the best interest of the individual or the Government (38 U.S.C. 1676 and 1723). During fiscal year 1979, VA disbursed about $300,000 in educational benefits to 150 eligible persons to attend foreign medical schools.

### Inadequate criteria for determining comparability

Until April 1979, ED approved foreign medical schools on an *ad hoc* basis for participation in the Guaranteed Student Loan Program. ED determined that a foreign medical school was comparable to a U.S. school primarily on the basis of its inclusion in WHO's "World Directory of Medical Schools."

Until November 1978, VA generally used the same basis, but had other requirements. For example, the foreign medical school must have been in operation at least 2 years, agree to maintain student records, agree not to charge U.S. students higher tuition rates than other foreign students, and agree not to use deceptive advertising.

Inclusion in the WHO "World Directory of Medical Schools" provides recognition of a medical school by the country's government, but provides little information about the nature of education offered, its quality, or curriculum. According to the March 1980 issue of the Journal of the American Medical Association, "This publication * * * simply lists schools at the request and advice of the government of the country. Such listing does not constitute accreditation, recognition, or approval by the World Health Organization."

On the other hand, it should be noted that, in accrediting U.S. medical schools, LCME makes onsite visits to U.S. medical schools and evaluates such factors as the number of full-time faculty; their academic credentials; student-to-teacher ratio; laboratory, research, and clinical facilities; laboratory equipment; and size of the medical library.

In January 1979, the Administrator of HHS' Health Resources Administration asked LCME to consider reviewing foreign medical schools to determine their comparability to U.S. schools. In April 1979, LCME declined this request. Various persons in the medical profession advised us of many problems involved in accrediting foreign medical schools, including:

--The national and international political implications, and possible court actions that could result from nonaccreditation of certain schools.

--The large number of foreign medical schools would make it difficult and costly to review schools in a timely manner.

In our opinion, many foreign medical schools, including many first-rate schools, would not seek accreditation because few of their graduates seek graduate medical education or licensure in the United States.

Revised criteria developed in response to recently established foreign medical schools

As a result of the recent proliferation of foreign medical schools that are attracting large numbers of U.S. citizens, ED and VA officials recognized the need to develop other criteria for determining comparability.

ED and VA have a somewhat common objective in evaluating foreign medical schools. However, as discussed below, each agency developed its own criteria.

VA's revised comparability criteria

In November 1978, VA implemented additional comparability criteria, which required that foreign medical schools that seek approval for the first time must also show that 75 percent of their U.S. citizen graduates who applied for licensure in the 2 preceding years obtained a license in 1 of the 54 licensing jurisdictions. VA officials said this was only applied to "new" foreign medical schools; however, they were unable to explicitly define what constituted a "new" school.

The new comparability criteria were applied to St. George's University and the University of Central del Este. In November 1978, VA denied eligibility for St. George's University because it had not graduated two classes and, therefore, could not meet the new criteria. As a result, qualified veterans, their spouses, and dependents at St. George's University could not receive VA educational benefits.

Central del Este had previously been approved in 1972 for VA benefits. However, because it was unable to demonstrate that it met VA's new criteria, VA eligibility was withdrawn effective August 1979. As a result, qualified veterans, their spouses, and dependents could no longer receive VA educational benefits. However, U.S. citizens at this school remained eligible for guaranteed student loans.

In September 1979, a complaint was filed in the U.S. district court in Puerto Rico objecting to the termination of VA benefits for students at the University of Central del Este. In March 1980, the court ruled that benefits could not be terminated because VA's new criteria constituted a regulation and VA had not followed the appropriate procedures for promulgating such a regulation. As a result, VA educational benefits were reinstated on June 10, 1980, and made retroactive to August 31, 1979, for U.S. citizens attending the University of Central del Este.

On August 4, 1980, we were advised that, as a result of the court's decision, VA has reverted to its previous comparability criteria and, since March 1980, has approved two foreign medical schools on this basis. VA officials also advised us that, in view of this court decision, it is reevaluating the process for approving foreign medical schools for VA educational benefits.

ED's revised comparability criteria

In April 1979, ED issued proposed rules, which establish procedures and criteria for determining whether medical schools outside the United States or Canada are comparable to U.S. medical schools. 1/ ED's proposed criteria for determining comparability include a requirement that at least 95 percent of a foreign medical school's graduates who are citizens of the United States pass the ECFMG examination, on their first attempt, during the most recent 24-month period. This would prevent most foreign medical schools from participating in the the Guaranteed Student Loan Program because only a few schools would be able to meet this requirement.

ED's proposed rules for determining the eligibility of foreign medical schools for the Guaranteed Student Loan Program caused great controversy when published for public comment. Objections were raised about a number of issues, including the method of determining comparability and the pass rate required on the ECFMG examination.

As of June 30, 1980, ED had not requested data from ECFMG that would enable it to assess the impact of implementing the proposed regulations. Moreover, on July 27, 1979, NBME advised the Administrator of the Health Resources Administration of its belief that this examination should not be used as a means of determining whether foreign medical schools are comparable to U.S. medical schools. The Board stated that passing this examination is not a good indication of a foreign medical school's quality or comparability to a U.S. medical school.

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1/In its proposed regulations, ED stated that the same nationally recognized accrediting agency accredits U.S. and Canadian medical schools.

After publishing its proposed rules in April 1979, ED established a policy of not declaring any additional foreign medical schools eligible for the Guaranteed Student Loan Program until the final regulation is published. ED had not finalized its regulations as of July 1980. On August 5, 1980, ED officials advised us they were awaiting the results of our review before determining what action to take on the proposed rules.

## THE DEPARTMENT OF EDUCATION'S ACCOUNTING SYSTEM DOES NOT PROVIDE COMPLETE AND ACCURATE LOAN AND DEFAULT INFORMATION

The Higher Education Act of 1965 (Public Law 89-329) requires us to annually examine the financial statements of the Student Loan Insurance Fund, which is used to finance Federal insurance and reinsurance of loans made under the Guaranteed Student Loan Program. Since 1968, we have issued several reports to the Congress on the inability of ED's accounting system to provide accurate information on either the Fund's financial statements or the program's operation. The deficiencies were so severe that we have either (1) issued an adverse opinion on the financial statements because they did not fairly present the Fund's financial position or (2) not expressed an opinion on the Fund's financial statement because of inadequate records.

During this review, we noted that ED's program statistics and financial information on U.S. citizens attending foreign medical schools and receiving guaranteed student loans are questionable. For example, ED does not know

--the number and amount of guaranteed loans it has directly insured or reinsured through State agencies for U.S. citizens attending foreign medical schools,

--whether U.S. citizens who received guaranteed loans actually attended the foreign medical school for which the loan was approved, or

--whether the U.S. citizens later graduated, withdrew, or defaulted on their loans.

ED does not have a complete and accurate list of all Federal and guarantee agency loans for U.S. citizens attending foreign medical schools. For example, ED's records do not include 2,875 loans made to students attending foreign

medical schools totaling $9 million, which were guaranteed by New York's State lending agency since 1976. Further, an ED official said that guarantee agency loan default data were not separately maintained for foreign medical schools.

## ED does not know the status of its loan recipients at foreign medical schools

ED is supposed to use student confirmation reports to determine that loan recipients are properly enrolled at eligible institutions. However, they are not serving the purpose intended. Foreign medical schools respond infrequently to ED's confirmation report requests, and ED does not always take appropriate action when the schools respond.

The ED student confirmation report lists, by school, the citizen who has received a guaranteed student loan and attended that school. Twice a year, ED sends a confirmation report to foreign schools to determine the current status of guaranteed student loan recipients. The school is supposed to indicate the student's current status and return the form. Once the confirmation report is received, ED is supposed to notify the appropriate lender of any U.S. citizen no longer enrolled in the school. The lender can then initiate loan repayment.

However, foreign medical schools have responded to confirmation reports infrequently; as a result, ED is unable to determine the status of guaranteed loan recipients or notify the lenders to initiate repayment when appropriate. This function is especially important, in our opinion, based upon the large numbers of U.S. citizens who were not enrolled at the foreign medical schools we visited even though they were listed on ED's student confirmation report.

Officials at the Universities of Bologna, Guadalajara, and Central del Este completed the March 31, 1979, ED confirmation report for us. We completed the March 31, 1979, report for the University of Bordeaux. Of the 2,099 students listed on these confirmation reports, the universities indicated

--1,586 were full-time students,

--115 were duplicative names,

--22 had graduated,

--250 had withdrawn, and

--126 had never enrolled.

Although eligible U.S. schools must agree to comply with all applicable laws and regulations of the program, including the timely completion of the confirmation reports, ED has not required similar agreements of foreign schools. Officials said such agreements are not required because they do not believe the agreements could be enforced.

Even when the schools returned the confirmation reports, ED did not completely update information in its files and notify lenders that students were no longer enrolled. For example, Guadalajara returned ED's October 8, 1978, confirmation report and indicated that 439 of the students listed never enrolled, 25 had graduated, and 106 had withdrawn. Yet 44 of the students who never enrolled, 3 who had graduated, and 8 who had withdrawn appeared on the next ED confirmation report. Students who graduated or withdrew several years ago still appear on ED's confirmation report.

More importantly, ED does not always notify the lender that students had never enrolled, graduated, or withdrew. ED could not locate the lender notification forms for 7 (about 13 percent) of the 54 student records we sampled.

Another problem with ED's records was the discrepancy between its confirmation reports and a list of loans to students at foreign medical schools that they prepared for us. This list was developed from ED's loan control master file and its loan disbursement file. ED's list indicated that 330 students received loans in fiscal years 1978 and 1979 to attend the University of Bordeaux. However, ED's confirmation report sent to the university listed nine students as loan recipients and one student's name appeared twice. Bordeaux medical school officials stated that only three of these students were currently enrolled. Further, university officials said a total of only 20 U.S. citizens were currently enrolled. ED officials could not explain this discrepancy but agreed to look into the matter.

Department officials later gave us a list of 597 loans which they believed had been guaranteed to students attending the University of Bordeaux since the program began, of which 504 had been guaranteed by the Pennsylvania Higher Education Assistance Agency. However, a Pennsylvania official told us that the agency has not guaranteed loans to students attending the University of Bordeaux and that these 504 students actually attended a college in West Virginia, which has a Pennsylvania school code number that is the same as the University of Bordeaux's Federal code number.

Additionally, several U.S. citizens received loan funds to attend the Universidad Central del Este, an eligible school. However, apparently after the loans were approved, the students transferred to the Universidad Nordestana, an ineligible foreign medical school, but did not notify the lender or ED. Data on these cases will be provided to the ED Inspector General for followup.

Loan defaults are increasing

ED records do not separately identify guarantee agency default data for foreign medical schools. However, defaults of direct federally insured loans to U.S. citizens at foreign medical schools have increased over the past 4 fiscal years. Specifically, from fiscal year 1975 to fiscal year 1979, the amount in default for these students increased by 297 percent--from about $81,000 to $320,000. During the same period, the amount in default for the total program increased by 31 percent--from about $76 million to $100 million. As pointed out previously, the Federal Government bears the entire cost of defaults on direct federally insured loans and reimburses guarantee agencies for at least 80 percent of their payments to lenders.

## CHAPTER 5

## CONCLUSIONS; RECOMMENDATIONS; COMMENTS BY FEDERAL AGENCIES, STATE LICENSING AUTHORITIES, AND THE MEDICAL PROFESSION; AND UNRESOLVED ISSUES

### CONCLUSIONS

The substantial numbers of U.S. citizens going abroad to study medicine with the goal of returning to practice in this country, together with the recent proliferation of foreign medical schools established to attract U.S. citizens, are reasons for growing concern, because foreign-trained U.S. citizens who return to the United States have varying degrees of professional competence. Questions have been raised about the adequacy and appropriateness of their education and training for practicing medicine in the United States.

We recognize that there are many first-rate medical schools located in foreign countries which produce excellent physicians; that many distinguished scholars from medical schools around the world are welcomed to this country as teachers and practitioners and make a valuable contribution; and that, even with limitations in a medical school's educational capabilities, some students will do well because of their own ability and willingness to study and learn.

In our opinion, none of the six foreign medical schools we visited offered a medical education comparable to that available in the United States because of deficiencies in one or more of the following areas--admission requirements, facilities, equipment, faculty, curriculum, or clinical training. While it is difficult to generalize about the adequacy of the foreign medical schools in all of these areas, a serious shortcoming we observed at each foreign medical school was the lack of adequate clinical training facilities. None of the foreign schools had access to the same range of clinical facilities and numbers and mix of patients as a U.S. medical school.

To supplement the inadequate clinical training opportunities at the foreign medical schools, many U.S. citizens obtained part or all of their undergraduate clinical training in U.S. hospitals under arrangements made by either the foreign medical school or themselves. However, the extent,

type, and length of training they received at most of the U.S. hospitals participating in these arrangements that we visited varied greatly and generally was not comparable to that provided to U.S. medical school students.

Moreover, most of the U.S. hospitals participating in these arrangements that we visited (1) were not affiliated with U.S. medical schools and (2) had no assurances that U.S. citizens from foreign medical schools were properly and adequately prepared for such training.

State licensing board officials we contacted in California, New York, and New Jersey said they require U.S. hospitals which provide clinical training programs for foreign medical school students to submit their programs for approval, while board officials in Florida said they had no such requirement. Nevertheless, State medical licensing boards in California, New York, and Florida generally had not approved these clinical training programs, nor were they aware of the extent to which such training programs existed in their States. The New Jersey licensing board had approved many but not all such training programs that existed in the State. Some State licensing boards are becoming increasingly concerned about U.S. citizens from foreign medical schools obtaining their clinical training in U.S. hospitals. As a result, for example, licensing boards in New York and New Jersey have cautioned hospitals in their States against conducting unapproved training programs.

Steps should be taken to address the current practice whereby U.S. citizen foreign medical school students receive part or all of their undergraduate clinical training in U.S. hospitals because no organization has overall responsibility for reviewing and approving such training and there are no assurances that the students are adequately and appropriately prepared to undertake such training.

ED and VA are providing financial assistance in the form of guaranteed student loans and educational benefits for several thousand U.S. citizens studying medicine abroad, including hundreds enrolled at four of the six foreign medical schools we visited. Before authorizing guaranteed student loans for studying abroad, ED is required by law to determine that the education and training is comparable to that provided by a U.S. institution of higher learning or vocational school.

The VA Administrator can deny or discontinue educational benefits if he finds that such enrollment is not in the best interest of the individual or the Government.

ED and VA determined that foreign medical schools were comparable to U.S. medical schools primarily on the basis of the foreign schools' listing in WHO's 'World Directory of Medical Schools." In our view, this approach only provides recognition of a medical school by the country's government--it does not provide sufficient information to assure that the schools are comparable to U.S. institutions.

As indicated above, ED and VA have a somewhat common objective in evaluating foreign medical schools. However, each agency developed its own comparability criteria as a result of the recent proliferation of foreign medical schools that are attracting large numbers of U.S. citizens.

However, even though these programs were enacted years ago, neither ED nor VA had issued regulations establishing procedures and criteria for making comparability determinations, although ED did issue proposed rules in April 1979.

In addition, ED does not have the information needed to effectively manage its Guaranteed Student Loan Program for U.S. citizens attending foreign medical schools.

U.S. citizen foreign medical graduates must pass the ECFMG examination to enter U.S. programs of graduate medical education. Less than 50 percent of the U.S. citizens pass this examination each year, although the pass rate is reportedly higher for first-time takers than repeaters. Further, members of the medical profession have questioned the appropriateness of the ECFMG examination, both as a test of the readiness for graduate medical education and as an adequate safeguard of the health and welfare of patients. Foreign citizen foreign medical school graduates seeking a visa to come to the United States for graduate medical education, on the other hand, must pass the VQE, even though they may have attended the same foreign medical school as U.S. citizens. Some in the medical profession consider it more comprehensive and difficult to pass than the examination given to U.S. citizen foreign medical school graduates.

Licensure for independent medical practice is a legal function of the 50 States, Guam, Puerto Rico, the Virgin Islands, and the District of Columbia. Although eligibility requirements differ among and within jurisdictions for U.S. and foreign medical school graduates, all applicants must submit evidence of their undergraduate medical education. However, State licensing boards have no way of adequately assessing the education and training provided in foreign medical schools in deciding whether the applicant is eligible to take the State licensing examination.

We recognize that U.S. citizens are free to go abroad to study medicine, and that many will continue to do so with the ultimate goal of returning to the United States to practice medicine. Because there are no adequate means of evaluating the education and training provided by foreign medical schools, we believe the Congress, the administration, State licensing authorities, and the medical profession need to consider how the matters discussed in this report can best be addressed and how the highest quality of patient care can be assured. We believe that a number of alternatives are available to ensure that students who attended foreign medical schools demonstrate that their medical knowledge and skills are comparable to those of their U.S.-trained counterparts before entering the U.S. health care delivery system.

## Alternatives for evaluating the education and training received in foreign medical schools

### Alternative 1

LCME, or some other body established for this purpose, could be given responsibility for visiting foreign medical schools, with the school bearing the cost, to determine if the education and training provided is comparable to that at a U.S. medical school. If so, the foreign school would be accredited by the body established for this purpose. Under this alternative, only students from such accredited foreign medical schools would be permitted to receive graduate medical education or medical licensure in the United States. This alternative would discourage U.S citizens from attending unaccredited foreign schools with the intention of returning to the United States to ultimately practice medicine.

Although worldwide accreditation of medical schools is a laudable goal, many problems exist. For example:

--There could be national and international political implications, pressures, and possible legal actions that could result from nonaccreditation of certain schools.

--The large number of foreign medical schools would make it difficult and costly to review schools in a timely manner.

--Many foreign medical schools, including many first-rate schools, would undoubtedly not seek accreditation because few of their graduates seek graduate medical education or licensure in the United States.

When previously asked, LCME declined to undertake accreditation of foreign medical schools for purposes of the Guaranteed Student Loan Program.

Alternative 2

A second alternative would be to establish a better examination to test students before permitting them to enter graduate medical education or receive medical licensure in the United States. All medical school graduates, U.S. and foreign trained, could be required to pass an examination, such as the proposed Comprehensive Qualifying Examination, in order to enter graduate medical education. All medical school graduates could be required to pass an examination, such as the proposed FLEX II, in order to obtain unrestricted licensure.

Passing an examination before participating in U.S. programs of graduate medical education would demonstrate a minimally acceptable standard of competence for assuming patient care responsibilities in a supervised setting. Passing an examination before licensure would demonstrate a minimally acceptable standard of competence for the independent practice of medicine.

This alternative would eliminate the multiple standards that now exist for U.S. medical school graduates, U.S. citizen foreign medical school graduates, and foreign citizen foreign medical school graduates and would also be relatively easy to

establish and relatively inexpensive to implement. However, there are also problems with this alternative, including:

--It is doubtful that any examination could be developed which would provide a completely satisfactory substitute for the rigorous supervised training that medical students in the United States undergo.

--Even if such an examination was developed, it could be many years before it would be uniformly accepted by the numerous independent State licensing jurisdictions.

--Students could probably pass any examination after study and coaching, even without having received "comparable training."

Alternative 3

A third alternative would be to establish an accrediting body, either by the private sector or by HHS, responsible for determining whether students who attend foreign medical schools are properly prepared to receive graduate medical education or licensure in the United States. Applicants would have to have completed their medical education and all of the foreign country's requirements for their medical degree--except for any internship and/or social service requirements.

This body would be responsible for:

--Establishing uniform standards, including an appropriate screening examination and criteria for evaluating applicants' credentials to determine whether they are adequately prepared to enter U.S. programs of graduate medical education without additional hospital training.

--Determining the length and scope of any additional hospital training needed to prepare each applicant for graduate medical education.

--Designating U.S. hospitals that would be approved for providing supervised hospital training of individuals who attended foreign medical schools and are deemed to need such training.

Under this alternative, individuals who attend foreign medical schools would not be permitted to receive any necessary additional hospital training, enter graduate medical education, or secure licensure unless they demonstrate to this body that they had a thorough understanding of the basic sciences. Following the additional hospital training specified by the accrediting body, the hospital program director would certify to that body whether the individual was properly prepared for graduate medical education. This certification could also be used as one of the licensure requirements in the States that do not now require graduates of foreign medical schools to have graduate medical education.

Accordingly, under this alternative, no applicant from a foreign medical school would be eligible to receive graduate medical education or licensure in the United States without the approval of this body, and the total cost of any additional hospital training needed would be borne by the individual. This alternative would also eliminate the need to continue a separate Fifth Pathway Program. This alternative offers the following advantages:

--Applicants from foreign medical schools would be screened before being permitted to enter the U.S. health care delivery system.

--It would provide flexibility to differentiate between those applicants from foreign medical schools who need additional training and those who do not, such as distinguished scholars and visiting professors.

--Applicants from foreign medical schools would receive any additional training needed only in U.S. programs and facilities approved for such purposes.

This alternative also poses some problems:

--This approach would be relatively expensive, and an applicant might have trouble absorbing the cost.

--Finding enough hospital training facilities might be difficult.

--This approach might be resisted by States that do not now require graduates of foreign medical schools to have some period of graduate medical education to secure licensure.

## RECOMMENDATION TO THE CONGRESS

We recommend that the Congress direct the Secretary of Health and Human Services to work with State licensing authorities and representatives of the medical profession to develop and implement appropriate mechanisms that would ensure that all students who attend foreign medical schools demonstrate that their medical knowledge and skills are comparable to those of their U.S.-trained counterparts before they are allowed to enter the U.S. health care delivery system for either graduate medical education or medical practice. We have identified a number of alternatives that should be considered in accomplishing this objective.

## RECOMMENDATION TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

We recommend that the Secretary, in cooperation with State licensing authorities and representatives of the medical profession, address the current practice whereby students attending foreign medical schools receive part or all of their undergraduate clinical training in U.S. hospitals.

## RECOMMENDATIONS TO THE SECRETARY OF EDUCATION

We recommend that the Secretary issue regulations establishing procedures and criteria for implementing the legislative requirement that ED ensure that foreign medical schools are comparable to medical schools in the United States before authorizing guaranteed student loans for U.S. citizens attending these schools.

We further recommend that the Secretary ensure that the Government's interest in outstanding guaranteed student loans at foreign medical schools is adequately protected by properly verifying the status of all U.S. citizens with outstanding loans and initiating repayment where appropriate.

## RECOMMENDATION TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator accept foreign medical schools approved by the Secretary of Education as a basis for authorizing educational benefits to qualified veterans, their spouses, and their dependents.

## COMMENTS BY FEDERAL AGENCIES, STATE LICENSING AUTHORITIES, AND THE MEDICAL PROFESSION AND UNRESOLVED ISSUES

A draft of this report was provided for comment to HHS, ED, VA, the Department of State, the Federation of State Medical Boards, the Coordinating Council on Medical Education and its Liaison Committees on Undergraduate and Graduate Medical Education, AAMC, AHA, AMA, NBME, and ECFMG.

On September 5, 1980, the Department of State advised us that it had no disagreement with our draft report and therefore would not be submitting written comments. The Coordinating Council on Medical Education and its Liaison Committees on Undergraduate and Graduate Medical Education chose not to comment on our draft report. (See apps. XIX, XX, and XXI.) Comments by ECFMG dealt only with its examination results. (See app. XXVI.)

### HHS

HHS believes that no steps should be taken that encourage U.S. citizens to seek medical training in foreign schools, because its estimates of supply and requirements for physicians to serve the U.S. population indicate that an adequate future supply can be trained in medical schools in this country. Nevertheless, since many U.S. citizens are studying medicine abroad, and in view of the problems discussed in this report, HHS believes that measures should be taken to assure the qualifications of U.S. citizens who study medicine abroad and return to enter the American medical system. (See app. XV.)

HHS recognizes the need for procedures to assure that persons entering the U.S. health care system for medical training or practice are adequately qualified. Therefore, HHS agreed it can work with State licensing authorities and representatives of the medical profession to accomplish this objective. In this regard, HHS pointed out that this responsibility for U.S.-trained personnel rests with State licensing bodies, the medical profession, and the educational community. Accordingly, HHS believes, and we agree, that those organizations should continue to exercise their responsibility for U.S. citizens attending foreign medical schools, but that HHS could help accomplish this by its cooperative participation.

HHS agreed with our recommendation that it address, in cooperation with State licensing authorities and representatives of the medical profession, the practice whereby foreign medical school students obtain part or all of their undergraduate clinical training in U.S. hospitals. HHS noted that the procedures used to arrange for clinical training of U.S. medical school students are essentially the responsibility of the profession and the educational establishment. HHS views this as a sound arrangement, which it believes should also apply to U.S. citizens studying medicine abroad. Accordingly, HHS said it will cooperate in developing improved procedures for U.S. citizens studying medicine abroad who obtain part or all of their undergraduate clinical training in U.S. hospitals.

ED

ED agreed with our findings and recommendations about the need to (1) issue regulations for assessing whether a foreign medical school is "comparable" to an American school in order to determine eligibility for the Guaranteed Student Loan Program and (2) protect the Government's interest in outstanding guaranteed student loans under both the Federal Insured Student Loan Program and those guaranteed by State or private nonprofit agencies. (See app. XVI.)

ED pointed out that it received substantial negative comment in response to its April 1979 Notice of Proposed Rulemaking, which anticipated assessing comparability on the basis of the scores that U.S. citizens at foreign medical schools received on their ECFMG examinations.

As a result of the negative comments, ED plans to convene interested and knowledgeable participants, including representatives from VA and HHS' Public Health Service, to reassess the available options. In this regard, AMA commented that it would be pleased to discuss possible mechanisms to accomplish this objective with ED and other interested parties.

However, ED believes there may be ways other than issuing regulations to implement the intent of our recommendation and resolve this matter since it stated that:

"The result of these consultations may include publication of a new Notice of Proposed Rule-making or other administrative action or a proposal that Congress reassess the conditions under which foreign medical schools may participate in the GSL [Guaranteed Student Loan] program. In the meantime, the Department will continue its current policy of implementing the statutory 'comparability' standard without regulations."

In view of the importance of this issue and the need for such regulations, we are concerned that the Department has not set forth a specific course of action it intends to take.

ED agreed that (1) its present process does not accurately verify the status of U.S. citizens enrolled at foreign medical schools and (2) a new process must be established to protect the Government's interest in outstanding guaranteed student loans. Moreover, ED pointed out that this problem is not limited solely to foreign "medical" schools; it applies to U.S. citizens attending any foreign educational institution and receiving assistance under the Guaranteed Student Loan Program.

Accordingly, ED stated it has:

"* * * initiated the process for reviewing alternative means to verify more accurately the status of U.S. citizens studying abroad. It is our intent to start a process for determining the correct student status for loans made under the FISLP [Federal Insured Student Loan Program]. A task order will be developed as soon as possible to identify all students receiving FISLP loans to attend any foreign school. For borrowers who are located through this process and who are no longer attending school, we will notify lenders immediately so that they may initiate the repayment of the loan and make necessary adjustments to amounts of interest benefits which have been incorrectly paid. Where we cannot locate the borrower, skip tracing efforts will be instituted. In the case of loans made under the guarantee agency programs, we will encourage guarantee agencies to follow a similar practice."

We believe this action represents a step in the right direction to protect the Government's interest in outstanding guaranteed student loans for all U.S. students studying abroad.

ED noted that there was legislation pending as part of the Education Amendments of 1980 (new section 487 of the Higher Education Act) that would require any institution wishing to participate in its student assistance programs to comply with numerous specific requirements. ED stated that, if schools do not comply, their eligibility would be withdrawn.

The Education Amendments of 1980 (Public Law 96-374), signed into law by the President on October 3, 1980, require that eligible institutions enter into a program participation agreement with ED. The agreement shall require that the institution establish and maintain such administrative and fiscal procedures and records as ED determines are necessary to insure proper and efficient administration of funds received from ED or students.

It is too early to determine what specific procedures ED will impose to meet these legislative requirements or whether foreign medical schools will comply with them. In any event, ED is still required by legislation to determine that a foreign medical school is comparable with an American school before authorizing guaranteed student loans for study abroad.

VA

VA had no objection to our recommendation that it accept those foreign medical schools approved by the Secretary of Education as a basis for authorizing educational benefits to qualified veterans, their spouses, and their dependents. (See app. XVII.) VA stated, however, that its legislation and attendant regulations would have to be considered when evaluating the adequacy of any new ED standards.

VA further stated that the adverse ruling of the court, discussed on page 43 of this report, impressed on VA the urgent need for proper regulation in this area and that VA has therefore been considering its own corrective regulations. Nevertheless, VA said it could abide by appropriate ED regulations, but would like to review the content of any such

new regulations before taking a final position on our recommendation.

Federation of State Medical Boards

The Federation of State Medical Boards 1/ agreed with our recommendations to the Congress and the Secretary of HHS. (See app. XVIII.) The Federation stated:

> "The growing number of U.S. citizens studying medicine abroad, especially in for-profit schools, is of grave concern to all segments of medicine, but especially to the medical licensing boards. These boards have the responsibility under law to determine that candidates for licensure have been thoroughly educated in the art and science of medicine so that they continually demonstrate competence in the practice of medicine. With limited resources, no one board is capable of undertaking the evaluation process for the several hundred schools abroad. As a result, the Federation of State Medical Boards has established a Commission to Evaluate Foreign Medical Schools. There is an urgent need to put some mechanism into place rapidly, as the influx of U.S. nationals from the new schools established in the Carribean and Mexico is just beginning to be felt."

The Federation believes that the alternatives we proposed for evaluating the education and training received in foreign medical schools are viable and reasonable. However, according to the Federation, the major problem with each alternative is the time required for implementation, given the State medical licensing boards' urgent need for documented information and guidelines on the education and training provided in foreign medical schools.

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1/We were advised that these comments represent the views of the Federation's executive director because there was insufficient time to obtain input from its board of directors. However, the executive director believed that these comments accurately reflect the Federation's views.

Accordingly, the Federation strongly believes that this urgent need can best be met for the short term by its Commission to Evaluate Foreign Medical Schools, established in April 1980. The Commission's purpose, as stated in the adopting resolution, is to help licensing boards determine whether a licensure candidate who attended a foreign medical school has had adequate training and to assure the public that the candidate meets the educational qualifications required by the relevant licensing jurisdiction.

For the long term, the Federation believes that establishing an examination process, such as the proposed FLEX I and II concept for all licensure candidates, would be the most desirable approach.

AAMC

AAMC said that our draft report raises urgent policy issues. (See app. XXII.)

AAMC stated that the performance of U.S. citizens attending foreign medical schools on the June 1980 Medical Sciences Knowledge Profile examination demonstrated that foreign medical schools did not provide the examinees an education comparable to that provided by U.S. medical schools, particularly for clinical training.

AAMC pointed out that, unlike the undergraduate clinical training U.S. foreign medical school students received at the nine hospitals we visited, students in U.S. medical schools are not passive observers; instead, they

> "* * * personally participate in the work up, diagnosis, and treatment of patients to which they are assigned. Under supervision, they take the patient's history, do the physical examination, make initial diagnostic hypotheses, and in collaboration with residents and faculty, plan laboratory studies and procedures. They are involved in carrying out procedures and planning treatment. Their closely supervised involvement with residents and faculty is as a member of the team."

AAMC further believes it is indefensible to continue the "double standard" that requires those alien foreign medical school graduates who need a visa to enter the United States for graduate medical education to pass the VQE, while U.S. citizen foreign medical school graduates are required to pass the ECFMG examination, which is generally considered a lesser standard.

Therefore, AAMC suggests that

--all graduates of foreign medical schools be required to meet the same standards for entry into graduate medical education and licensure in this country and

--State medical boards be encouraged to establish uniformly high standards for licensure in all jurisdictions and develop rigorous practical clinical examinations for foreign medical school graduates.

Specifically, AAMC believes that the Liaison Committee on Graduate Medical Education, which sets the standards for eligibility to enter graduate medical education in the United States, should be urged to require that U.S. citizen foreign medical school graduates pass the same examination as other graduates of foreign medical schools. AAMC also believes that all foreign medical school graduates, including U.S. citizens, should be required by State licensing boards to take a special examination to demonstrate their clinical knowledge and ability to solve patient management problems and that those who pass should take a further practical examination given by qualified examiners during which their skills in history-taking, physical diagnosis, and clinical judgment are directly observed. AAMC noted that (1) such examinations will, to a degree, supplant the lack of quality control in most foreign institutions and (2) graduates of meritorious foreign schools should have little difficulty in meeting those standards for clinical knowledge and the clinical skills necessary for the care of U.S. citizens.

AAMC believes that our third alternative (see p. 54) is based on the concept that the United States has an obligation to rehabilitate graduates of foreign medical schools who are deemed to have received an inferior education. However, AAMC believes that the United States has no obligation to remedy the educational deficiencies of foreign medical school graduates and that expending scarce resources cannot

be justified at a time when it is predicted the Nation will have too many physicians.

AAMC also said that guaranteed student loan support and VA benefits for U.S. citizens studying in foreign schools is appropriate and that many students have undoubtedly benefited from having had the opportunity to obtain their higher education in other countries. However, AAMC opposes continuing such support for U.S. citizens to study medicine abroad in light of the uneven distribution of U.S. citizens in a few foreign medical schools and the growing recognition that U.S. medical schools are supplying more than enough physicians to meet the Nation's needs. Therefore, AAMC supports the Graduate Medical Education National Advisory Committee's recommendation that both State and Federal loan and scholarship support for the study of medicine in foreign schools be terminated for U.S. students entering such schools after 1980.

AHA

AHA agreed to work with the private sector and public governmental bodies to address the practice whereby U.S. citizens attending foreign medical schools receive part or all of their undergraduate clinical training in U.S. hospitals. (See app. XXIII.) Moreover, AHA says that it has addressed this issue:

> "* * * Aware of the problems created by anomalous loopholes in the screening of such medical students and the attendant threat to an appropriate standard of patient care, the AHA Board of Trustees took the following action in May 1979:
>
> "To alert member hospitals and medical staff members to the increasing number of requests from U.S. students in foreign medical schools for clinical clerkship positions in U.S. hospitals; further,
>
> "To urge that hospitals and physicians assess most carefully (1) the individual qualifications and educational backgrounds of the prospective participants, (2) the quality of the educational program at the individual's foreign medical school, and (3) the relative value of the clerkship experience to the participant, the hospital,

and the public in reviewing such requests before making the institution's facilities and staff available for educational opportunities; and further

"To reaffirm the American Hospital Association's 1976 Guidelines on Mutual Responsibilities in Education Health Manpower."

We were advised that, in the debate that preceded adoption of this motion, members of AHA's policymaking bodies recognized the need for collaboration in solving a complex problem and the need for those with legitimate interests in setting standards for medical education to develop mechanisms jointly while remaining sensitive to the individual's rights.

However, AHA recognizes that its hospitals are not in a position to effectively make the careful assessments called for in the May 1979 resolution since AHA stated, and we agree, that "Individual hospitals are not equipped to determine the quality of medical education but * * * hospitals have a legitimate claim to participate in the process."

AHA's views on the alternatives we identified for evaluating the education and training provided in foreign medical schools (discussed beginning on p. 52) were as follows:

"* * * the AHA does not believe the first alternative to be a plausible solution. The second and third alternatives each have advantages in that the second would introduce parity for all medical students--U.S. and alien--whether trained abroad or within the U.S., and the third would focus specifically on those students currently giving rise to the problem. We do, however, advise caution with respect to the third suggestion since in a climate of extreme fiscal stringency and with a projected surplus of U.S. educated physicians, the motivation to implement a new credentialing mechanism requiring extensive collaboration will not be high. This motivation may be further reduced by the recommendations expected to emanate from the report to the Secretary of Health and Human Services by the Graduate Medical Education National Advisory Committee."

AMA

AMA agreed with our recommendation to participate, in cooperation with HHS and others, in addressing the practice whereby students attending foreign medical schools obtain part or all of their undergraduate clinical training in U.S. hospitals. (See app. XXIV.) AMA saw this as a valid issue for concern and pointed out in part that

> "In the United States and Canada all undergraduate medical education programs are accredited by a single agency to ensure standards of curriculum, faculty, and resources as well as to assure the student and the public that such standards are met. The educational program is usually provided in one defined geographic site under the direct supervision of selected faculty and occasionally at a remote site also under the direction of full time faculty. Clinical components of the curriculum are accredited only as a portion of the whole program and not separately. The Liaison Committee on Medical Education, the nationally recognized agency for accreditation of programs in medical education leading to the M.D. degree, does not recognize programs in the basic sciences alone unless the institution has established its intent to provide a complete program. Nor does it recognize clinical programs alone.
>
> "The GAO report notes that there is a lack of clinical facilities at all six schools visited and that, to a great extent, so called 'clinical rotations' must be arranged by the students themselves. These 'clinical rotations' are analogous in intent to the core clinical clerkships of U.S. and Canadian medical schools. The core clerkships are, however, an integral part of the U.S. total curriculum, usually its third year, and are monitored by carefully chosen faculty of the school and provided in a medical care institution where the educational programs are supervised by the school's faculty. During the fourth year or final period of an accredited program students may be permitted to select an elective course or experience at another institution. In no case, however, is responsibility for the students

education vested in another totally unrelated institution."

On the other hand, AMA does not believe the Federal Government should become involved in accrediting programs or in establishing prerequisites for licensure or graduate medical education in the United States because adequate safeguards already exist.

AMA pointed out, and we agree, that, since medical licensure is a purely State function, the competence and skills necessary to practice medicine are established by the State licensing authorities and are not in the direct Federal domain. According to AMA, no licensing jurisdiction allows the practice of medicine without proof that an individual meets its established criteria for licensure, and States have met this responsibility by accepting certain objective indicators of competence, including passage of the ECFMG examination and completion of graduate medical education. Therefore, AMA concluded that instituting further Federal regulation is inappropriate because safeguards for licensure to practice medicine have already been established voluntarily by the private sector.

AMA added that admission standards to graduate medical education programs are determined by the program director and medical staff to assure that the participant benefits from the program and that patients in the institutions are protected.

We disagree with AMA that adequate safeguards already exist. HHS, the Federation of State Medical Boards, and other members of the medical profession reached different conclusions than AMA regarding this issue.

First, as discussed in the report, NBME and AAMC have previously raised questions about the adequacy of the ECFMG exam, both as a test of the readiness for graduate medical education and as an adequate safeguard of patients' health and welfare. We also point out in the report (see p. 34) that State licensing boards have no adequate way of assessing the quality of education and training provided in foreign medical schools and, therefore, must rely on documents provided by the student in deciding whether these applicants are eligible to take the State licensing exam. We believe that directors of graduate medical training programs are at a similar disadvantage in discharging the responsibility pointed out by AMA for assessing whether a foreign-trained

physician is properly prepared to enter their graduate medical training programs.

Although each State is responsible for ensuring that patient care and safety are safeguarded and that those licensed to practice medicine meet certain standards, the Federation of State Medical Boards acknowledged that no State medical licensing board is in a position to assess the quality of education and training provided in all foreign medical schools. Therefore, the Federation established its own Commission in April 1980, as an interim measure to help State licensing boards determine whether a licensure candidate who attended a foreign medical school has had adequate training and to assure the public that the candidate meets the educational qualifications required by the relevant licensing jurisdiction.

We did not recommend that the Federal Government assume responsibility for program accreditation or licensure, as AMA contends. On the contrary, the report recognizes that this responsibility rests with state licensing bodies and the medical profession. At the same time, however, we believe HHS can and should actively participate in these deliberations because the judgments involved, which affect U.S. citizens as well as foreign nationals, will benefit from public participation, an open deliberative forum, and a close relationship to the public policy development process to ensure equitable solutions that are sensitive to the needs and rights of all involved parties.

NBME

NBME said the draft report clearly delineates the complex issues relating to education in foreign medical schools and the implications this has for entry into the U.S. educational and health care system. (See app. XXV.)

According to NBME, the three options we proposed seem to present mutually exclusive strategies for evaluating the education and training received in foreign medical schools. If so, NBME said such an approach would present problems conceptually by not recognizing the clear and distinct differences in accreditation functions and responsibilities on the one hand, and assessing individual capabilities on the other. NBME pointed out that the accreditation process assesses the quality of an education program or institution, but it cannot assure the competence and capabilities of the

individuals participating in that program. An examination system, on the other hand, assesses the knowledge and capabilities of individuals, but it cannot assure the quality of the educational program itself.

While we agree that ideally both assessments are required to assure the qualifications and demonstrated competence of physicians to provide health care to the public, accreditation of foreign medical schools did not seem to be a viable alternative for the reasons discussed in the report. In any event, we did not intend to suggest that each alternative be viewed as mutually exclusive of the others, or that these were the only options available.

APPENDIX I

## ORGANIZATIONS INVOLVED IN EDUCATION, TESTING, AND LICENSURE OF PHYSICIANS IN THE UNITED STATES

### COORDINATING COUNCIL ON MEDICAL EDUCATION AND ITS LIAISON COMMITTEES ON UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

The Coordinating Council on Medical Education (CCME) was established in 1972 by five sponsoring medical organizations: AAMC, AHA, AMA, the American Board of Medical Specialties, and the Council of Medical Specialty Societies. CCME membership is comprised of three representatives from each of the five sponsoring organizations along with public and Federal representatives.

CCME is responsible for reviewing matters affecting all levels of medical education and recommending policies to its five sponsoring organizations for their approval. Before matters become official CCME policy, they must be reviewed and unanimously approved by its five sponsoring organizations.

As previously discussed, LCME is the official accrediting body for the educational program leading to the M.D. degree and is recognized for this purpose by the Department of Education.

The Liaison Committee on Graduate Medical Education (LCGME) was established as (1) the accrediting body for graduate medical education (residency) programs and (2) the body to develop the most effective methods to evaluate graduate medical education, to promote its quality, and to deal with other appropriate matters relating to graduate medical education. LCGME began to function as the recognized body for accreditation of graduate medical education programs on January 1, 1975.

Policies developed by LCME and LCGME must be reviewed by CCME and have the unanimous approval of its five constituent organizations.

### ASSOCIATION OF AMERICAN MEDICAL COLLEGES

AAMC is composed of representatives of academic medical centers, teaching hospitals, and academic societies. These are the principal institutions and organizations responsible for educating physicians from the time they enter medical

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school until they leave their formal training and assume professional roles in the health care system.

## AMERICAN HOSPITAL ASSOCIATION

AHA comprises more than 29,000 hospitals and individuals. Its objective is to promote the public welfare by developing better hospital care for all the people. Historically, it has been concerned with graduate medical education in its desire to establish objective standards for hospital appointments.

## AMERICAN MEDICAL ASSOCIATION

AMA has 172,000 physicians in good standing in 55 State associations. Among other things, it provides information to members on national and State medical and health legislation, represents the profession to the Congress and Government agencies, and cooperates in setting standards for medical schools and graduate medical education training programs.

## FEDERATION OF STATE MEDICAL BOARDS

Membership in the Federation of State Medical Boards includes all State licensing boards. Among the Federation's purposes are to develop and improve the quality of licensing examinations and to study, determine, advocate, and/or advance the adoption of adequate and uniform standards for licensure. However, licensure is a legal function of each of the 50 States, Guam, Puerto Rico, the Virgin Islands, and the District of Columbia.

## NATIONAL BOARD OF MEDICAL EXAMINERS

NBME was founded in 1915. Its membership includes representatives from the Federation of State Medical Boards of the United States, AMA's Council on Medical Education, AAMC, AHA, Council of Medical Specialty Societies, American Board of Medical Specialties, student and housestaff organizations, along with public and Federal representatives.

NBME's purposes are to prepare and administer qualifying examinations of such high quality that legal agencies governing the practice of medicine within each State may, at their discretion, grant successful candidates a license without further examination; to assist the State examining boards, medical specialty boards, medical schools, hospitals, and related medical organizations concerned with the education

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and qualifications of health personnel; to advance the effectiveness of the evaluation of knowledge, competence, and qualifications in health-related fields; and to provide educational opportunities for persons interested in evaluation processes.

NBME is not a licensing body. The individual States have responsibility for determining who shall practice medicine within their borders and for maintaining high standards of medical practice in accordance with their own rules and regulations.

EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

ECFMG is sponsored by the American Board of Medical Specialties, AHA, AMA, AAMC, the Association for Hospital Medical Education, the Federation of State Medical Boards of the United States, and the National Medical Association.

Incorporated in 1956, the Educational Council for Foreign Medical Graduates began operation in 1957. The agency initially served the public interest by verifying credentials, evaluating educational qualifications, and conducting examinations to determine that foreign medical graduates were ready to benefit from graduate training in the United States and were qualified to assume responsibility for the care of patients in those training programs. Later, it became active in providing information about training programs and their requirements so that foreign medical graduates could select education programs best suited to their needs.

On June 30, 1974, the Educational Council for Foreign Medical Graduates and the Commission on Foreign Medical Graduates combined to form ECFMG. The combined agency identified the following as its missions: (1) provide information to foreign medical graduates regarding entry into graduate medical education and health care systems in the United States, (2) evaluate their qualifications for such entry, (3) identify foreign medical graduates' cultural and professional needs, (4) assist in the establishment of educational policies and programs to meet the cultural and professional needs of foreign medical graduates, (5) gather, maintain, and disseminate data concerning foreign medical graduates, and (6) assist other individuals and agencies concerned with foreign medical graduates.

## APPENDIXES II TO VII

## OBSERVATIONS AT FOREIGN MEDICAL SCHOOLS

Summaries of our observations on their medical education and training programs were sent on March 14, 1980, to each of the foreign medical schools we visited. All schools responded by June 2, 1980.

Comments from all the schools have been incorporated as appropriate and recognized in appendixes II to VII. Because the University of Central del Este was the only school which disagreed with our observations, its comments are included in their entirety at the end of appendix II.

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## UNIVERSITY OF CENTRAL DEL ESTE

## MEDICAL SCHOOL

The University of Central del Este is on the southern coast of the Dominican Republic in the old port city of San Pedro de Macoris, approximately 40 miles east of Santo Domingo. The university facilities were scattered throughout the city; however, a central campus was under construction. Central del Este offers education in many fields, including medicine. Founded by Dr. Jose Hazim, it enrolled its first class in October 1970. At the time of our visit, the total enrollment was about 13,000 students

The medical school at Central del Este began in 1972 and had an enrollment of about 3,000 students at the time of our visit. About 2,200 (73 percent) of these students were U.S. citizens. The medical school appeared to primarily serve U.S. citizens who were unable to secure admission to U.S. medical schools.

Before 1975, U.S. citizens attending the medical school were mainly Hispanic and, according to university officials, could understand and adjust more easily to the local culture. However, in 1975, the first influx of non-Hispanic U.S. citizens began enrolling at the medical school. Dominican government and health officials saw no need for U.S. citizens to become practicing physicians in the Dominican Republic and did not expect any of them to do so.

### FACULTY

Almost all of the approximately 150 faculty members listed at the University of Central del Este Medical School were Dominicans. Most faculty members had private practices. Because physician incomes in the Dominican Republic were low by U.S. standards, many physicians supplemented their incomes through teaching.

Some students with whom we spoke reported that professors often did not show up or arrived late for scheduled

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lectures. 1/ In addition, teaching monitors were used fairly extensively for laboratory sessions. We were told that these individuals were generally senior medical students, who were in a position to help students answer specific questions.

The medical school did not have U.S. professors on its faculty, and we were told the university did not have a visiting professor program. Students told us that, although many medical school professors were bilingual, English was seldom spoken. Professors were not required to do research.

We were told that, because of a recent fire at the school, only six faculty personnel files were available for review. Our chief medical advisor reviewed these 6 faculty vitae as well as 22 additional vitae that the university later mailed us. Based on a review of these 28 faculty vitae, he concluded that most faculty were reasonably well qualified but that four did not have qualifications for the subjects they were teaching. For example, an individual who graduated from medical school in 1978 with no special training in rheumatology was responsible for teaching that subject.

ADMISSION REQUIREMENTS

The medical school had an open admissions policy; almost all who applied, Dominican or foreign, would qualify. In fact, Central del Este advertised in U.S. newspapers to attract students. A university official told us they did not have any formal contract agreements with student placement agencies in the United States. However, this official noted that four placement agencies advertised the medical school "on their own."

Entrance exams or preliminary interviews were not required, but certain basic science courses (e.g., biology, chemistry, and physics) were offered before the beginning of the school year for students with weak science backgrounds. A Spanish class was also offered for students who needed to improve their language proficiency.

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1/In commenting on our observations, the university said that absenteeism or lateness of professors is not as bad as the report makes it out to be and that no school in the world has 100-percent attendance of professors. They further commented that the university deducts a portion of the professors' salaries when they are late or do not appear for classes.

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The medical school had different tuition policies for Dominican and foreign students. Dominican students were charged $50 per semester plus additional fees. Foreign students (including U.S. students) paid a tuition of $1,405 per semester plus fees. We were told tuition was raised to $1,655 effective in September 1979. According to university officials, the main reason for the difference between Dominican and foreign student tuition was because of the Dominican students' inability to pay. Payment of this tuition was required even while students performed clinical clerkships in U.S. hospitals.

Additional fees required by the university included a transcript fee ($3 per transcript) and a $400 thesis fee. According to university officials, other fees can also be assessed for such items as taking makeup exams or retaking a previously failed course. We were told that, except for tuition, fees were the same for all students.

CURRICULUM

The medical school curriculum consisted of a 10-semester course of study. Each semester lasted about 4 months, and three semesters were offered each year. The first six semesters essentially covered the basic sciences; clinical training predominated during the last four semesters. During the 10 semesters, the subjects offered were similar to those at U.S. medical schools. After the 10th semester, students were required to complete a 1-year clinical internship. After this internship, students had to present a thesis, following which they were awarded their M.D. degrees. To practice medicine in the Dominican Republic, a year of social service was required.

The language of instruction was Spanish. The six semesters of basic science instruction consisted of classroom sessions. There were a few demonstrations and limited laboratory practical work.

Many students dropped out or failed during the first three semesters because of academic problems or difficulties adjusting to the foreign culture and environment. Most textbooks used were written in Spanish, and many were translations of American texts. Many U.S. citizens, for reference and study purposes, also had current American texts.

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Clinical opportunities were severely limited, and students were not exposed to patient care in many areas. According to U.S. citizens we spoke with, the extent of available clinical opportunities varied with professors and resulted in no clinical training being available in some areas because provisions were not made by the professor. We were also told that most U.S. citizens attending Central del Este sought clinical clerkships in a U.S. hospital, a practice allowed by medical school officials. The school had no affiliation, nor did the university pay U.S. hospitals for clinical training. The university had no role in supervising, monitoring, or evaluating this training. The U.S. citizens sought out U.S. clinical clerkships on their own, often to make up for a perceived lack of clinical training at Central del Este. Students told us of instances where (1) they paid the U.S. hospital for the training opportunity, (2) the hospital allowed them to work for free, or (3) the hospital paid the student. U.S. citizens not only sought U.S. clerkships for their clinical training, but also attempted to fulfill the 1-year internship requirement after their 10th semester in U.S. hospitals. Central del Este Medical School officials accepted internship training based upon a confirmation letter from the hospital that the student attended.

FACILITIES AND EQUIPMENT

The University of Central del Este facilities were located in various parts of the city of San Pedro de Macoris. The administration building, located in the center of town, was a small converted store and served as the only administrative building for the university. This building was obviously inadequate for the needs of a student body of 13,000.

A central campus was under construction about 3 miles from the center of town. However, some classrooms and basic science laboratories were on the site of what will become the central campus.

Two classroom buildings, about 3 years old, were used by all university students. There were also two laboratory buildings used primarily by medical students. The laboratory facilities contained separate rooms for microbiology, biochemistry, physiology, pharmacology, and pathology. Equipment in the laboratories was extremely limited. Microscopes had to be shared by many students, and no pathology specimens were available at the time of our visit.

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The university had no medical library. University officials told us that the central campus under construction at the time of our visit would include a new library/conference center and a new administration building.

The anatomy laboratory and three or four classrooms were about 2 miles from the central campus in the rear of the Carl George Hospital. The laboratory contained ceramic tile anatomy tables, had poor lighting, and was not air-conditioned. There was no refrigeration equipment--cadavers were stored in liquid tanks. The number of cadavers was limited, and they were clearly very old, which made identifying nerves, arteries, veins, and other tissues quite difficult. University officials indicated that the anatomy laboratory would remain at its present location and would not be moved to the central campus facilities.

Students received some clinical training at the Carl George Hospital. This hospital, built in 1935, was a tropical non-air-conditioned facility containing about 200 beds. The hospital was crowded, unclean in appearance, fly infested, and had limited equipment. Much of the facility had been converted to a geriatric center. Patient rooms were without toilets, water, suction facilities, or oxygen outlets.

University officials stated that medical students would be able to receive clinical training at the newly opened social security hospital--Jaime Oliver Pino Hospital. However, at the time of our visit, students were not using this hospital. The hospital, a new, 120-bed hospital with a large outpatient facility, contained an X-ray department and a laboratory with a reasonable amount of equipment for the size of the hospital. Some of the laboratory's equipment was automated. Patient rooms were well-equipped, and the surgery and delivery rooms were modern.

U.S. CITIZEN INFORMATION

As of June 1979, about 2,200 U.S. citizens were attending the Central del Este Medical School. Many of the students were Puerto Ricans or Cuban-born U.S. nationals; the others were [illegible]. Students [illegible] were predominately [illegible] and New Jersey.

The [illegible]zens indicated that many had attended college in the [illegible]ced States and had relatively low grade point averages. Most had tried to enter a U.S. medical school, and

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all seemed motivated to obtain a medical education. A few had gone through placement agencies to gain admission to the university, but most of the students we spoke with said they had heard about the medical school through newspaper and other advertisements. The U.S. citizens wanted to return to the United States, receive licensure, and practice medicine.

University officials noted that, in the past, most U.S. citizens who graduated from Central del Este were from Puerto Rico. They added that about 350 North Americans had finished their 10th semester of study at the university, but only 35 had presented a thesis and been given an M.D. degree at the time of our visit.

About one-third of the U.S. citizens had received guaranteed student loans; a much smaller number received veterans' benefits. ED confirmation reports were being received at the university about 2 to 3 months after their effective date. Reports, although updated by school officials, continued to contain the names of students that the university indicated were no longer, or in some cases, never enrolled. According to university officials, student confirmation reports and other student loan information were mailed to the university without instructions on how to complete them. They also said that attempts to contact ED or VA for needed information had been unsuccessful.

Effective August 31, 1979, VA terminated Central del Este's eligibility because the university was unable to demonstrate that it met VA's November 1978 comparability criteria. (See p. 43.) However, a law suit was filed, and in March 1980, the court ruled that benefits could not be terminated because VA's new criteria constituted a regulation and VA had not followed the appropriate procedures for promulgating such a regulation. As a result, VA educational benefits were reinstated on June 10, 1980, and made retroactive to August 31, 1979.

Between 1976 (the first year students from the university took the ECFMG examination) and 1979, the pass rate for U.S. citizens ranged from 2 to 22 percent and averaged about 14 percent. In 1980, 764 U.S. citizens from the university took the ECFMG examination, and 208 (27 percent) passed.

Students were being coached in preparation for the ECFMG examination during the time of our visit. The Rector of the university stated that each year the Director of Medical Education at St. Barnabas Hospital, Livingston, New Jersey, visits

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the university with a group of professors from different U.S. universities to conduct such a course for seventh through ninth semester students.

COMMENTS BY THE MEDICAL SCHOOL

The University of Central del Este, in an April 10, 1980, letter 1/ took issue with a number of our observations but seldom categorically disagreed with what we said. For example, in response to our discussion of the limited number and age of the cadavers at the school, university officials commented that it was fairly easy to get cadavers in the Dominican Republic. However, they did not say that they had acquired any additional cadavers. Likewise, they commented that, although we did not see many instruments at the university, this did not mean the university did not have them. They said that "* * * professors in the labs put away all the instruments, samples, microscopes, etc., therefore they leave nothing outside * * *." We saw the equipment when the Rector of the university and or the medical school Dean took us on a tour of the school's facilities (see p. 78), and neither the Rector nor the Dean told us that the reason we saw only limited equipment was because it had been put away.

Following are additional university comments and our responses:

--The university said that its professors "* * * are all specialists in the areas they teach, * * *." We were told, at the time of our visit, that only six faculty vitae were available because of a recent fire. Our chief medical advisor reviewed these 6 faculty vitae as well as 22 additional vitae that were later mailed to him. Based on a review of these 28 faculty vitae, he concluded that most faculty were reasonably well qualified but that 4 did not have qualifications for the subjects they were teaching.

--The university said that at present it has a very small library and that three projection rooms and audio-visual aids have been introduced in a great number of the faculty classes. At the time of our visit, there

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1/The response from the University of Central del Este included the joint comments of the Rector, President of the Superior University Council, and the Dean and Vice-Dean of the medical school.

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was no medical library and the limited audiovisual aids were intended for the entire university.

--The university said it had 42 anatomy tables where eight students can work on a cadaver and that there are cadavers for each table. At the time of our visit, however, we saw only 22 tables and not enough cadavers for each of the tables. In addition, the cadavers we saw were in such condition that identifying nerves, arteries, veins, and other tissues was difficult.

--The university said that 100 percent of the foreign students who graduated from the university passed their revalidation examinations or obtained their licenses in their countries of origin. However, in 1978 and 1979, when asked by VA to identify U.S. citizens who had graduated from the university and obtained licensure in the United States, the university was unable to do so.

--The university said the only teaching monitors they use are top students, who only give explanations on lab techniques and then only with the professor present. This is contrary to (1) what we were told by students and (2) our observations--we saw a student monitor teaching without a professor present.

--The university pointed out that the [illegible]xth semester courses require students t[illegible]l visits. School officials said tha[illegible] sixth and seventh semesters, students serve in neighborhood clinics run by the university. Students told us, however, that the extent of clinical training opportunities varied with professors and, because some professors made no provision for clinical training, there was no opportunity for clinical training in some areas. The university also said that, contrary to our report, university stu[illegible] interview patients and even gave their o[illegible]nding physician regarding the treatmen[illegible] follo[illegible]d, which they had heard was not done i[illegible]d States. Fi[illegible]st, we made no observation or [illegible] regarding university students interviewing patients and giving their opinion regarding treatment. Second, taking a history and physical, and discussions with medical school faculty concerning patient diagnosis and treatment, is routine for U.S. medical school students.

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The university also pointed out a number of changes which it said have occurred since our visit, including the following:

--The university has contacts with several U.S. hospitals where students can go for their "internship" before graduation.

--Students from the university are now using the new social security hospital.

--A new, 300-bed public health hospital is being built which will be a university hospital under the joint administration of the university and the country's public health agency. According to the university, the facility of this hospital will be used for treatment and education.

In addition to the above changes, the university also submitted to us a list of visiting professors who came to the university from the United States and Latin American countries to give lectures on various subjects. We assume that this list was intended to demonstrate a change which occurred since our visit because we were told by the registrar that they did not have a visiting professor program. (See p. 75.)

We did not verify any of the changes the university said it made after our visit.

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Universidad Central del Este
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April 10, 1980

Mr. Robert W. Wilson
Team Leader
United States General Accounting Office
Washington Regional Office
441 G Street NW 5th Floor
Washington, D.C. 20548, USA

Dear Mr. Wilson:

Thank you for sending us a copy of the draft report with your letter of March 14, 1980, which we received through the American Consulate in Santo Domingo on March [illegible], 1980.

Enclosed for you and the other members of the team is our statement and comments on your draft report.

We trust that when the final report is issued we will receive a copy for our records.

If we can give you any additional information please let us know.

Sincerely,

Dr. José E. Hazim
Rector

JEH/omh
encls.

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April 10, 1980

This will constitute an answer to the draft report received from GAO through the American Consulate in the Dominican Republic, on the visit made to Universidad Central del Este in July 1979. The comments appearing below are the joint comments of:

Dr. José E. Hazim , Rector

Dr. José A. Hazim, President, Superior University Council

Dr. Juan A. Silva S., Dean, Sch of Medicine

Dr. Juan Musa, Vice-Dean, School of Medicine.

We would like to make a small change in the dates shown in the report, as the beginning of Universidad Central del Este was October 1970, but the School of Medicine itself only started in 1972.

When the GAO commission visited Universidad Central del Este it had a number of students registered of 13,000, the number has now passed the 15,000. When the GAO commission was here approximately 2,200 were foreign students of these only about 800 were born in the USA, the rest was divided evenly between Puerto Ricans, naturalized USA citizens and others.

Regarding the absenteeism or lateness of the professors this is not as bad as the report makes it out to be. Nowhere in the world is there 100% attendance of professors and as in UCE we control attendance and the lateness of any professor, we state again this is not as prevalent as the report says. Whenever a professor does not appear for classes or is late a portion of his salary is deducted, for this reason alone absence from classes is not as common. Some students not passing their courses will find fault and quote cases only existing in their active imaginations.

The monitors we do use are students, only top students, for the lab classes and not for the theory part of the subjects. These monitors only give explanations on lab techniques with a professor present, never with the professor absent.

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The School of Medicine in the Dominican Republic of course uses Dominican professors and not American professors. We have visiting professors who come to the University from the United States and from other Latin American countries and give lectures on various subjects to our medical students, we list below most of the visiting professors and lecturers:

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|---|---|
| Dr. Theodore H. Miller | Surgeon, St. Barnabas Hospital<br>Previously Head of Surgery at Memorial Sloan Kettering Hospital, N.Y.<br>At present Consultant at Memorial-Sloan Kettering |
| Dr. Francis A. Beneventi | Urologist<br>Past Head of Urology of New York Hospital and New York Medical School<br>also Polyclinic and French Polyclinic Hospitals, New York |
| Dr. Abdol H. Islami | Surgeon,<br>Director Department of Medical Education<br>President, Medical Staff, Saint Barnabas Hospital, Livingston, N.J. |
| Dra. Maria Thereza Dantas Loures da Costa | Psicologist<br>Coordinator in charge of Psico-profilactic Surgical Equipment at the Municipal Hospital in Rio de Janeiro, Brazil |
| Dr. William R. Bell | Associate Professor of Medicine<br>Hematology Division<br>Johns Hopkins Hospital, Baltimore, Md. |
| Dr. Jack M. Bowerman | Associate Professor of Medicine<br>Radiology Department<br>Johns Hopkins Hospital, Baltimore, Md. |
| Dr. Tah-Hsiung Hsu | Associate Professor of Medicine<br>Endocrinology Division<br>Johns Hopkins Hospital, Baltimore, Md. |
| Dr. Carlos Dante Heredia Garcia | Ophthalmologist<br>Professor at the Clinica e Instituto Baraquer<br>Barcelona, Spain |

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| Dr. Juan E. Acevedo G. | Cardiologist<br>Mayaguez, Puerto Rico |
| Dr. Ramon M. Suarez C. | Cardiologist<br>Mayaguez, Puerto Rico |
| Dr. Adolfo Perez Comas | Endocrinologist<br>Mayaguez, Puerto Rico |
| Dr. Rafael Diaz Martinez | Pneumologist<br>Mayaguez, Puerto Rico |
| Dra. Angela Ramirez Irizarry | Plastic Surgeon<br>Mayaguez, Puerto Rico |
| Dr. Luis Torres | Surgeon<br>San German, Puerto Rico |
| Dr. Hector Ortiz Sambolin | Traumatologist and Orthopedic<br>Mayaguez, Puerto Rico |
| Dr. Paul E. Kindy | Traumatologist and Orthopedic<br>Mayaguez, Puerto Rico |
| Dr. Ramón D. Acosta | Radiologist<br>Mayaguez, Puerto Rico |
| Dra. Acacia Mercedes | Pediatrician<br>Dominican Republic |
| Dra. Consuelo Mendoza | Pediatrician<br>Dominican Republic |
| Dra. Maria Vargas | Pediatrician<br>Dominican Republic |
| Dr. Bdo. Sanchez Martinez | Pediatrician<br>Dominican Republic |
| Dr. Marcos Diaz | Pediatrician<br>Dominican Republic |
| Dr. Homero Rivas | Pediatrician<br>Dominican Republic |
| Dra. Angelica Floren | Pediatrician<br>Dominican Republic |

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|---|---|
| Dr. Alejandro Mallet Arellano | Professor of Pediatrics<br>Universidad Autonoma de Mexico<br>Head of Medicine of the Pediatrics Unit<br>of the General Hospital of Mexico |
| Dr. Jaime Lopez Ortiz | Pediatrics Professor of<br>Pediatrics Institute of Mexico<br>Head of the Nutrition Department of<br>the General Hospital of Mexico |
| Dr. Antonio Chavez Perez | Coordinator of the Cicles IX and X<br>of Universidad Autonoma de Mexico<br>Professor of Pediatrics of Universidad<br>Autonoma de Mexico |
| Dr. Julio C. Castillo Vargas | Endocrinologist<br>Dominican Republic |
| Dr. Manuel C. Diaz Baez | Endocrinologist<br>Dominican Republic |
| Dr. Richardo R. Rodriguez | Endocrinologist<br>Dominican Republic |
| Dr. Eduardo Coll García | Endrocrinologist<br>Dominican Republic |
| Dr. Felix Puchulu | Endocrinologist<br>Dominican Republic |
| Dr. Enrique Pimentel | Endrocrinologist<br>Dominican Republic |
| Dra. Josefina Salas M. | Endocrinologist<br>Dominican Republic |
| Dr. Luis J. Cardonnet | Endocrinologist<br>Dominican Republic |
| Dr. Francois Xavier Bourdeau | Endocrinologist<br>Dominican Republic |
| Dr. Máximo Ruiz | Endocrinologist<br>Dominican Republic |

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|---|---|
| Dr. Diego Hurtado Brugal | Endocrinologist<br>Dominican Republic |
| Dra. María Rosa Belliard | Endocrinologist<br>Dominican Republic |
| Dra. Josefina García de Coén | Endocrinologist<br>Dominican Republic |
| Dr. Néstor A. Serantes | Endocrinologist<br>Argentina |
| Dra. Corina de Js. de Ramirez | Endocrinologist<br>Dominican Republic |
| Dr. Victor Ml. Perrotta M. | Endocrinologist<br>Dominican Republic |
| Dr. Francisco J. Valerio G. | Endocrinologist<br>Dominican Republic |
| Dr. Socrates Mañón Alcántara | Endocrinologist<br>Dominican Republic |
| Dr. Pablo Barinas Robles | Endocrinologist<br>Dominican Republic |
| Dr. Francisco Arrieta Alvarez | Endocrinologist<br>Spain |
| Dr. Román Arreaza Cardier | Endocrinologist<br>Dominican Republic |
| Dr. Alfonso Castillo Navarrete | Endocrinologist<br>Venezuela |
| Dr. Bernardo Nusimovich | Endocrinologist<br>Argentina |
| Dr. Carlos H. Espinel | Nephrologist<br>Medical Director of Mid Atlantic Nephrology Center Ltd.<br>Professor of Internal Medicine of Georgetown University Medical School<br>Washington, D. C. |

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|---|---|
| Dra. Marianela de Ariza | Prof. Pediatrics<br>Universidad Central del Este and<br>Universidad Autonoma de Santo Domingo<br>Dominican Republic |
| Dr. William Harrington | Emeritus Professor of the<br>University of Miami and Director<br>of Medical Department of same |
| Dr. J. Bocles | Titular Professor of Pneumopathology<br>University of Miami |
| Dr. José G. Sobá | Cancer Specialist and Radiologist<br>Investigator<br>Dominican Republic |

Besides every year Dr. Abdol Islami, Director of Medical Education of St. Barnabas Hospital, Livingston, N.J. visits our University with a group of professors from different universities in the United States and they conduct a course for the 7th, 8th, 9th and 10th semester students preparatory for the ECFMG examination. This course lasts six weeks.

The professors we have in our University are all specialists in the areas they teach, all graduates who have taken their specialties in the Dominican Republic as well as other countries such as USA, Mexico, Rusia, etc. We are always trying to improve our teaching staff and raise our educational level by helping our professors to obtain up to date knowledge and teaching aids.

Of course in our country the classes are in Spanish, this is our language and English is only secondary, though a lot of our people know English.

It is an internal policy of Universidad Central del Este to allow anyone who fills our requirements for admission and want to register to do so. The great majority

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of our foreign students have already taken college courses completing the pre-med, those who do not have the complete pre-med must take the subjects they are missing and in some cases they are allowed to take some subjects from faculty with those from college, only when those subjects from college are not pre-requisites to the faculty subjects.

Students that have taken only high school must enroll in our University College or Pre-Med, this is compulsory. If a student has passed the pre-med in his own country he has had an entrance exam in his country. Through the years we have found out that entrance exams do not serve the purpose they are intended for. We do have entrance exams for the University College or Pre-Med.

Spanish is a compulsory language, and when the student registers he is warned that all faculty classes are conducted in Spanish and if they not know the language they will not be able to follow the classes. The student is given the opportunity to come to the school knowing Spanish which they can take at home, or they do so in San Pedro de Macoris where there are three school specializing in teaching Spanish to the foreign born.

The curriculum of our medical school is made up in such a way that the clinical training starts from the 6th semester, Medical Semiology and Orthopedics and Trumatology both require hospital visits for the students.

In the 6th and 7th semesters the students must serve the community under the supervision of a licensed physician in neighborhood clinics run by the University. The students do first or prima-ry level work such as vaccinations, epidemiology reports, contact with the neighborhood families to acquaint them with health problems. We are sure that clinical training for studetns in this country is more readily available than in the USA.

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When they reach the 10th semester and within the clinical training some students are selected to serve in a rural clinic during 8 weeks for 24 hours a day, under the supervision of a Dominican physician.

Contrary to what the report says the students have the opportunity to interview patients and even give their opinion to the attending physician regarding the treatment to be followed, we heard that this is not done in the USA.

Many students if they spend their free time in the United States in clerkships, it is to become acquainted with the American methods, but they do not get any credit for these clerkships, and most of the studnets do these in an effort to get money to pay for their studies.

Universidad Central Del Este has control over the internships students do in the Dominican Republic as the students are under the supervision of a licensed physician of the departments and these phycians have the approval of the hospitals. As far as internships in the United States or the student's country of origin, the control is that the certificates they receive are signed by the heads of the departments of a recognized hospital these signatures are notarized and legalized by the Dominican Consulate in the country. The foreign students can do their internship in the Dominican Republic, but the great majority of them prefer to return to their own country.

At present we have contacts with several hospitals in the United States that have had students from UCE and now they have offered to receive more students to do their internships, it is standard procedure that a hospital will not set up any contacts or offer to receive students from a University until they have had experience with their students.

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We have also received offers from hospitals that have openings for residencies in various branches, again these contacts are results of experiences with our students doing their internships before graduation.

The report talks about the facilities in the University campus. The University at present has 3 buildings for classrooms and various labs for medicine, dentistry and other schools of engineering. The Rectory building (administration) will be finished in three months, the library will be finished in October. At present do have a very small library it has 5,000 volumes in a very small space, but it is available to all students. The new library will have a capacity for 500,000 books and 2,000 students seated in reading rooms.

The University has 3 projection rooms and audio-visual aids have been introduced in a great number of the classes in all faculties.

The fact that the GAO commission did not see many instruments does not mean we do not have them. The professors in the labs put away all the instruments, samples, microscopes, etc. therefore, they leave nothing outside, following our instructions.

It is true that the lights were poor in the Anatomy Institute when the GAO commission visited it, this has been remedied so has the air conditioner. Except that our country as the rest of the work is suffering from a shortage of oil and we are in an energy preservation plan, which means that when a classroom is not in use (it also goes for the labs and institutes) the air- conditioners are turned off, the lights are either dimned or turned off. For the same reason the preservation of the cadavers is in formalin and not in refrigeration. Our institute has 42 tables where 8 students with a professor can work on a cadaver. We have cadavers for each one of the tables, however, these cadavers are not taken out unless it is for classes.

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As a matter of information in the Dominican Republic it is still fairly easy to get cadavers so that we have opportunities to get fresh cadavers for our medical students' use in classes.

The GAO commission pointed out that the Anatomy Institute was 2 miles from the school, this as far as we are concerned is an ideal location as UCE is now setting up an Oncological Hospital and an Anatomy museum in the same area as the institute.

The new Social Security Hospital Dr. Jaime Oliver Pino is now being used by our students as well as using the Dr. Carl Th. Georg. We must disagree with the report of GAO about the radiology facilities at the Social Security Hospital, this hospital has X-Ray equipment in all the surgical rooms, the urology and orthopedics examination rooms, the internal medicine examining rooms. It also has a complete radiology department with four (4) large X-Ray Units.

We must also disagree with the report regarding the laboratory this hospital has, the one it has is well equipped and capable of all types of tests.

San Pedro de Macoris will have another hospital in 1980, a 300 bed facility being built by Public Health and it will be a University Hospital to be under the joint administration of the University and Public Health with all the facilities for medical attention and education.

The criticismo that the Dr. Carl Th. Georg Hospital is old and has no facilities for oxygen and suction can be made about a great many other hospitals in other parts of the world, as you know it is very costly to add up to date facilities to old hospitals. The patients do not suffer as whenver they need any procedure calling for oxygen or suction they receive it.

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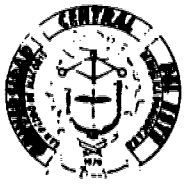

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A final comment we would like to make is that 100% of the foreign students that have graduated from Universidad Central del Este have passed their revalidation exams or obtained their licenses in their countries of origin. When we talk about graduates we mean those st nts that have obtained their MD degrees at UCE.

APPENDIX III

## UNIVERSITY OF NORDESTANA

## MEDICAL SCHOOL

The University of Nordestana was founded in March 1978 by a group of people that included the former Vice-Rector of the University of Central del Este, businessmen, and clergymen. The university is in the northeast part of the Dominican Republic in the city of San Francisco de Macoris. The university was recognized by the Dominican government in July 1978, and is a nonprofit private institution. Classes commenced in September 1978 with 204 students, including 10 medical students. By the time of our visit, enrollment had increased to 850 students, including over 300 in the medical school. About 240 (80 percent) of the medical students were U.S. citizens, and most had previously attended the University of Central del Este Medical School. University facilities consisted of a one-story building in the center of the city, which included both classrooms and administrative offices.

Many of the Nordestana students attributed their transfers to displeasure with Central del Este administrators and faculty. Another possible reason appeared to be the arrangements Nordestana had made for U.S. citizens to return to U.S. hospitals, after 2 years of study in the Dominican Republic, for clinical clerkships.

Officials in San Francisco de Macoris were pleased with the presence of U.S. citizens at the medical school because of the revenue brought to the city. However, Dominican Republic government and health officials said that, although there were not enough physicians in their country, the large number of Dominican students in the country's medical schools would create an oversupply in the future. Therefore, there was no need for U.S. citizens to become practicing physicians in the Dominican Republic.

### ADMISSION REQUIREMENTS

The Nordestana medical school's admissions policy was the same for both Dominican and foreign students. The requirements included a high school diploma and two semesters of premedical background sciences (biology, chemistry, and physics). University officials said they also plan to require an entrance examination. Once enrolled, both Dominican and foreign students must take Dominican history. According to university officials, transfer students would no longer be

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accepted into the medical school with advance standing beginning with the fall 1979 semester. We were advised that the university had no affiliations with placement agencies at the time of our visit.

Tuition at the Nordestana Medical School was about $1,300 a semester for foreign students and $60 a semester for Dominican students. Tuition increased to $2,550 a semester when students took clinical clerkships at hospitals in the United States. University officials told us that the increased tuition covered the cost of obtaining and maintaining the arrangements with U.S. hospitals. Additional fees assessed by the university included $130 for each course repeated, a $20 to $30 graduation fee, and a $650 thesis fee. The medical school offered scholarships ranging from 25 to 100 percent of the cost of tuition to the top eight students of each semester's class. Dominican and foreign students competed for scholarships based on academic standing.

CURRICULUM

The requirements for graduating from the Nordestana Medical School and obtaining an M.D. degree were the completion of a 10-semester curriculum and a 1-year internship program and presentation of a thesis. The first six semesters involved basic sciences, with all instruction in Spanish. Course requirements were similar to U.S. medical schools, but the courses were primarily lectures with minimal laboratory sessions or demonstrations. Students primarily used lecture notes for study, and some U.S. citizens used American medical textbooks for reference.

Clinical studies were taken during the 7th through 10th semesters. Students had the option of taking their clinical studies in hospitals and clinics in San Francisco de Macoris or working in a U.S. hospital as part of a clinical clerkship program, without any monitoring of that training by Nordestana. Students electing to take their clinical training in the United States must return to Nordestana at the end of each semester to be examined by university professors. According to university officials, an evaluation of the student's performance would be received from the hospital. Clinical facilities were very limited in the San Francisco de Macoris area, and most U.S. citizens planned to take their clinical training in a U.S. hospital. At the time of our visit, only 30 students were enrolled in the clinical semesters and none were beyond the eighth semester.

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Once the clinical semesters had been completed and before award of the M.D. degree, the student was required to do a 1-year internship. As with the clinical training, U.S. citizens were allowed to perform this internship in a U.S. hospital. To practice medicine in the Dominican Republic, 1 year of social service was required.

FACULTY

University officials said the medical school had 30 to 35 faculty members. Six faculty members were full time; the others taught part time and also had a private medical practice. About half of the faculty lived in the San Francisco de Macoris area; the rest came from Santo Domingo (about a 2- to 3-hour drive one way).

According to university officials, each professor was encouraged to publish articles or books in his field. Many faculty members had received specialty training in the field in which they taught, and a few had received postgraduate medical training in the United States. No U.S. professors were on the faculty, and the university had no visiting professor program.

We requested additional information on the qualifications of the medical school faculty members, but it has not been provided as of November 1980.

FACILITIES

Nordestana Medical School facilities were in the center of San Francisco de Macoris in a renovated, one-story building that contained both classrooms and administrative offices. The 130-year-old building contained six classrooms with seating capacities ranging from 20 to 100 students. These classrooms were for students from both the medical school and other curriculums. Classrooms were separated by partitions; however, partitions did not extend to the ceilings. Administrative offices for the entire university were also in this building.

The medical school was affiliated with one Dominican Republic hospital--St. Vincent de Paul Hospital. This was where all clinical training in the Dominican Republic was received. St. Vincent de Paul Hospital was about 27 years old and contained 300 beds. There were 60 physicians and 45 nurses on the hospital staff, and equipment was minimal. The hospital did not have air-conditioning, even in the

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operating and emergency rooms. Flies and other insects were noticeable everywhere.

Laboratories for the medical school were located at the hospital and included only microbiology, histology, and hematology. There was no equipment for histology and only three microscopes for each of the other two laboratories. In addition, there were no cadavers for anatomy, although hospital officials stated that cadaver refrigeration equipment was being built.

U.S. CITIZEN INFORMATION

Most U.S. citizens with whom we spoke had previously applied to medical schools in the United States but had been denied admission, primarily they thought, because of their low grade point averages. U.S. citizens appeared highly motivated, and all desired to practice medicine in the United States.

Most of the U.S. citizens were enrolled in the basic science semesters (one through six) and only a few in semesters seven and eight. Of the latter, some were studying in the United States on clinical clerkships, while others were obtaining their clinical experience in the St. Vincent de Paul Hospital. No students were enrolled beyond the eighth semester, and no one had graduated from the medical school at the time of our visit.

Many U.S. citizens said they had received either guaranteed student loans or VA benefits while at the University of Central del Este but had given them up to come to Nordestana. However, we found that several students applied for loans to attend Central del Este and, apparently after the loans were approved, transferred to Nordestana.

University officials said they had contacted ED and VA for approval to have the U.S. citizens receive guaranteed student loans and/or VA benefits. However, at the time of our visit, no approvals had been received.

U.S. citizens at Nordestana first took the ECFMG examination in 1980. During this period, 37 U.S. citizens took the examination, and 11 (30 percent) passed.

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COMMENTS BY THE MEDICAL SCHOOL

The Administrative Vice-Rector of the University of Nordestana said in a May 23, 1980, letter that our observations accurately reflected the situation at the time of our visit. However, he pointed out that the university's administration has changed and that the new administration is trying to make an "authenic" university. University officials said the new Rector has a goal of providing quality education in an atmosphere of discipline and honesty. He has obtained a donation of land from the Dominican government for a new campus. He is also exploring the possibility of an affiliation between Nordestana and a U.S. medical school for the exchange of students and training of personnel.

Specifically, the university pointed out a number of changes which it said occurred since our visit, including the following:

--In the near future, transfer students will not be accepted into the medical school with advanced standing.

--Tuition will be $1,550 a semester when students take clinical clerkships in U.S. hospitals.

--The practical portions of courses are being expanded extensively with the addition of new equipment and teachers.

--School-appointed coodinators in Miami, New York, and Puerto Rico will monitor clinical training for its students in U.S. hospitals.

--The medical school now has 43 faculty members, of whom 22 are on a full-time salary basis. Most of these are residents of San Francisco de Macoris and also work in the hospital and have private practices. There are 14 professors who live in Santa Domingo who teach mainly subspecialty courses.

--The university now has three buildings--one for the Faculty of Engineering, one for the Faculty of Agronomy, and one for the Faculties of Medical and Business Administration. The building used by the Faculty of Medicine has been renovated and new classrooms added.

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--The hospital operating rooms are now air-conditioned.

--Laboratories for the medical school are located in the hospital and now also include parisitology, physiology, and pathology. The school recently acquired eight additional microscopes and has bought microscope slides and will do so on a regular basis.

--The university has acquired several cadavers and built a facility with four dissecting tables and a capacity for preserving 24 cadavers.

We did not verify the changes described above.

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## ST. GEORGE'S UNIVERSITY

## SCHOOL OF MEDICINE

St. George's University School of Medicine was founded as a for-profit institution in January 1976 by Charles Modica, former admissions director of the University of Central del Este Medical School. Upon leaving of Central del Este, Mr. Modica was commissioned by a number of U.S. physicians to study the possibility of establishing a medical school outside the United States primarily to educate U.S. citizens who were unable to obtain admission to U.S. medical schools. As a result, he established a school of medicine near the city of St. George on the island of Grenada, the southernmost of the Caribbean Windward Islands. Additional medical school facilities are located on the neighboring island of St. Vincent. The university's administrative offices are located in New York City.

St. George's University is primarily a medical school and offers limited curricula in other fields. The medical school primarily serves U.S. citizens who have been unable to secure admission to medical schools in the United States. Grenadian health officials saw a need for more physicians on the island, but did not see the medical school filling this need. None of the U.S. citizens with whom we spoke planned to practice medicine in Grenada. However, university officials said they plan to require all students to provide some medical care services in Grenada for one semester, thus contributing to the island's available medical care. Further, each year they were enrolling a few Grenadian and Vincentian students tuition free.

At the time of our visit, about 800 students were enrolled in the school of medicine. About 710 (90 percent) were from the United States--primarily from New York and New Jersey. Students were enrolled in the first six semesters of the school's nine-semester program; none had graduated from the university.

### ADMISSION REQUIREMENTS

The school of medicine had no formal admission requirements. University officials told us that admission requirements for U.S. citizens are generally a college degree, acceptable scores on the standardized test (MCAT), and an interview with university staff. We were advised that some students

were allowed to apply with only 3 years of college, but this was rare. No entrance exam or language requirements were imposed, and we were advised that no placement agencies were affiliated with the university. All application and admissions processing was performed at the administrative office in New York City. University officials said they received between 1,500 and 2,000 applications for enrollment into the medical school each semester, primarily from U.S. citizens. About 800 of the applicants were interviewed in five locations in the United States, and 150 were selected by an admissions committee that met in New York and Grenada. We were told that U.S. students selected for admission tended to have above-average scores on a standardized test, and grade point averages ranging from 3.0 to 3.7. According to the Chancellor, the final selections are made by an admissions committee which meets in Grenada and New York, and selections are made in consultation with the Vice Chancellor and the Dean of Faculty. The New York office was also responsible for appointing faculty and purchasing equipment and supplies.

Tuition at St. George's was $2,850 per semester; it was the same for all students, except for the few local students who paid no tuition. Additional fees imposed by the university included $45 for application, $25 for interview, $500 per semester for the dorm, $620 per semester for the meal plan, $100 per semester for air-conditioning, and $150 to $210 for books. In addition, students incurred annual living and transportation expenses ranging from $5,000 to $6,000.

CURRICULUM

The medical school program was nine semesters long covering 4-1/2 years; teaching was entirely in English. The first four semesters covered the basic sciences and included preclinical subjects similar to those taught in U.S. medical schools. In addition, students were exposed to a course in physical diagnosis and another entitled an introduction to clinical medicine. Current American medical texts were used, and exams were given each semester. Instruction was by lecture and laboratory demonstrations, and all basic science classes were held on campuses in Grenada. University officials said that students used the St. George's General Hospital for physical diagnosis and patient histories.

The fifth semester of study was taken on the island of St. Vincent at the Kingstown Medical College. There, students were introduced to clinical rotations, which included lectures in each of the five major medical areas (medicine,

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surgery, obstetrics/gynecology, pediatrics, and psychiatry) plus working with patients at the Kingstown General Hospital. The lectures were conducted by visiting professors from the United States and England who spent 2 to 3 weeks teaching students the major clinical subjects. While at the hospital, students worked under the general supervision of medical and surgical registrars from English hospitals, who were recruited by St. George's specifically for that purpose. Students accompanied physicians on ward rounds and were exposed to direct patient care. University officials on the Kingstown medical campus stated that the Kingstown General Hospital was sufficient for exposing a student to the major clinical areas during orientation but was inadequate for clinical training.

The sixth, seventh, and eighth semesters were spent in clinical rotations at U.S. hospitals. At the time of our review, students were dispersed among 13 hospitals affiliated with St. George's University and located primarily in New York, New Jersey, and California. Four of the hospitals were teaching facilities affiliated with U.S. medical schools; the others were community hospitals with no such affiliation. The three clinical semesters included clinical theory, ward rounds, conferences and seminars, and rotation through the five major services. University officials said that the hospitals were paid $1,000 per student per semester for their teaching activity. Students continued to pay $2,850 tuition each semester to the university while they were in U.S. hospitals. In addition, officials said that the university employed five U.S. physicians (one on each of the five major specialties) to monitor the hospitals' clinical teaching.

The ninth and final semester had not been finalized at the time of our visit, but university officials said that plans called for 6 months of work in hospitals, clinics, or schools in Grenada and St. Vincent, assisting local physicians and providing patient care. A final comprehensive exam would be required to complete the curriculum and receive an M.D. degree.

Once graduated, the student would have received medical education over a period of 4-1/2 years as follows: four semesters of basic sciences in Grenada, one semester of an introduction to clinical rotation in St. Vincent, three semesters of clinical rotations in U.S. hospitals (including one-half semester of elective didactic study), one semester of patient care in Grenada or St. Vincent, and a final comprehensive exam.

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## FACULTY

There were about 28 full-time faculty members at St. George's University School of Medicine teaching mainly in the basic sciences. The faculty was composed primarily of professors, both M.D.s and Ph.D.s from the United States. Two Grenadian physicians and a few St. Vincent physicians also taught at the university. Although personnel files were not available for our review, we were told that many professors previously taught at U.S. medical schools.

No research was conducted by faculty members at the school of medicine; emphasis was on teaching. The recruitment of faculty was enhanced by a desirable climate and environment, together with a reasonable amount of time off. With some exceptions, notably pathology, the university had had success in recruiting faculty.

The university placed great emphasis on using visiting professors, mainly from the United States. University officials contended that the visiting professors keep students in the mainstream of medical education by lecturing and conducting demonstrations on current medical topics. Each university faculty member was allowed three visiting professors per course each semester. Professors visited the campus in Grenada for about 3 weeks to lecture on a specific topic. However, at the St. Vincent campus, "teams" of visiting professors sometimes taught an entire clinical subject. It was the university's intention to use visiting professors extensively for providing instruction to medical school students.

## FACILITIES

In Grenada, the university occupied two campus sites. One, on the Grande Anse Beach, was a small administrative building for the office of the Vice-Chancellor as well as clerical staff, a dome amphitheater with a seating capacity for 600 students (the only campus lecture hall at Grande Anse), a cafeteria, and recreation facilities. Also on the campus were air-conditioned dormitories for about 150 students. These dormitories, formerly a motel, were available for third and fourth semester students only. The only laboratory building was an air-conditioned facility with rooms for anatomy and neuroanatomy and a refrigeration room for cadavers. There were only 10 cadavers; however, a number of plastic models were available for teaching anatomy.

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The other campus in Grenada was in an area called True Blue, about 2-1/2 miles from Grande Anse, on the former site of Expo 69. A non-air-conditioned converted motel served as a student dormitory for 120 to 150 students. Some administrative offices, a cafeteria, and the university bookstore were also on this campus. The one lecture hall at True Blue had a seating capacity of about 150. Newly constructed on the True Blue campus, but not yet equipped for operation at the time of our visit, was a large medical library. The library had old editions of current texts and no current periodicals; however, many journals had been ordered. Audiovisual equipment was to be included in the library but had not yet been installed.

The histology and microbiology laboratories were modern. Pathology was taught in a portion of the microbiology laboratory while a small pathology laboratory was being constructed. St. George's did not have biochemistry, physiology, and pharmacology laboratories. We recognize, however, that some U.S. medical schools do not have such laboratories.

St. George's General Hospital--the only hospital on the island--is an old facility with about 250 beds. It was a non-air-conditioned tropical-type hospital with old equipment. The chief of the hospital's medical staff said that St. George's General Hospital was grossly inadequate for clinical training. University officials maintained that the hospital was used by students only for physical diagnosis and patiert histories. However, hospital officials said few students ever work at the hospital.

The campus at St. Vincent consisted of two buildings on 5 acres of land outside the capital city of Kingstown. One building contained the administration office, a small reference library, and the office of the dean. The other building was an open-air lecture hall with a seating capacity of about 150. Six faculty offices were also located in this building. These were the only school facilities on the island; however, the university was affiliated with the island's general hospital.

The Kingstown General Hospital was a non-air-conditioned, 250-bed tropical hospital, similar to St. George's General Hospital. The facility was drab and unclean, and wards were crowded. Equipment was minimal and much of it was inoperative. The hospital was used by the university to introduce fifth semester students to clinical rotations.

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St. George's University was using U.S. hospitals to provide clinical training, since there were few clinical facilities available on the islands.

## U.S. CITIZEN INFORMATION

At the time of our visit, about 800 students were enrolled in St. George's University School of Medicine, of whom about 710 (90 percent) were from the United States. There were about 600 students on the two Grenada campuses, 100 in St. Vincent, and 100 in U.S. hospitals receiving clinical training.

A number of students had advanced degrees, and others indicated they were dentists or podiatrists. We were advised that students' grade point averages ranged from 3.0 to 3.7, and scores on a standardized test were generally high. Students we talked to said they had unsuccessfully applied to U.S. medical schools before coming to St. George's. All students we talked to expressed a desire to do their clinical training in the United States and hoped to transfer to a U.S. medical school at some point during their medical education. All wanted to eventually practice medicine in the United States.

VA denied eligibility to St. George's University because it had not met VA's November 1978 comparability criteria. As a result, qualified veterans, their spouses, and dependents could not receive VA educational benefits to attend St. George's.

St. George's was denied eligibility to participate in the Guaranteed Student Loan Program in July 1979 because it did not meet ED's standards as set forth in its April 23, 1979, proposed rulemaking notice. As a result, U.S. citizens at St. George's were not eligible for federally guaranteed student loans at the time of our visit.

U.S. citizens at St. George's first took the ECFMG examination in January 1979. During 1979, eight U.S. citizens from the university took the examination and four passed. During 1980, 122 U.S. citizens took the examination, and 101 (83 percent) passed.

## COMMENTS BY THE MEDICAL SCHOOL

The Chancellor of St. George's University, in an April 8, 1980, letter, said that overall our observations were accurate. Additional information was provided to clarify

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some of the information in this appendix. The Chancellor also pointed out the following changes that occurred after our visit as well as future plans for the medical school.

--The pathology and microbiology laboratories are separate, and the microbiology laboratory is somewhat larger than the histology laboratory.

--The university plans to hire additional registrars (physicians) both in St. Vincents and Grenada for the ninth semester of studies. All students will be required to return to the West Indies area to complete their studies and undergo their final comprehensive examination. At that time, clinical activities in both hospitals as well as minor health facilities on the islands will be suitable for clinical training.

--Recruitment problems in pathology have been somewhat solved by hiring a second full-time pathologist as well as using a number of visiting pathologists. The university plans to hire a third pathologist in the fall of 1980.

--Arrangements have been made with the government of Guyana to supply 60 cadavers per year to the university in exchange for considerable medical equipment and scholarships for Guyanese citizens.

--The university library now has many new textbooks and over 300 current journals.

--The university is using hospitals in the United Kingdom as well as the United States for clinical training and also plans to look at other countries for this purpose.

We did not verify the changes described above.

APPENDIX V

## AUTONOMOUS UNIVERSITY OF GUADALAJARA

### MEDICAL SCHOOL

The Autonomous University of Guadalajara, founded in 1935, is a private, nonprofit multidisciplinary university with 18 schools of study. Located on three campuses in the city of Guadalajara, it had a full-time enrollment of about 18,700. The medical school had about 7,500 students, of whom about 3,000 were from foreign countries. U.S. citizens (about 2,100 at the time of our visit) were the largest group of foreign sutdents at the medical school. Mexican government officials told us that the vast majority of U.S. citizens studying medicine in Mexico were enrolled at Guadalajara.

Mexican government and medical society officials said that the country had an oversupply of physicians. These officials added that over 83,000 students were enrolled in Mexico's 55 medical schools. About 17,000 medical students graduated each year, but only 2,000 positions were available in Mexico's official residency programs. Entrance to the residency program was based on a competitive exam, and students selected were usually assured of a job within Mexico's health or social security system once their training was completed. According to a Mexican health official, students not selected for the residency program ended up in (1) private practice, (2) the United States for specialty training, or (3) Mexico's large cities working as physician assistants.

A Mexican health official said that oversupply of physicians in Mexico was due to a geographic maldistribution. According to this official, physicians were reluctant to relocate to rural areas, even though many had difficulty establishing practices in the large cities. However, Mexican students continued to enroll in medical school because the career carried great social prestige and the public universities charged no tuition. Mexican officials indicated that Mexican medical schools enrolled more medical students than the United States, and although U.S. citizens came to Mexico for a medical education, they were not needed after graduation to supplement Mexico's health system.

### ADMISSION REQUIREMENTS

The medical school operated on a semester basis, with new classes enrolling every January and July. Admission requirements varied, depending on whether a student was from Mexico, another Latin American country, or elsewhere.

The university had an open admissions policy for all Mexican students who had the equivalent of a high school degree. University officials said about 20 percent of the Mexican students dropped out--mostly in the first year of study. We were advised that the open admissions policy for Mexican students is generally adhered to by all Mexican universities.

University officials told us that foreign students (including U.S. citizens) who applied to the medical school must meet their home country's requirements for studying medicine. We were advised that U.S. applicants were usually required to be college graduates, have completed premed courses, have about a 3.0 grade point average, and have at least average scores on a standardized test. However, university officials said that exceptions were made under a special admissions program and that they looked for students with strong science grades and with the ability to adjust to Mexican culture. They said foreign students were also required to pass a proficiency exam in Spanish before being enrolled and to take courses in Mexican history, geography, and government.

The Autonomous University of Guadalajara has become increasingly more selective about foreign students. We were advised that over the last 5 years enrollment of foreign students decreased significantly. For every four U.S. citizens who applied for admission to the medical school, one was enrolled. University officials expected the percentage of U.S. citizens enrolled in the medical school to decline because of the restrictions on admission.

Tuition at the medical school was much higher than that at Mexico's public universities. According to university officials, about 85 percent of the university's operating budget came from tuition. Tuition varied by degree program and by the nationality of the student. Medical school tuition was based on nationality as follows: Mexican students were required to pay about $550 per semester over the eight-semester medical program, while Latin, non-Mexican students paid about $1,500 per semester. Tuition for non-Latin students was $3,200 for each of the first four semesters and $2,000 for the last four. University officials stated that non-Mexican students were charged more because they (1) could afford to pay and (2) were taught by Mexican professors using Mexican equipment yet leave the country upon graduation (or transfer before graduation) without giving anything to Mexico in return. University officials explained the difference in

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tuition charged non-Mexican Latins and other foreign students by stating that many Latin-American governments limited the amount of money that can be taken out of the country.

U.S. citizens also pay the following fees: a $1,000 one-time inscription fee, 1/ $1,150 if they take the Spanish course, and an $800 graduation fee. Tuition for U.S. citizens was $300 per semester during the internship year (9th and 10th semesters) and $120 per semester during the social service year (11th and 12th semesters). There was also a $920 fee for the professional examination taken before the year of social service. In addition to the fees stated, a $1,500 bond was required to be paid by all U.S. citizens before they enter a Fifth Pathway Program or take their 9th and 10th semesters in a U.S. hospital. The bond was forfeited to the university (which we were advised was used to partially support the community medical programs) if the student failed to return to the university to perform the required 1 year of social service. According to university officials, in previous years, about 90 percent of the U.S. citizens forfeited the bond by not returning. Lately, however, more U.S. citizens were returning for their social service year and completing their medical education requirements at the university.

University officials said that about 1,900 foreign students, including about 1,100 U.S. citizens, were receiving various types of loans. University administrative officials were aware of the ED guaranteed student loan application forms. These officials also said that confirmation reports were usually received 3 months after their effective date and contained no instructions. Officials refused to give us a list of students attending the university because, as a policy, students' names are not released to any outside organization.

CURRICULUM

The Autonomous University of Guadalajara was established through an affiliation with the National Autonomous University of Mexico in Mexico City. Through this affiliation, Guadalajara was required to meet certain standards established

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1/We were advised that all students are required to pay an inscription fee, which is proportional to the tuition.

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by the National University, including a mandatory minimum curriculum outline. All the Guadalajara faculty vitae must be submitted to the National University for review, and the final medical degree, "Titulo," was awarded to students jointly by Guadalajara and the National University upon graduation. Nevertheless, Guadalajara was considered a private, autonomous institution. Guadalajara officials indicated that they established curriculum standards for the medical school that were higher than those required by the National University.

The curriculum at the medical school was based on a 6-year program of study (two semesters each year) divided into 4 years of didactic training, 1 year of internship, and 1 year of social service. All 6 years plus a national exam must be completed before the final medical degree and license to practice medicine can be received. Instruction was in Spanish except for presentations given by English-speaking visiting professors and lecturers.

According to a university official, almost all U.S. citizens did their internship year in a U.S. hospital, and about 90 percent of them entered the Fifth Pathway Program and did not return to Guadalajara. As a result, these U.S. citizens did not finish their medical education at the university and never received the final medical degree and license.

The didactic program of study at the medical school was divided into five activities that are used for teaching both basic and clinical science courses. Activity I was mainly theory given in lectures to a large number of students (about 150 to 200). During activity II, students continued to receive theory lectures but also discussed practical patient problems in groups of 40 to 50. In Activity III, small groups of students (6 to 10) performed patient examinations under an instructor's guidance. Demonstrations were also given using models. Activity IV involved self-learning through the university's audio-visual library, and activity V concluded the program of study with informal student-teacher discussions.

The curriculum during the didactic years of study was based on the block system of teaching and was used in all semesters except the fourth. The university began using the block system in 1974 with the idea of putting emphasis exclusively on the subject over a short time. The duration of

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a course depended on its importance and the number of credits offered. University officials said the block system enabled the curriculum to be more organized and efficient and allowed for better student concentration and learning.

The fourth semester medical curriculum was the culmination of a student's preclinical training. During this semester, patient interrogation and clinical reasoning were taught through an integrated program of study. According to university officials, subjects taught during this semester required a logical system of progression that was not possible under the block system of teaching. Under the integrated program of study, all courses required in the semester were taken simultaneously and were related to specific subject matter. The emphasis was on developing a student's clinical skills. The integrated program included lectures and lab demonstrations as well as direct patient care. Ambulatory patients were used, with emphasis on general practice type of patient diagnosis.

## VISITING PROFESSOR PROGRAM

In 1974 the Guadalajara Medical School organized a visiting professor program to supplement their students' education with lectures and demonstrations on current clinical topics. During the 1979-80 school year, about 70 professors from Mexico, the United States, and other foreign countries were scheduled to visit the university campus and give lectures and classroom presentations. Visiting professors from the United States were not used as extensively during the seventh and eighth semesters because most U.S. citizens were studying in U.S. hospitals during this time.

## CLINICAL TRAINING OPPORTUNITIES

Clinical training at the medical school was received during the fourth through eighth semesters. Clinical science courses were taught at the 150-bed Angel Leano Hospital campus, where students have access to direct patient care. In addition to participating in ward rounds at the hospital, students observed and examined nonacute patients. According to university officials, the emphasis during these clinical semesters was on aspects of primary care; that is, the use of patient interrogation and clinical reasoning. Laboratory diagnostic skills, although taught, were used as a secondary source of administering patient care.

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The medical school operated programs of clinical study in the surrounding community of Guadalajara and elsewhere. Such programs as the Medicine in the Community Program and Co-op Program, as well as affiliations with Mexican and foreign hospitals, offered students numerous opportunities for clinical training.

The university was affiliated with about 190 hospitals throughout Mexico and recognized the training received in some 280 foreign hospitals (including 82 in the United States). These hospitals can be used by the university's medical students to satisfy their Medicine in the Community requirements and also the 1-year internship requirement during the 9th and 10th semesters.

## MEDICINE IN THE COMMUNITY PROGRAM (GUARDIAS)

The Medicine in the Community Program gave medical students additional opportunities to receive clinical experience. During each of the eight semesters of didactic studies, students were required to work for 2 to 4 weeks in the rural Mexican countryside at health clinics and mobil health units administered by the medical school. These periods--referred to as "guardias"--are intended to expose students to clinical aspects of direct patient care. In addition, students can work in hospitals affiliated with or recognized by the university in either Mexico or the United States.

The clinics and mobile units used in this program were operated under the direction of physicians. Students administered direct patient care under the supervision of other students (pasantes) who practiced under a 1-year temporary license while satisfying their social service requirement before graduation. A student's normal activities during this program included the elaboration of clinical histories, physical examinations, differential diagnosis, and supervised treatment of patients.

## CO-OP PROGRAM

The Cooperative Medical Education Program was established to give U.S. citizens attending the medical school the opportunity to receive clinical training in an environment in which they will practice. The university established agreements with teaching and community hospitals in the United States to provide clinical training to its students. University officials said that U.S. hospitals are not paid to provide

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this training. According to university officials, hospitals participating in the Co-op Program were monitored by university representatives to ensure that students are receiving proper training in the clinical sciences.

U.S. citizens in the seventh and eighth semesters, who met the academic eligibility requirements, were eligible to receive training in these hospitals. Students rotated through the major services in U.S. hospitals but were still responsible for exams in courses covered during those semesters at the medical school. University officials said that U.S citizens can work in Co-op Program hospitals to satisfy their fifth and sixth semester community medicine requirements. 1/

University officials believed the Co-op Program gave the medical student greater exposure to direct bedside teaching at clinical facilities and offered the U.S. citizens an opportunity to begin to integrate into U.S. medicine during undergraduate training.

GRADUATION REQUIREMENTS

Requirements for receiving the final medical degree and licensure from the Guadalajara Medical School and the National University included 4 years of didactic studies, 1 year of internship, 1 year of social service, and a final examination. Once all were completed, the final medical degree and licensure were awarded by the two universities.

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1/In commenting on our observations, the Assoicate Dean of Special Programs said that, once a year, all U.S. hospitals are invited to send representatives (at the university's expense) to Guadalajara for a week-long discussion of the curriculum, administration, and problems of the cooperative medical education program. We were also advised that about 70 hospitals participated in the second annual conference held in January 1980.

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FACULTY

The Guadalajara Medical School had about 830 faculty members, 1/ of whom 598 taught on the basic and clinical science campuses. About 400 of the latter were full time, but also had limited private practices. The other faculty were associated with the Medicine in the Community Program and taught at health clinics in the Guadalajara area.

Minimal medical research was being conducted at the medical school, but continuing medical and nonmedical postgraduate education was heavily stressed. According to university officials, faculty members were encouraged to pursue a graduate degree in education under a joint program with the University of Houston. We were further told that faculty members are encouraged to publish textbooks and pursue individual research in their specialty areas.

As discussed earlier, the university operated an extensive visiting professor program, which included professors from Mexico, the United States, and other countries. The visiting professors supplement the university's faculty by offering lectures and class presentations.

FACILITIES

Facilities at the university were modern and extensive. The main campus, located on about 120 acres, was completely self-contained. Most of the nonmedical teaching facilities were located on this campus, including the central library, administration and computer center, and foreign student affairs office. Classroom facilities on the campus ranged from small seminar rooms to auditoriums, each with audiovisual capabilities. Recreation, service, and eating facilities were also contained on the main campus. The university provided no student housing on its facilities. Medical school teaching facilities were located mainly on the campus known as ICB and at the Angel Leano Hospital complex.

The ICB campus provided laboratory and teaching facilities for the basic sciences and also had a medical library

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1/This includes an undetermined number of upper semester students who we were advised had a temporary license and who were teaching at the university to satisfy their social service requirement.

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and audiovisual facility. These facilities were used by all health science students, including those studying medicine. Classroom and laboratory facilities at ICB were modern. Classes were large and crowded; however, equipment in most cases was up to date and of sufficient quantity to enable students to use it with minimal sharing. Laboratory facilities, with reasonably modern equipment, were available for all the major basic science courses. Although cadavers were available, the anatomy laboratory was the least adequate because it was relatively small. ICB also contained the main offices of the university's division of continuing education. In addition, the university owned three hotel/resort facilities for continuing education activities and for special conferences and events.

The Angel Leano Hospital complex was the medical school's main clinical facility. The facility was used solely by medical students for courses taught during the fourth through eighth semester of the curriculum. Formerly a seminary, this complex had been reconditioned into a modern 150-bed treatment and teaching facility. Construction of an adjoining facility with about 100 additional beds was underway. The complex also had an outpatient clinic with 140 beds for nonacute patients. This clinic, known as EPE, was a separate facility within the hospital complex where students bring their own patients for examinations. People with no financial means were brought to the clinic and agreed to be examined by medical students in return for medical treatment. These beds were used solely for teaching purposes by the medical school.

The Angel Leano Hospital complex also contained emergency room facilities, psychiatric offices, pathology and nuclear medicine labs, and about 115 classrooms of various sizes. A medical library and audiovisual facility were also available to students. Facilities and equipment were modern. However, the Angel Leano Hospital complex, by itself, did not provide enought clinical patients for the large number of medical students.

An older facility, the Ramon Garibay Hospital, was also used by medical school students. This hospital was essentially an obstetrical facility with some pediatric beds. Patient rooms were modest, and the nursery was quite small; however, university officials recognized this. The facility was being renovated and enlarged.

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The university supplemented its clinical teaching capacity by operating over 40 clinics and two mobile health units in the Guadalajara area under the Medicine in the Community Program. In addition, the university was affiliated with about 190 hospitals in Mexico where students received clinical training and also recognized training received at over 280 foreign hospitals. The University's Co-op Program also offered additional opportunities for clinical exposure to U.S. citizens during their fourth year of didactic studies as well as during their internship year.

U.S. CITIZEN INFORMATION

About 2,100 U.S. citizens were enrolled in the Guadalajara Medical School. The majority of the U.S. citizens came from New York, New Jersey, and California, but many other States were also represented. We were advised that most had applied to and been rejected by U.S. medical schools. We were also advised that students' grade point averages were generally in the low to mid 3s and scores on a standardized test were about average.

Most U.S. citizens with whom we spoke were receiving guaranteed student loans, but only a few received veterans' benefits. According to a student representative, the annual cost of living in Guadalajara ranged between $2,000 and $4,000.

In March 1979, the North American Student's Association, which represents U.S. citizens at the medical school, established a financial aid program. One part of the program dealt with researching the availability of grants, loans, and scholarships for U.S. citizens. The other dealt with a subprogram called Physician Shortage Sponsorship Program. Under this program, the association sent letters to the 3,200 counties in the United States requesting the names of towns that needed physicians. The purpose was to obtain financial backing for a student's remaining semesters at the school in exchange for having that student practice medicine in the town after graduation.

The students we spoke to appeared highly motivated and planned to practice medicine in the United States. Furthermore, most preferred, if possible, to transfer to a U.S. medical school or enter a Fifth Pathway Program. University officials stated that U.S. citizens who enter a Fifth Pathway Program do not receive their final medical degree from the Autonomous University of Guadalajara; however, the students

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can still become licensed in most States. In this regard, university officials stated that ECFMG certification cannot be received until the entire medical program at the university was completed, but pointed out that certification is not required for licensure for students who complete a Fifth Pathway Program in States where it is recognized.

During the period 1975 through 1979, about 40 percent of the U.S. citizens from the Autonomous University of Guadalajara passed the ECFMG examination. During 1980, 1,076 U.S. citizens took the ECFMG examination, and 483 (45 percent) passed. U.S. citizens at the university pointed out that they tended to take the examination early in their medical curriculum, before many of the subjects tested have been taken. Nevertheless, U.S. citizens at the medical school continued to take the ECFMG examination in an attempt to transfer into the U.S. medical system. University officials said most U.S. citizens eventually pass the ECFMG examination and enter Fifth Pathway Programs.

## COMMENTS BY THE MEDICAL SCHOOL

We received comments in a May 3, 1980, letter from the Associate Dean, Special Programs, Universidad Autonoma De Guadalajara. His comments primarily related to clarifying and expanding the information in this appendix.



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## UNIVERSITY OF BOLOGNA

### MEDICAL SCHOOL

The University of Bologna Medical School was founded in 1267. Italian health and education officials said that enrollment in Italian medical schools increased rapidly in recent years (particularly 1968-72, according to the university Rector), creating a physician surplus in Italy. These officials said that increased enrollments were caused by a recent Italian law prohibiting medical schools from denying admission to any academically qualified student. However, Italian educational officials said that, while total medical enrollment increased over the past 2 years, the number of foreign students decreased by 15 percent. 1/

Government officials believed that the length of medical study (6 to 8 years) was one factor contributing to the decline in foreign student enrollment. There was no limitation on the number of foreign students who could enter Italian medical schools, but government policy required that foreign students be distributed among Italy's 26 medical schools to prevent large numbers from one country attending the same school and the overloading of some schools. However, after their first year of study, foreign students can transfer to any Italian medical school.

The University of Bologna offered undergraduate and graduate degrees in many academic fields. Total student enrollment in the university as of June 1979 was about 59,300. The medical school, the oldest in Italy, had an enrollment of about 13,000 students, 159 of whom were U.S. citizens. The U.S. citizens tended to come from New York or New Jersey. U.S. citizens with whom we spoke indicated that another 20 to 30 U.S. citizens were expected to transfer to Bologna within a month from other Italian medical schools.

### ADMISSION REQUIREMENTS

Admission requirements for Italian students included successful completion of high school studies, including courses in biology, physics, and chemistry. All students

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1/The Rector said that this trend conforms to the trend of medical enrollment of Italian students in the University of Bologna.

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who met this requirement were accepted with no limitations on total enrollment. University officials were unsure of the admission requirements for U.S. citizens, but believed a college degree and an evaluation of grades received in science courses were necessary. Italian government education officials said that only a high school diploma and passage of an Italian language and culture exam were required for U.S. citizens.

Tuition and related fees at Bologna Medical School, amounting to about $150 per year, were the same for Italian and foreign students. Annual living expenses ranged from $7,000 to $7,500.

CURRICULUM

The University of Bologna medical program was approximately 6 academic years 1/ long (as are all Italian medical schools, according to the Rector) and all instruction was in Italian. Twenty-eight courses had to be taken during the 6-year program (19 required; 9 electives). In each course--some of which lasted 2 years, some 1 year, and some 1 semester--each student must pass an exam. Most were oral exams given individually, but a few were written. We were advised that clinical exams were not taken with patients because of the large ratio of students to patients. The first 3 years are devoted to basic science courses and the last 3 years to clinical subjects. Subjects were similar to those given in a U.S. medical school.

We were advised by medical school faculty that attendance at lectures and laboratory sessions was not required. During the fourth, fifth, and sixth years, students could apply for internship in their clinical subjects. The number of slots available varied by course. Students who were selected to intern generally followed assistant professors on ward rounds, observed patients, took histories, did physicals, and were exposed to routine patient care procedures. In general, the number of available intern slots was limited because of the small number of patients in the different clinical areas. The professors noted that most U.S. citizens did not apply for the intern program in many clinical areas. However, university officials told us that many U.S. citizens performed clinical externships at U.S. hospitals, during

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1/The academic year at the school began in November and ended in June.

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which U.S. citizens believed they obtained the necessary clinical exposure. Professors we talked to also said the U.S. citizens were motivated only to obtain a degree and not to learn medicine. According to them, some U.S. citizens would graduate from the University of Bologna Medical School without seeing a patient or providing patient care.

Clerkships were arranged between the student and the U.S. hospital without any university involvement. Representatives of the U.S. citizen medical student association told us that students would usually arrange a 9-month clerkship (3 months each summer for 3 years), during which they would be exposed to clinical procedures while working alongside U.S. medical school students. University officials did not monitor, supervise, or evaluate this training.

To graduate, a student must have completed the 28 courses and pass oral and/or written exams in each course. Once all courses were completed, a thesis was presented and the M.D. degree could be received. There was no social service requirement or any formal internship program that required students to rotate through various clinical areas. As a result, a U.S. citizen can attend the University of Bologna Medical School, complete the classroom studies, participate in laboratory demonstrations, present a thesis, and graduate. But unless the student applied for an intern position during the clinical years or arranged a clerkship in a U.S. hospital, he or she may have had very few patient contacts before receiving an M.D. degree.

FACULTY

The University of Bologna Medical School had about 160 faculty members divided into two groups--69 full-time professors and most of the others "in-charge-of professors." Full professors were responsible for entire departments, groups of courses, or entire clinical areas. In-charge-of professors were responsible only for a particular course. Faculty members may teach until they are 75 years old and remain as members of the faculty. Professors who teach basic science courses were, for the most part, physicians, chemists, physicists, or microbiologists. Most faculty members at the medical school were involved in extensive research. During our discussions, some faculty members placed more emphasis on developing their department's research than teaching their students.

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Most professors, in addition to teaching at the medical school, maintained a private practice. Italian government officials said that pending legislation, if enacted, would require all university professors to teach full time. The University of Bologna Medical School had no U.S. professors, and there was no visiting professor program.

In 1922, the Italian university system established that, for every subject, an official professor would be hired based on competitive selection and would be paid by the government. Applications were submitted through the Italian Ministry of Public Instruction. Applicant qualifications (publications, written texts, etc.) were reviewed by a commission set up by the ministry. The commission selected the three best qualified applicants, from whom the university filled its vacancy.

## FACILITIES AND EQUIPMENT

Facilities and equipment at the Bologna Medical School were primarily research oriented, and most were not available for use by medical students. One or two classrooms and one or two moderate-sized laboratories were available for student lectures and laboratory work in each basic science department. Some of the equipment appeared adequate, but the anatomy department had no cadavers for the students to dissect. Professors responsible for the basic science departments believed the facilities were adequate because (1) students were not required to attend labs or lectures, (2) a great deal of knowledge is expected to be acquired from texts, and (3) students were free to choose which lectures to attend. However, basic science facilities and equipment were limited when compared to the number of enrolled students.

Clinical science facilities were modern but most were research oriented and not available to medical students. Also, because of the large number of students in the medical school, not all received clinical training in direct patient care.

## U.S. CITIZEN INFORMATION

At the time of our visit, 159 U.S. citizens were enrolled in the University of Bologna Medical School. However, even though classes had started for the semester, many were not being held because facilities were being renovated. Further, most U.S. citizens were away from Bologna over a 5-day period observing a U.S. holiday. This limited the number of U.S. citizens that we could talk to.

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Student representatives told us that most U.S. citizens were from New York and New Jersey and that many had relatives who had attended the university. They said students generally had undergraduate grade point averages ranging from 3.0 to 3.4 and average scores on a standardized examination. They added that many had applied to U.S. medical schools and been rejected, whereas others came to the University of Bologna as their first choice. According to them, some U.S. citizens had chosen this medical school because of the unrestrictive admission policy and the low cost.

University administrative officials said that many U.S. citizens received guaranteed student loans and/or VA benefits. The officials were familiar with the loan forms and confirmation reports received from ED and VA, but said they usually received them 2 to 3 months after the report's effective date. However, officials said they had not received an ED student confirmation report for the past 1 to 2 years.

University administration officials said they did not sign guaranteed student loan forms because the forms required personal information about students which the university could not supply or verify, namely housing and living expenses. The officials added that U.S. banks often sent guaranteed student loan checks to the university, listing the student and the university as co-payees. The university would not endorse these checks because this appeared to the Italian government as if the university received foreign funds.

We were told that most U.S. citizens planned to take clinical clerkships at a U.S. hospital during the summer break. The U.S. citizens we talked to planned to eventually practice medicine in the United States, but did not indicate an interest in transferring to a U.S. medical school.

Some University of Bologna professors were openly critical of the U.S. citizens at the medical school. They believed that generally the quality of U.S. citizens was not very high and that many were motivated to obtain only the M.D. degree and not the medical education. The professors added that, although the U.S. citizens believed clinical teaching in Italy was insufficient, they did not avail themselves of the clinical training opportunities that were available.

Overall, U.S. citizens at the university had about a 40-percent pass rate on the ECFMG examination during 1975-79. During 1980, 60 U.S. citizens took the ECFMG examination, and 19 (32 percent) passed.

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## COMMENTS BY THE MEDICAL SCHOOL

Comments dated April 23, 1980, from the Rector of the Universita degli Studi Bologna were limited to clarifying the information in this appendix.

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## UNIVERSITY OF BORDEAUX

## MEDICAL SCHOOL

The University of Bordeaux, located in southwest France, was founded in 1441. In 1970, as a result of a 1968 law reforming higher education in France, the university was separated into three universities, each financially and academically autonomous.

The University of Bordeaux II (medicine and health sciences) is a multidisciplinary university offering degree programs in medicine, dentistry, pharmacy, basic sciences, and wine studies. Approximately 15,000 students were enrolled, about 8,800 of whom were in medicine. University officials said that 4,500 students were in the first 6 years of the medical program, and the other 4,300 were in the undergraduate internship year or postgraduate residency programs. At the time of our visit, about 30 U.S. students were enrolled in the medical school.

Government and health officials in France were concerned about the possibility of an oversupply of physicians in France. In 1968, there were about 60,000 practicing physicians in France, or 1 for every 600 persons. With the increase in medical school enrollment, the number of physicians practicing medicine in France had doubled, and government officials estimated that by 1985 there could be 1 physician for every 300 persons. In July 1979, however, the French Parliament passed legislation to reduce the number of new physicians entering the medical system from 9,000 to 6,000 each year. The law was aimed at relating medical school enrollment to the nation's needs and the available medical school clinical facilities. The law limited the number of students who could enter the second year of medical school based on the clinical facilities available to the school. A competitive exam was given at the end of the first year, and only a specified number of students were selected for the second year. All medical schools in France were required to adhere to the law and limit their enrollment. French government officials said that the full effect of the July 1979 legislation would not be felt until 1985, when there would be about 6,000 medical students graduating from all medical schools in France each year and entering the medical system.

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## ADMISSION REQUIREMENTS

Admission to the first year of medical school was open to any French student who had the baccalaureate (high school diploma). Foreign students were required to have this baccalaureate, or its equivalent, and to pass a French proficiency exam.

University officials said that each year, about 2,000 students enter the first year of medical school. About 11 percent of those admitted were foreign students, mainly from Africa and the West Indies. University officials said that 20 to 25 percent (about 400 to 500) of the students enrolled in the first year would pass the requisite exam and gain admission to the second year. Students not passing the exam are allowed to repeat the first year of medical school and retake the exam. University officials said that about 97 percent of the students who entered the second year would complete their medical education and receive an M.D. degree.

Tuition at Bordeaux II medical school was minimal (less than $100 per year) and was the same for both French and foreign students. U.S. citizens we spoke with said that the living expenses while attending the school ranged from about $3,000 to $4,800 a year. In addition, the students said that, during the clinical years of their studies (fifth and sixth years), stipends were received from the university which offset some of their expenses.

## CURRICULUM

The medical curriculum at the University of Bordeaux II consisted of three cycles covering a 7-year period. Each year's class was divided into three units for teaching and research. Students in each unit received the same lectures and lab demonstrations, were given the same opportunities for clinical exposure, and were required to pass the same exams. Each unit had its own professors, instructors, and in some cases facilities.

Instruction was in French and courses offered were generally similar to those offered in U.S. medical schools. However, textbooks were not required, and lessons were taught from professors' notes and manuals. U.S. citizens said that they used textbooks mainly for reference. Many U.S. citizens were not familiar with the current texts used in U.S. medical schools.

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The first cycle involved 2 years of study in the basic sciences. As noted earlier, a competitive exam is given to all students at the end of the first year. University professors and students with whom we spoke said that almost all U.S. citizens failed the exam at the end of the first year, repeated the year of study, and retook the exam. The professors we talked to attributed this to the U.S. citizens' lack of French language proficiency.

The second cycle involved 4 years of lectures and practical instructions. During the third year, studies in the basic sciences were completed. The remaining 3 years (fourth, fifth, and sixth) focused on clinical sciences, during which time clinical procedures and patient care were taught. However, laboratory exposure in the basic sciences was limited because there were too many students for the available facilities. In the clinical sciences, the problem was even more acute because of the inadequate supply of patients compared to the large number of students. University officials stated that, although all students were required to pass the examinations in clinical subjects, relatively few can be exposed to direct patient care. Officials said that the students who received practical clinical experience were chosen by lottery in each clinical subject. As a result, students could graduate without working with a patient in certain clinical subjects. University professors and U.S. citizens said that U.S. citizens acquired clinical clerkships in a U.S. hospital during the summer to obtain clinical experience. These clerkships were arranged by the students.

During the seventh and final year (considered the third cycle of the curriculum), students received a stipend of about $200 per month and were required to do a 1-year internship, usually at a nonteaching hospital. During this internship, however, some students did not have the opportunity to rotate through all five basic medical services (i.e., medicine, surgery, obstetrics/gynecology, pediatrics, and psychiatry). U.S. citizens we talked to said they arranged to do their internship year in a U.S. hospital. This was accepted by university officials based on documentation from the hospital. However, some U.S. citizens said that they would not rotate through all the basic sciences while at a U.S. hospital. The University of Bordeaux II Medical School was not affiliated with any U.S. hospitals and did not monitor the training received by U.S. citizens at such hospitals.

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After completing the internship year, students were required to pass a clinical exam and present a thesis before receiving an M.D. degree. University officials noted that most U.S. citizens who attended the medical school transferred to U.S. medical schools before obtaining an M.D. degree in France.

FACULTY

Legislation passed in 1960 required that French medical school faculty members teach full time. However, they were allowed to split their time between the university and the university hospital. By doing so, they were paid by both the Ministry of Health and Ministry of Universities. All faculty members must be approved by both ministries. University officials said that faculty members are required to have specialty training in the field of study they teach and to conduct research. Research was stressed, and many professors pointed to the sophisticated research laboratory equipment. Research was a major concern of the faculty, sometimes almost to the exclusion of teaching.

FACILITIES

Physical facilities and equipment at the University of Bordeaux II Medical School were generally excellent. For example, the anatomy department had a considerable supply of cadavers and excellent refrigeration and other containment facilities for their preservation. Dissecting rooms in the laboratory were also good. Biochemistry laboratory facilities were excellent. Throughout each basic science department, the equipment was modern and sophisticated; however, the emphasis was on research. Professors with whom we spoke also generally placed more emphasis on their research programs than on teaching.

Clinical facilities were equipped with modern, sophisticated equipment. University officials said there were about 3,800 teaching beds available to the medical school. According to these officials, these beds covered all the medical specialties and were located in about seven hospitals in Bordeaux. However, faculty at the school indicated that these facilities were inadequate to meet the needs of the large number of students requiring clinical training. University professors in several departments agreed that clinical slots were limited because of the small number of patients

compared to the large number of students. The professors indicated that, because of this, most students did not receive practical experience in all the clinical services.

U.S. CITIZEN INFORMATION

As mentioned earlier, about 20 U.S. citizens were enrolled in the medical school at the time of our visit. About 10 were studying at the university campus in Bordeaux; the others were in U.S. hospitals doing their internship year. Students we talked to said that they had college grade point averages ranging from 3.0 to 3.5, and most had previously applied to and been rejected by a U.S. medical school. Students were from New York, New Jersey, Massachusetts, and Florida. The low cost of education in France was not a consideration in choosing the University of Bordeaux.

Some U.S. citizens used U.S. placement agencies, and one student paid $3,500 to secure admission at Bordeaux. All but one U.S. citizen we spoke with had failed the examination to enter the second year of medical school and had repeated it in order to proceed. The U.S. citizens, except for one who did not plan to practice medicine, planned to do their internship at a U.S. hospital and eventually practice medicine in the United States.

The students generally agreed that opportunities for clinical training at the University of Bordeaux were extremely limited. One U.S. citizen said that he never received clinical training in pediatrics, obstetrics/gynecology, or general surgery. He added that, during his upcoming internship year (which would be done in a U.S. hospital), no training in pediatrics or obstetrics/gynecology would be available.

Most U.S. citizens we talked to said they had received guaranteed student loans. Although the University of Bordeaux II Medical School is an eligible institution under the VA programs and Guaranteed Student Loan Program, university administrative officials were unaware of the student confirmation reports required by VA and ED. Students told us that practically any university official would sign the loan application forms and there was no central office for recording or documenting such matters.

APPENDIX VII

None of the students we talked to said they had taken the ECFMG examination. This was surprising since university officials commented that most U.S. students usually took the ECFMG examination in their third year at Bordeaux II and then transferred to a U.S. medical school.

Only 14 U.S. citizens from the University of Bordeaux took the ECFMG examination during the 5-year period 1975-79, and 11 (79 percent) passed. In 1980, five U.S. citizens took the examination, and only one passed.

COMMENTS BY THE MEDICAL SCHOOL

By letter dated April 30, 1980, the Vice President for the Universite de Bordeaux II agreed with the information in this appendix.

APPENDIX VIII

## EDUCATIONAL COMMISSION FOR

## FOREIGN MEDICAL GRADUATES EXAMINATION

The ECFMG examination is designed to assess the medical knowledge of foreign medical school graduates who plan to participate in graduate medical education in the United States.

To be eligible to take the examination, a candidate must have successfully completed 2 years in a foreign medical school listed in the "World Directory of Medical Schools" published by WHO.

The examination is designed as a comprehensive test of the applicant's knowledge in the principal fields of medicine. It is a written examination that includes about 360 multiple-choice questions and is given only in English. One-sixth of the questions are drawn from the basic medical sciences: anatomy, biochemistry, microbiology, pathology, pharmacology, and physiology. The other questions are taken from the traditional clinical fields: surgery, obstetrics/gynecology, pediatrics, and internal medicine, including mental diseases and preventive medicine.

The ECFMG examination is a 1-day test given semiannually, usually in January and July, at 157 centers throughout the United States and the world. An English proficiency test is a required portion of the examination.

The minimum passing score on the medical portion of the ECFMG examination is 75. A review of the test performance of U.S. citizen foreign medical students on the examination showed that less than 50 percent pass, although the pass rate is higher for first-time takers than repeaters. Over the past 5 years (1975-79), the pass rate for all U.S. citizen foreign medical students ranged from 34 to 41 percent. Many who passed the examination repeated it one or more times. NBME estimated that, based on U.S. medical school performance on the NBME Parts I and II examinations, about 95 percent of these students would pass the ECFMG examination if they took it near the end of medical school.

APPENDIX IX

## VISA QUALIFYING EXAMINATION

The VQE is taken by foreign citizens who graduated from foreign medical schools and are seeking a visa to come to the United States for graduate medical education. This examination has been accepted by the Secretary of HHS as equivalent to the NBME Parts I and II examinations for this purpose.

To be eligible to take the VQE, a candidate must have successfully completed the full medical curriculum at a medical school listed in the "World Directory of Medical Schools." The candidate must also have met the English language prerequisite by passing an English test.

The VQE is given once each year, usually in September, at 30 centers throughout the world. It is a 2-day written examination composed of about 950 multiple-choice questions and is given only in English. The first day of the examination consists of about 500 questions from the basic science disciplines of anatomy, behavioral sciences, biochemistry, microbiology, pathology, pharmacology, and physiology. The questions are devised to test not only knowledge, but also subtle qualities of judgment and reasoning. The second day of the examination consists of about 450 questions drawn from the clinical science disciplines of internal medicine, obstetrics and gynecology, pediatrics, preventive medicine and public health, psychiatry, and surgery.

These questions are designed to explore the examinees' knowledge of clinical situations and to test ability to bring information from many different clinical and basic science areas to bear upon these situations. A "pass" level of performance is required on (1) the group of basic science questions and (2) the group of clinical science questions.

The VQE was given for the first time in 1977. Over the past 3 years, the pass rate of foreign citizen medical school graduates ranged from about 25 to 30 percent.

APPENDIX X

## NATIONAL BOARD OF MEDICAL EXAMINERS'

## PART I EXAMINATION

The NBME Part I examination is designed to measure the candidate's knowledge and comprehension of the basic medical sciences.

To take the NBME Part I examination, an individual must be either a student officially enrolled in a medical program within an accredited medical school in the United States or Canada or a graduate holding an M.D. degree from such a school. Students usually take the NBME Part I examination after completing 2 years of the medical curriculum. Before June 1980, U.S. citizens enrolled in foreign medical schools could take Part I if they were sponsored by a U.S. medical school or the Coordinated Transfer Application System. In these instances, the NBME Part I examination was used as a screening device to determine the eligibility of the U.S. citizen foreign medical student for transferring to a U.S. medical school with advanced standing.

The examination is administered twice each year, in June and September, in testing centers throughout the United States and Canada. It is a comprehensive 2-day written examination consisting of about 1,000 multiple-choice questions equally distributed across the basic science disciplines of anatomy, behavioral sciences, biochemistry, microbiology, pathology, pharmacology, and physiology. The questions are devised to test not only knowledge, but also judgment and reasoning abilities.

The minimum passing score on the NBME Part I examination is 380 on a standard score scale. The average standard score for the second year U.S. medical student is 500. U.S. citizen foreign medical students do not perform as well as their U.S. medical school counterparts on the examination. For example, 946 (51 percent) of the 1,855 U.S. citizen foreign medical students who took the examination in 1978 passed, compared to 11,607 (84 percent) of the 13,797 U.S. medical school students who took the Part I examination.

## NATIONAL BOARD OF MEDICAL EXAMINERS'

## PART II EXAMINATION

The NBME Part II examination is designed to measure the candidate's knowledge and comprehension of the clinical sciences in medicine.

To take the NBME Part II examination, an individual must be either a student officially enrolled in a medical program within an accredited medical school in the United States or Canada or a graduate holding an M.D. degree from such a school. The NBME Part II examination is usually taken during the fourth year of the medical curriculum.

The examination is administered twice each year, in April and September, in testing centers throughout the United States and Canada. It is a 2-day written examination consisting of about 900 multiple-choice questions equally distributed across the clinical science areas of internal medicine, obstetrics and gynecology, pediatrics, preventive medicine and public health, psychiatry, and surgery, with related subspecialties. The questions are designed to explore the examinees' knowledge of clinical situations and to test their ability to bring information from many different clinical and basic science areas to bear upon these situations.

The minimum passing score on the NBME Part II examination is 290 on a standard score scale. The average standard score for fourth year U.S. students is 500. Over the past 9 years (1970-78) the pass rate for U.S. medical school students on the examination has been over 96 percent.

APPENDIX XII

## NATIONAL BOARD OF MEDICAL EXAMINERS'

## PART III EXAMINATION

The NBME Part III examination designed is to assess the measurable aspects of competence after the recently graduated physician has gained experience in graduate medical education, including patient care under supervision.

Candidates are eligible for the NBME Part III examination when they have received an M.D. degree from an accredited medical school in the United States or Canada and, after receiving or completing all requirements for the M.D. degree, have served with a satisfactory record for at least 6 months in an approved hospital residency.

The NBME Part III examination is an objective, 1-day interdisciplinary examination of additional aspects of clinical competence. The examinee is tested, by the use of special techniques, on how knowledge is used in the interpretation of clinical data and in the evaluation, diagnosis, and management of clinical problems.

The examination is scheduled in early March in centers established at selected schools and affiliated hospitals in the United States and Canada, with a makeup examination at a few centers in May primarily for candidates who fail the March examination.

The minimum passing score on the NBME Part III examination is 290 on a standard score scale. The average standard score for first year U.S. residents is 500. Over the past 9 years (1970-78), the pass rate for first year U.S. residents has been over 97 percent.

APPENDIX XIII

## FEDERATION LICENSING EXAMINATION

FLEX is designed to measure the knowledge and comprehension of basic and clinical medical sciences and to evaluate clinical understanding and competence uniformly.

All States and the District of Columbia have adopted FLEX as their State medical board examination. Eligibility to sit for the examination is determined by the various participating State medical boards and not by the Federation of State Medical Boards. The examination is given twice each year, in June and December, at examination centers established by the various State medical boards.

FLEX is a three-part examination given over 3 days. Day I is a written examination composed of about 77 multiple-choice questions in each of the seven basic medical sciences--anatomy, behavioral science, biochemistry, microbiology, pathology, pharmacology, and physiology. The questions are presented in interdisciplinary form and are selected for clinical applicability. Day II of the examination covers the six traditional clinical sciences of medicine--obstetrics and gynecology, pediatrics, preventive medicine and public health, psychiatry, surgery, and related subspecialties. There are about 90 questions in each clinical area, presented in interdisciplinary form, with emphasis on clinical evaluation. Day III tests the applicant's knowledge of the indications for and the application of specific forms of therapy and patient management.

Passing requirements are a function of the State administering the examination. In all States, a minimum weighted average of 75 is required for passing. Most State medical boards use a single weighted average score for the entire examination to determine pass/fail. However, some States have further stipulations as to minimal acceptable individual subject or day levels.

Foreign medical graduates, including U.S. and foreign citizens, have not performed as well as their U.S.-trained counterparts on FLEX. For examinations given from June 1968 to June 1979, only 47 percent of the foreign medical graduates passed, compared to 87 percent of the U.S. medical school graduates. A Federation of State Medical Boards' official said data are not available to differentiate between the test results of foreign and U.S. citizen graduates of foreign medical schools.

APPENDIX XIV

## MEDICAL SCIENCES KNOWLEDGE

## PROFILE EXAMINATION

The MSKP examination is used to give U.S. medical schools an assessment of the medical science knowledge of students being considered for placement with advanced standing. This examination was given for the first time in June 1980.

Any citizen of the United States or Canada, permanent resident alien in the United States, or landed immigrant in Canada may take the examination upon completing the application and paying the required fees.

The objective of the examination is to measure the knowledge and comprehension of the medical sciences and introduction to clinical diagnosis. The examination is administered in eight test centers in the United States and six overseas locations. It is a 1-1/2-day examination consisting of 800 to 850 multiple-choice questions. The examination covers anatomy, behavioral sciences, biochemistry, introductory clinical diagnosis, microbiology, pathology, pharmacology, and physiology. Each subject contributes about the same number of questions to the examination. Certain questions test the examinee's recognition of the similarity or dissimilarity of diseases, drugs, and biochemical, physiologic, behavioral, or pathologic processes. Other questions evaluate the examinee's judgment about cause-and-effect relationships.

Because the examination is intended to provide information for U.S. medical schools to use in evaluating an applicant for placement with advanced standing, there is no passing or failing score.

FAIME provided information on the results of the June 1980 MSKP examination as part of its comments on the draft report. (See app. XXV.)

APPENDIX XV

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

SEP 15 1980

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Policies Regarding U.S. Citizens Studying Medicine Abroad Are in Need of Careful Review and Reappraisal." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard B. Lowe III
Inspector General (Designate)

Enclosure

GAO note: Any page references in appendixes XV through XXVI may not correspond to page numbers in the final report.

APPENDIX XV

## COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED "POLICIES REGARDING U.S. CITIZENS STUDYING MEDICINE ABROAD ARE IN NEED OF CAREFUL REVIEW AND REAPPRAISAL"

### General Comments

The Department's estimates of supply and requirements for physicians to serve the U.S. population indicate that an adequate future supply can be trained in schools in the U.S.. We, therefore, believe that no steps should be taken which encourage U.S. citizens to seek medical training in foreign schools.

We believe, nevertheless, that the problems discussed in the report are significant, since a considerable number of U.S. citizens do, in fact, study medicine abroad and return to the U.S. for clinical training and practice. Taking measures to assure their qualifications is essential.

### GAO Recommendation to the Congress

"We recommend that the Congress direct the Secretary of Health and Human Services to work with representatives of the medical profession and State licensing authorities with the objective of developing and implementing appropriate mechanisms that would ensure that all students who attend foreign medical schools demonstrate that their medical knowledge and skills are comparable to those of their U.S. trained counterparts before they are allowed to enter the U.S. health care delivery system either for training or independent practice. We have identified a number of alternatives that should be considered in accomplishing this objective."

### Department Comment

We recognize the need for procedures to assure that persons entering the U.S. health care system for training or practices are adequately qualified. The procedures now in general use applying to U.S. trained personnel are the product of evolving practice administered by State licensing bodies, the medical profession and the educational community, and we believe that this is also the appropriate arrangement to apply to U.S. citizens trained in foreign schools. The Department of Health and Human Services can assist this process by participating cooperatively, as it does currently in several national voluntary bodies.

### GAO Recommendation

"We recommend that the Secretary of Health and Human Services, in cooperation with representatives of the medical profession and state licensing authorities, address the current practice whereby students from foreign medical schools received part or all of their undergraduate clinical training in U.S. hospitals."

APPENDIX XV

Department Comment

We concur. The procedures used to arrange for clinical training of medical students in the U.S. are essentially the responsibility of the profession and the educational establishment. We believe that this is a sound arrangement, and should apply as well to U.S. citizens studying abroad who seek training in the U.S.. The Department will cooperate in the development of improved procedures to be utilized for the latter group.

APPENDIX XVI

U.S. DEPARTMENT OF EDUCATION
OFFICE OF POSTSECONDARY EDUCATION
WASHINGTON, D.C. 20202

SEP 15 1980

Mr. Gregory J. Ahart
Director
Human Resources Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on the draft report entitled, "Policies Regarding U.S. Citizens Studying Medicine Abroad Are In Need of Careful Review and Reappraisal."

The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely,

Albert H. Bowker
Assistant Secretary for
Postsecondary Education

Enclosure

APPENDIX XVI

Comments of the Department of Education
on the
Comptroller General's Draft Report to the Congress
"Policies Regarding U.S. Citizens Studying Medicine Abroad
Are In Need of Careful Review and Reappraisal"

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GAO Recommendation

We recommend that the Secretary of Education issue regulations establishing procedures and criteria for implementing the legislative requirement that the Department of Education ensure that foreign medical schools are comparable to medical schools in the United States before authorizing guaranteed student loans for U.S. citizens attending these schools.

Department's Comment

The Department of Education agrees that under current law the Secretary is obligated to assess whether a foreign medical school is "comparable" to an American school in order to determine eligibility to participate in the Guaranteed Student Loan Program. In an effort to improve this process, the Secretary of HEW on April 23, 1979, issued a Notice of Proposed Rulemaking which assessed comparability on the basis of the scores that American students at foreign medical schools achieved on the examination of the Educational Commission for Foreign Medical Graduates (ECFMG).

This NPRM generated considerable negative public response. More than 1,000 written comments were received, of which over 90% came from affected students and parents of students studying medicine abroad. A central theme of the negative comments was the inappropriateness of using the pass rate on the ECFMG examination as an index of comparability. The Public Health Service (PHS) made this point in a letter dated May 6, 1980, and also documented the difficulty of obtaining data from the private sector needed to administer the evaluative system proposed in the NPRM.

As a result of this negative public comment, the Department plans to convene interested and knowledgeable participants, including representatives of the Public Health Service and the Veterans Administration, to reassess the available options. The result of these consultations may include the publication of a new Notice of Proposed Rulemaking or other administrative action or a proposal that Congress reassess the conditions under which foreign medical schools may participate in the GSL program. In the meantime, the Department will continue its current policy of implementing the statutory "comparability" standard without regulations.

APPENDIX XVI

The Department also notes that at this time there is legislation pending as part of the Education Amendments of 1980 (new section 487 of the Higher Education Act) that would require any institution wishing to participate in Education Department student assistance programs to enter into an agreement complying with numerous specific provisions. It is our belief that many if not most foreign educational institutions will be either unable or unwilling to agree to the requirements set forth in this legislation. If such legislation becomes law, therefore, it is expected that students at many foreign medical schools will no longer be able to participate in the GSL program.

GAO Recommendation

We further recommend that the Secretary of Education ensure that the Government's interest in outstanding guaranteed student loans at foreign medical schools is adequately protected by properly verifying the status of all U.S. citizens with outstanding loans and initiating repayment where appropriate.

Department's Comment

We concur with the finding of the General Accounting Office that the present process utilized by the Department of Education does not accurately verify the status of U.S. citizens enrolled at foreign medical schools. We also concur that a new procedure must be established in order to protect the Government's interest in outstanding Guaranteed Student Loans. However, this problem is not limited just to foreign medical schools--it obviously applies to students attending any foreign school and receiving assistance under the Guaranteed Student Loan Program (GSLP).

As the report acknowledges, there are two sets of concerns which have to be addressed: those that relate to the Federal Insured Student Loan Program (FISLP) and those that relate to loans guaranteed by the state or private nonprofit agencies that administer the GSLP in most states.

We have initiated the process for reviewing alternative means to verify more accurately the status of U.S. citizens studying abroad. It is our intent to start a process for determining the correct student status for loans made under the FISLP. A task order will be developed as soon as possible to identify all students receiving FISLP loans to attend any foreign school. For borrowers who are located through this process and who are no longer attending school, we will notify lenders immediately so that they may initiate the repayment of the loan and make necessary adjustments to amounts of interest benefits which have been incorrectly paid. Where we cannot locate the borrower, skip tracing efforts will be instituted. In the case of loans made under the guarantee agency programs, we will encourage guarantee agencies to follow a similar practice.

APPENDIX XVI

As noted in the response to the first recommendation, proposed legislation would require that GSLP participating institutions enter into formal agreements containing numerous specific provisions. One requirement would be agreement to complete the Student Confirmation Reports for each student. In the event that schools do not comply, their eligibility would be withdrawn.

APPENDIX XVII

Office of the
Administrator
of Veterans Affairs

Washington, D.C. 20420

Veterans
Administration

SEPTEMBER 2 5 1980

Mr. Gregory J. Ahart
Director, Human Resources Division
U. S. General Accounting Office
Washington, DC 20548

Dear Mr. Ahart:

Thank you for the opportunity to review your August 15, 1980 draft report, "Policies Regarding U. S. Citizens Studying Medicine Abroad Are in Need of Careful Review and Reappraisal," which states there has been a great deal of concern about the recent proliferation of medical schools established to attract United States citizens who were unable to gain admission to medical schools in this country. Questions were raised about the quality of medical education in those schools most willing to accept American students, and the adequacy and appropriateness of that educational experience as preparation for practicing medicine. The General Accounting Office (GAO) compared the training received in six medical schools abroad to that provided in the United States. The schools visited differed considerably; however, in GAO's opinion, none offered a medical education comparable to that available in the United States.

In your report, you recommend that I accept those foreign medical schools approved by the Secretary of Education as a basis for authorizing educational benefits to qualified veterans, their spouses, and dependents. We have no objection to this recommendation in general. However, as pointed out on page 58 of the report, the Veterans Administration (VA) is required by law to impose certain criteria on our approvals which are not found in the previously proposed Department of Education (ED) regulations. These criteria include the provisions of sections 1775, 1789, 1790, and 1796 of title 38, United States Code. Such provisions of law and their attendant regulations would have to be considered when evaluating the adequacy of any new ED standards.

The adverse ruling of the court in Del Valle v. Cleland, the Puerto Rican case referred to in the report, has impressed upon us the urgent need for proper regulation in this area. Thus, the VA has been considering its own corrective regulations. Nevertheless, we believe we could abide by appropriate ED regulations, but would like to have the opportunity to review the content of any such new regulations before making final comments on the GAO recommendation.

We suggest that some of the language concerning the reference to the Del Valle case be changed in this report. We believe the outcome of the case can best be described if the present wording on page x and continuing through line 4 of page xi, and the second sentence of the first full paragraph on page 61 is changed. In the first instance, we suggest the following be substituted:

APPENDIX XVII

Mr. Gregory J. Ahart

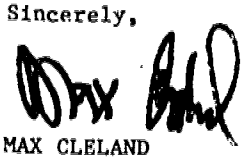
> VA lost a court case in March 1980 because it had not formally published regulations, pursuant to appropriate procedures, setting forth the criteria used as the basis for its discontinuing educational benefits to U.S. citizens attending a previously approved foreign medical school.

As a substitute for the referenced sentence on page 61, we suggest the following language:

> In March 1980, the court ruled that VA benefits could not be terminated because the VA's new criteria constituted a regulation and the VA had not followed the appropriate procedures for promulgating such a regulation.

We will pursue the feasibility of formally amending VA regulations to ensure the quality of foreign medical school programs and appreciate the opportunity to comment on this draft report.

Sincerely,



MAX CLELAND
Administrator

APPENDIX XVIII



The Federation of State Medical Boards
of the United States
INCORPORATED

HAROLD E. JERVEY, JR M.D.
EXECUTIVE DIRECTOR-SECRETARY
2626 S W FREEWAY, SUITE #200
FORT WORTH, TEXAS 76102
TELEPHONE (817) 335 1141

September 16, 1980



Gregory J. Ahart, Director
United States General Accounting Office
Human Resources Division
Washington, DC 20548

Dear Mr. Ahart:

In the limited time, it has not been possible to obtain input from the Federation's Board of Directors. The comments which follow will be brief and limited to the recommendations. Although they are mine, I believe they accurately reflect the thinking of the Federation.

The GAO has performed a valuable service to the American public with its report "Policies Regarding U.S. Citizens Studying Medicine Abroad Are in Need of Careful Review and Reappraisal". It clearly documents the magnitude of the problem.

The growing number of U.S. citizens studying medicine abroad, especially in for-profit schools, is of grave concern to all segments of medicine, but especially to the medical licensing boards. These boards have the responsibility under law to determine that candidates for licensure have been thoroughly educated in the art and science of medicine so that they continually demonstrate competence in the practice of medicine. With limited resources, no one board is capable of undertaking the evaluation process for the several hundred schools abroad. As a result, the Federation of State Medical Boards has established a Commission to Evaluate Foreign Medical Schools. There is an urgent need to put some mechanism into place rapidly, as the influx of U.S. nationals from the new schools established in the Caribbean and Mexico is just beginning to be felt. It would seem reasonable that the results of the site visits made by GAO might eliminate the need for additional information from these four schools.

APPENDIX XVIII

All alternatives proposed for evaluating the education and training received in foreign medical schools are viable and reasonable. The major problem with each of them is the time required to implement. The licensing boards are in urgent need of documented information and guidelines. For this reason, the Federation strongly believes that for the short term, the needs of the boards can best be met by the Commission to Evaluate Foreign Medical Schools. For the long range, alternative #2 and the implementation of the FLEX I-II concept is the most desirable. It is agreed that this is several years in the future, but considerable progress has been made to date. When this is in place, there will be a single track for licensure which all candidates will be required to follow.

The Federation enthusiastically supports the recommendations made to the Secretary of Education and the Administrator of V.A. Affairs. If these procedures and criteria had been established as directed, the problem may not have been as large.

The Federation concurs with the recommendations to the Congress and the Secretary of Health and Human Services. In addition, we would request that the efforts begun with the Commission to Evaluate Foreign Medical Schools be acknowledged and supported.

I appreciate the opportunity to comment on the report. If you have any questions, please let me know.

Sincerely,

Harold E. Harvey, Jr., MD
Executive Director/Secretary

HEJ:pc

APPENDIX XIX

# COORDINATING COUNCIL ON MEDICAL EDUCATION

**Member Organizations**

American Board of Medical Specialties
1603 Orrington Ave., Evanston, Ill. 60201

American Hospital Association
840 N. Lake Shore Dr., Chicago, Ill. 60611

American Medical Association
535 N. Dearborn St., Chicago, Ill. 60610

Association of American Medical Colleges
One Dupont Circle, N.W., Washington, D.C. 20036

Council of Medical Specialty Societies
P.O. Box 70, Lake Forest, Ill. 60045

**Office of the Secretary**

P.O. Box 7586
Chicago, Illinois 60680
(312) 751-6299

September 3, 1980

Mr. Gregory J. Ahart
Director, Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

Thank you for the opportunity to review the draft of a proposed report: "Policy Regarding U.S. Citizens Studying Medicine Abroad Are in Need of Careful Review and Appraisal". I note that your letter calls for review and comments prior to the September 15, 1980 deadline. The Coordinating Council on Medical Education held its last meeting in March and at the present time does not have another meeting scheduled. I note that three of the five parent organizations of the Coordinating Council on Medical Education (Association of American Medical Colleges, American Hospital Association, and American Medical Association) all received copies and have been asked for comment, therefore, the Coordinating Council will not file separate comments.

Sincerely yours,

Jackson W. Riddle, M.D., Ph.D.

rkt

APPENDIX XX

# LIAISON COMMITTEE ON MEDICAL EDUCATION

Council on Medical Education
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

Edward S. Petersen, M.D.
LCME Secretary, 1979-80
(312) 751-6310

Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

J.R. Schofield, M.D.
LCME Secretary, 1980-81
(202) 828-0670

October 7, 1980

Mr. Gregory J. Ahart
Director, Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

Thank you for your invitation to the LCME to review and comment on the draft of your proposed report to the Congress on U.S. students studying medicine abroad.

Professional staff members of the LCME have reviewed your report and have discussed its findings with the principal officers of the LCME, all under the rules of confidentiality you have established. We believe that your report, if promptly made public, would render a decidedly beneficial public service to the American people.

The LCME, following its long established practice, declines to comment on the specific contents of your report and instead refers you to the two associations which sponsor the LCME, i.e., the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association, both of which have prepared specific comments for your use in developing your final report. We believe it inappropriate for the LCME to provide specific comments on your report since the function of the LCME is confined to the formulation of judgements on the quality of programs of medical education leading to the M.D. degree in the U.S.A. and Canada.

Sincerely,

J.R. Schofield, M.D.
LCME Secretary, 1980-81

cc:
Edward S. Petersen, M.D., LCME Co-Secretary
John A.D. Cooper, M.D., Ph.D., President, AAMC
Richard Egan, M.D., Secretary, AMA-CME

APPENDIX XXI

# LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

**Office of the Secretary**
535 N. Dearborn St
Chicago, Ill. 60610

**Member Organizations**
American Board of Medical Specialties
1603 Orrington Ave., Evanston, Ill. 60201
American Hospital Association
840 N. Lake Shore Dr., Chicago, Ill. 60611
American Medical Association
535 N. Dearborn St., Chicago, Ill. 60610
Association of American Medical Colleges
One DuPont Circle, N.W., Washington, D.C. 20036
Council of Medical Specialty Societies
P.O. Box 70, Lake Forest, Ill. 60045

September 12, 1980

Mr. Gregory J. Ahart
Director
Human Resources Division
United States General Accounting Office
Washington, D. C. 20546

Dear Mr. Ahart:

Thank you for your letter of August 15, 1980 to Dr. E. L. Becker with the enclosed draft document concerning U.S. citizens in foreign medical schools.

This Committee does not plan to comment. However, the American Hospital Association, American Medical Association and the Association of American Medical Colleges are going to respond. These organizations are three of the five sponsoring agencies of this Committee.

Thank you again.

Sincerely,

William B. Deal, M.D.
Interim Secretary
Liaison Committee on
Graduate Medical Education

WBD/es

cc: Dr. John Glenapp

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aamc association of american medical colleges

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

September 26, 1980

202: 828-0460

Mr. Gregory J. Ahart
Director
Human Resources Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

Thank you for permitting me and my staff to review the draft of the GAO's report on U.S. citizens studying medicine abroad. Enclosed are a few suggestions for corrections and modifications and a more lengthy comment on the report with information which should bolster your findings. Contained in those comments are the Association's views of how the Congress should deal with the issue of guaranteed student loans and VA educational benefits to U.S. citizens studying medicine abroad and how state licensing boards should improve their standards for licensure for medical graduates.

The Graduate Medical Education National Advisory Committee report is referenced in our comments. Therefore, I am enclosing a copy of the recommendations from that Committee which are being sent to the Secretary on September 30. Recommendation #2 concerns foreign medical graduates.1/For your interest, also enclosed is a table illustrating the impact of an 18 percent reduction in entering class size on each U.S. medical school.

Once again, thank you for permitting us to review the draft.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

Enclosures

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1/This material has been deleted from their comments; pertinent recommendations by the Graduate Medical Education National Advisory Committee are discussed in chapters 1 and 3.

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The Association of American Medical Colleges is pleased to comment on the draft of the report by the General Accounting Office entitled, Policies Regarding U.S. Citizens Studying Medicine Abroad are in Need of Careful Review and Reappraisal.

The Association, whose membership includes 126 accredited medical schools in the United States and Puerto Rico, 425 major teaching hospitals, and 70 academic medical societies, has, from its founding, been concerned primarily with assuring and improving the quality of medical education and medical care in the United States. Through the Association's efforts, and through collaborative efforts with other professional organizations, medical education and medical care in this country have achieved a remarkably high standard.

For several years the Association and its constituent institutions and organizations have been troubled by the growing expectation on the part of some U.S. citizens that attending a foreign medical school provides them a right to return to the United States to enter graduate medical education and, ultimately, to be licensed to practice medicine. This timely report by the General Accounting Office exposes the deficiencies of medical education in six schools which enroll a large number of U.S. citizens. The report raises urgent policy issues. These comments will particularly focus on the following:

- The history of competition for admission to U.S. medical schools.

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- The skewed distribution of U.S. citizens in foreign medical schools.
- An assessment of the educational achievement of U.S. foreign medical students compared to students in accredited domestic medical schools.
- The provision of clinical education to U.S. foreign medical students by hospitals in the United States.
- The provision of indirect federal subsidies to foreign medical schools through guaranteed student loans and VA benefits to U.S. citizens studying medicine abroad.
- The responsibility for assuring adequate preparation for medical practice.

HISTORY OF COMPETITION FOR ADMISSION TO U.S. MEDICAL SCHOOLS

The opening paragraph of the report states, "Despite significant growth in the enrollment capacity of U.S. medical schools, thousands who apply are not accepted because of the intense competition for a limited number of positions. As a result, substantial numbers of U.S. citizens attend foreign medical schools with the goal of practicing medicine in the United States." The implication that competition for admission to U.S. medical schools has caused the growing problem relating to U.S. citizens studying medicine abroad needs to be examined in the light of the history of medical school admissions since World War II.

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The impression of intense competition for admission to U.S. medical schools has been largely based upon anecdotal accounts about the number of students applying to a single U.S. school. Newspaper stories, which conclude that 50 or more applicants are applying for each position available in the United States, fail to consider that, on the average, each applicant applies to nine schools. The actual number of applicants per position across the nation is much smaller. Figure 1 shows the number of applicants per position in U.S. medical schools at intervals since 1947.

The greatest number of applicants per position was experienced between 1947 and 1949 when returning veterans raised the average for three years to 3.3 applicants per position. During the 1950s and 1960s the figure averaged 1.9 to 2.0 with a nadir in 1960 and 1961 of 1.7. During the 1970s the ratio increased to 2.8 applicants per position for three years (1973-1976), but never approached the immediate post-World War II level. It is now returning to a ratio of 2 to 1. In 1979 there were 2.1 applicants per available position.

The majority of applicants to U.S. medical schools are college seniors, most of whom are applying for the first time. This prime group has experienced less severe competition than usually thought.

FIGURE 1

RATIOS OF APPLICANTS FOR AVAILABLE POSITIONS
IN U.S. MEDICAL SCHOOLS

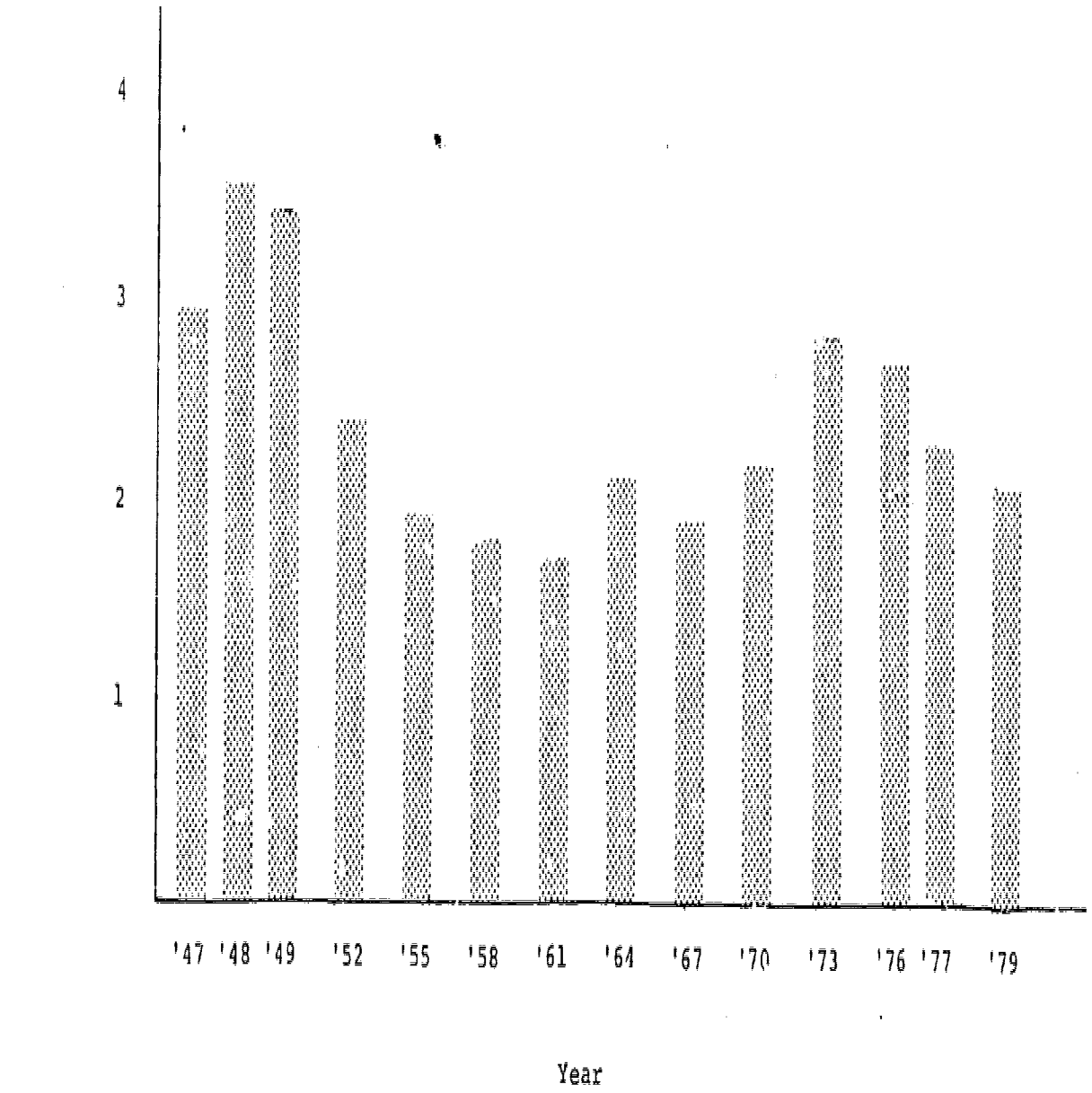




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TABLE 1

| Year | Seniors/Position |
|---|---|
| 1974 | 1.15 |
| 1975 | 1.24 |
| 1976 | 1.19 |

It is apparent from Table 1 that, during the most competitive period of the past decade, there were approximately 1.2 graduating senior applicants for each available position in U.S. medical schools. The faculties and their admissions committees have been able to select students with strong academic records and the personal qualities consistent with a career in medicine. That they have rejected large numbers of applicants only because of an insufficiency of positions is open to question.

Data are not available on the number of disappointed applicants who went abroad to study in the 1940s and early 1950s, but a careful perusal of the Association's archives failed to reveal any significant concerns expressed at that time about there being a problem with U.S. citizens studying medicine abroad. Doubtlessly, many factors have contributed to the large number of U.S. medical students attending foreign schools in the recent era when competition for positions was less intense than in the 1940s, but a major factor appears to be the development of foreign schools catering to the career aspirations of American citizens who desire to become physicians.

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The skewed distribution of U.S. citizens in foreign schools, discussed below, gives strong credence to this.

THE SKEWED DISTRIBUTION OF U.S. CITIZENS IN FOREIGN MEDICAL SCHOOLS

The report estimates (page 10) that the six schools studied had about one-half (5,400) of all U.S. citizens studying medicine abroad. The fact that only six schools contain one-half of the U.S. citizens certainly supports a skewed distribution. The Association's analysis of the distribution of examinees in its 1980 Medical Sciences Knowledge Profile examination provides further evidence that U.S. citizens are predominately enrolled in only a few schools.

In June 1980, 1,601 U.S. citizens, presently or previously enrolled in 130 foreign medical schools, took an examination to demonstrate their profile of medical sciences knowledge. These students seek advanced placement in a U.S. medical school. Their distribution among foreign medical schools is shown in Table 2.

TABLE 2

| Examinees | Number of Schools | Number of Examinees | Percent of Total |
|---|---|---|---|
| 1-9 | 107 | 256 | 16 |
| 10-24 | 13 | 187 | 12 |
| 25 or more | 10 | 1,158 | 72 |
| TOTALS | 130 | 1,601 | 100 |

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SCHOOLS WITH 25 OR MORE EXAMINEES

| School | Country | Number of Examinees |
|---|---|---|
| U. Auto Guadalajara | Mexico | 421 |
| St. George's | Grenada | 245 |
| U. Del Noreste | Mexico | 149 |
| U. Central Este | Dominican Republic | 73 |
| Amer. U. Carribean | Montserrat | 63 |
| U. Monterrey | Mexico | 51 |
| U. Roma | Italy | 46 |
| U. Catholic Lille | France | 42 |
| U. De CD Juarez | Mexico | 38 |
| Far Eastern U. | Philippines | 30 |

Ten schools contributed 1,158 (72%) of the examinees, while 107 schools accounted for only 256 (16%). Further, three schools, St. George's, U. Autonoma Guadalajara, and U. Del Noreste, provided 50% of the total examinees. All three share the common characteristics of actively recruiting U.S. citizens and charging them tuitions significantly higher than for other students. Two, St. George's and Guadalajara, were studied by the GAO and their policies towards U.S. citizens are confirmed by the report. Four others, Central Este, Juarez, Monterrey, and the American University of the Carribean, which also actively recruit U.S. students, contributed an additional 14% of the examinees. To emphasize, nearly two-thirds of the

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United States citizens seeking advanced placement in U.S. medical schools came from only seven foreign schools. Data from the 1979 Educational Commission for Foreign Medical Graduates supports these findings. Of the 3,150 U.S. citizens taking the ECFMG exam, 53% came from five of the top ten schools contributing to the Medical Sciences Knowledge Profile pool of examinees.

This skewed distribution is evidence that a few foreign institutions are both exploiting the career aspirations of our citizens and our national policy of encouraging international student exchange. The GAO report correctly acknowledges that a number of the world's medical schools have long-standing traditions of excellence in medical education and have contributed significantly to medicine. Such meritorious schools do not admit a significant number of U.S. citizens.

THE EDUCATIONAL ACHIEVEMENT OF U.S. FOREIGN MEDICAL STUDENTS COMPARED TO STUDENTS IN ACCREDITED DOMESTIC MEDICAL SCHOOLS

The opening paragraph of chapter two states, "None of the foreign medical schools we visited offered a medical education comparable to that available in the United States because of deficiencies in one or more of the following areas--admission requirements, facilities, equipment, faculty, curriculum, or clinical training." This is a clear and startling refutation of the claim that U.S. citizens studying medicine abroad constitute an appropriate resource to serve the medical care needs of our citizens. This statement by the GAO is buttressed by an analysis of the performance on the Medical Sciences Knowledge Profile examination of U.S. citizens attending foreign medical schools.

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The examination program, which is sponsored by the Association, tests students' knowledge in the sciences basic to medicine and in introductory clinical diagnosis. The subtests on basic science subjects were constructed by the National Board of Medical Examiners from its pool of questions for which the performance of students from U.S. medical schools is known. An additional subtest composed of questions covering material normally included in introductory courses in clinical diagnosis was developed and administered to students in U.S. medical schools to establish their performance on this part of the examination. Scores achieved on the examination are reported on a nine point scale. The percentage of examinees and the reference group of U.S. students achieving each score on the nine point scale was determined and compared for the two groups.

Of the 1,601 examinees from foreign schools, 1,327 had completed or were currently enrolled in courses in anatomy, biochemistry, microbiology, pathology, pharmacology, and physiology. Figure 2 illustrates that this group of U.S. citizens from foreign schools achieved significantly lower scores on all subtests of the examination. Overall, about 40% of the examinees from foreign schools failed to achieve the average score of 5. Overall, only 8% of the students from U.S. schools failed to achieve a score of 5. It is evident that the foreign schools did not provide the examinees an

FIGURE 2

PROPORTION OF STUDENTS SCORING BELOW AVERAGE








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education comparable to that provided to students from U.S. schools. On the average, foreign school examinees fell in the 17th percentile when ranked with U.S. students. Only 282 of the 1,327 achieved a score placing them at the 50th percentile or higher. The percentile rank of the average of examinees from the ten schools which contributed 72% of those who took the exam was the same as for the examinees from the other 120 contributing schools. In would appear that the efforts of these schools to recruit U.S. citizens are not matched by efforts to provide an adequate education.

The lack of preparation for education in clinical settings is of particular concern. The average performance on the introduction to clinical medicine subtest placed the examinees from the foreign schools at the 8th percentile of U.S. student performance. This low performance is consistent with the GAO's findings that clinical educational resources were inadequate in all of the study schools.

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THE PROVISION OF "CLINICAL EDUCATION" TO U.S. FOREIGN MEDICAL STUDENTS BY HOSPITALS IN THE UNITED STATES

The report particularly emphasizes the deficiencies in education in clinical settings provided by foreign medical schools. A particular strength of U.S. medical schools is the education provided in the clinical disciplines. To accomplish this, U.S. schools own, operate, or are affiliated with hospitals dedicated to patient care, teaching, and advancing medical knowledge. These institutions and their faculties are the central facilities for both undergraduate and graduate medical education.

None of the foreign schools studied by the GAO has the clinical facilities and resources needed to educate the number of students they enroll. As a consequence, U.S. citizens attending these schools seek to gain clinical experience in U.S. hospitals. In the case of three of the study schools, St. George's, Nordestana, and Guadalajara, school officials have actively sought agreements with U.S. hospitals to provide clinical education. The report confirms that most hospitals which either accept U.S. citizens who individually seek a clinical experience or who have entered into agreements with foreign schools are not recognized as teaching hospitals. Further, students who participate in clinical activities are largely placed in an observer status. Students in accredited U.S. medical schools personally participate in the work up, diagnosis, and treatment of patients to which they are assigned.

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Under supervision, they take the patient's history, do the physical examination, make initial diagnostic hypotheses, and in collaboration with residents and faculty, plan laboratory studies and procedures. They are involved in carrying out procedures and planning treatment. Their closely supervised involvement with residents and faculty is as a member of the team. They are not passive observers. The Association believes that the GAO report supports its contention that U.S. students from foreign schools have an inadequate clinical education, even when "clinical experiences" have been arranged in this country.

It should be particularly noted that by entering into agreements with foreign schools, U.S. hospitals are subsidizing them. The three schools which have negotiated agreements with hospitals in the United States charge tuition to U.S. students while they are assigned to U.S. hospitals and retain all, or the major portion of, the tuition while providing little or no education or supervision.

THE PROVISION OF INDIRECT FEDERAL SUBSIDIES TO FOREIGN MEDICAL SCHOOLS THROUGH GUARANTEED STUDENT LOANS AND VA BENEFITS TO U.S. CITIZENS STUDYING MEDICINE ABROAD

The General Accounting Office estimates that 45 million dollars in guaranteed student loans have been provided to U.S. citizens studying medicine abroad and that 12 million dollars or more have been expended in the past decade to meet the federal

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obligations to this program. Veterans Administration educational benefits are estimated to be 5 million dollars. The provision of guaranteed student loan support and VA benefits to U.S. citizens studying in foreign universities is appropriate and, doubtlessly, many students have benefited from having had the opportunity to obtain part or all of their higher education in colleges and universities in many countries. However, continuing guaranteed student loan support and VA educational benefits for U.S. citizens studying medicine abroad must be examined in light of their peculiar distribution in foreign medical schools and the growing recognition that U.S. medical schools are more than supplying the need for physicians to serve our citizens.

The Graduate Medical Education National Advisory Committee (GMENAC), which was chartered in 1976 by the Secretary of HEW, estimates that by 1990 there will be an excess of 69,750 physicians in the United States. The Committee has recommended that U.S. medical schools reduce their entering class size by 1984 to a level of 10% below that of 1978. The Committee's report goes on to say that an expected 4,100 annual influx of foreign medical graduates must be severely curtailed or the entering size of domestic schools will have to be even more severely restricted. The recommendation of a class size of 10% below 1978 would require an 18% reduction in the projected domestic class for 1982. This could distort the educational

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programs of many of our schools. A greater reduction would render many of them nonviable.

Although our national policy of encouraging international exchange and educational experiences is basically sound and should continue in other disciplines, the continuation of guaranteed student loans and GI benefits to U.S. citizens studying medicine abroad should be examined.

The Graduate Medical Education National Advisory Committee has recommended that both state and federal loan and scholarship support for the study of medicine in foreign schools be terminated for students entering such schools after 1980. The Association supports this recommendation. The skewed distribution of our citizens in a few foreign schools which cater to their career aspirations clearly demonstrates that the intent of Congress to encourage international exchange is being exploited. The Association is convinced that U.S. citizens who gain entrance to meritorious foreign schools will be able to find the resources necessary to support their education. The Congress should amend P.L. 86-698, the Higher Education Act of 1966, to exclude students enrolled in medical schools not accredited by the Liaison Committee on Medical Education.

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SETTING STANDARDS FOR ENTRY INTO GRADUATE MEDICAL EDUCATION AND MEDICAL PRACTICE IN THE UNITED STATES

The General Accounting Office points out that a universal requirement for entry into graduate medical education and/or practice for physicians who are educated in the United States is that they be graduates of an accredited medical school. All U.S. jurisdictions require that their schools be accredited by the Liaison Committee on Medical Education (LCME) in order for graduates to be considered for licensure. The report points out the paradox that had the American University of the Carribean remained in Ohio, its graduates would not have been eligible for a medical license under any circumstances, but because the school moved to the island nation of Montserrat, its graduates can potentially be licensed in the United States. The first alternative proposed by the General Accounting Office is to have the LCME (or another body) accredit foreign medical schools. Doubt is cast on the practicality of having a U.S. agency enforce its accreditation authority on a foreign institution. Further, many schools with only a few U.S. students would not seek accreditation, thereby eliminating some international educational opportunities. These issues, in addition to the difficulties and the cost of mounting a worldwide accreditation program, make the accreditation of foreign medical schools by a U.S. authority an unsatisfactory solution.

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In addition to requiring graduation from an accredited domestic medical school, state licensing boards also require passing an acceptable examination, either the three-part National Board of Medical Examiners sequence or the Federation Licensing Examination (FLEX). The National Board of Medical Examiners' examinations are available only to students enrolled in or graduates of U.S. and Canadian medical schools. Thus, the FLEX examination is the only one available to graduates of foreign schools, whether they are U.S. citizens or aliens. This means that all graduates of foreign schools must meet the same examination standards. This is appropriate, and further efforts on the part of the Federation of State Medical Boards and its constituent boards to ensure that a uniformly high standard is achieved and maintained in every jurisdiction should be encouraged.

The Federation and its constituents should take especial cognizance of the GAO's finding that the clinical education of foreign medical graduates is particularly deficient. The assessment of the clinical knowledge and skills of students in accredited U.S. medical schools is accomplished by the faculties through close contact and direct observation of how students perform in their daily interactions with patients. Because similar clinical education and evaluation of performance is rarely required by foreign schools, all foreign medical school graduates, including U.S. citizens, should be required by state licensing boards to

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take a special examination to demonstrate their clinical knowledge and their ability to solve patient management problems. Those who pass that exam should take a further practical examination proctored by qualified examiners during which their skills in history-taking, physical diagnosis, and clinical judgment are directly observed. Such examinations will, to a degree, supplant the lack of quality control in most foreign institutions. Graduates of meritorious foreign schools should have little difficulty in meeting the standards for clinical knowledge and the clinical skills necessary for the care of our citizens.

To enter programs in graduate medical education, there are two standards. Alien foreign graduates who need a visa to enter the U.S. for graduate medical education must pass one standard, the Visa Qualifying Examination, while U.S. citizen graduates of foreign schools are permitted to enter graduate medical education if they pass what is generally considered a lesser standard, the Educational Commission for Foreign Medical Graduates'examination. This double standard is indefensible. The Liaison Committee on Graduate Medical Education (LCGME), which sets the standards for eligibility to enter graduate medical education in the United States, should require all graduates of foreign medical schools to meet the same standards. The LCGME should be urged to require that U.S. citizen graduates pass the same examination as other graduates of foreign medical schools to enter accredited graduate medical education programs in the United States.

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The General Accounting Office, in its presentation of the third alternative for evaluating the education and training received in foreign medical schools, points out that no examination can effectively determine that a foreign medical school graduate has had an education comparable to that received in U.S. medical schools. This is a problem which has plagued both medical educators and licensing boards. The solution proposed in the third alternative combines approaches already tried in the past. It is based on the concept that this country has an obligation to rehabilitate graduates of foreign medical schools who are deemed to have received an inferior education. It combines elements of the program, which has been conducted by the Educational Commission for Foreign Medical Graduates since 1958, and the Fifth Pathway Program, which has existed since 1972. The Educational Commission for Foreign Medical Graduates sets a minimal standard through its examination and reviews and approves the credentials of foreign graduates. Medical schools which sponsor Fifth Pathway programs are supposed to determine the educational deficiencies of students they accept into these programs and only permit those who satisfactorily complete a series of clinical clerkships to go on to graduate medical education. Neither program has

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proven to be a satisfactory solution. Both raise the expectations of U.S. foreign medical graduates that enrolling in a foreign school will allow them to pursue a medical career in this country. The expenditure of scarce educational resources on such a program does not appear to be justifiable.

SUMMARY

This report by the General Accounting Office exposes the inadequacies of the foreign medical schools studied. It paints a clear picture of schools which have policies particularly directed toward attracting large numbers of U.S. citizens. Some of these schools have been established only within the past three years. All of them were found not to provide an education comparable to U.S. medical education. The report, and additional data from the AAMC, demonstrate a skewed distribution of U.S. citizens in a few foreign medical schools.

United States citizens studying abroad are eligible for federally guaranteed student loans and veterans are eligible for VA educational benefits if their education is comparable to the education they would receive in this country. Although the exact figure is not known, many U.S. students in foreign medical schools are recipients of guaranteed student loans and VA benefits. The concentration of U.S. citizens in a few schools of dubious quality is a clear distortion of our national policy encouraging international educational exchange. The Graduate Medical Education

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National Advisory Committee reports that by 1990 there will be an excess of 69,750 physicians in the United States. The Committee recommends that U.S. medical schools reduce their entering class size to a figure 18% below the class projected for 1982 and severely restrict the entry of physicians educated abroad.

- The Graduate Medical Education National Advisory Committee recommends that all federal and state assistance given through loans and scholarships to U.S. medical students initiating study abroad after the 1980-81 academic year should be terminated.

  The Association supports that recommendation. The few U.S. citizens who gain admission to meritorious foreign schools should be able to finance their education through other sources.

The General Accounting Office is rightfully concerned that U.S. citizens attending foreign medical schools which do not provide an education comparable to that received by students in U.S. medical schools expect to be accorded the privilege to practice medicine in a U.S. jurisdiction. A proposal is made to provide educational rehabilitation to foreign medical graduates similar to programs tried by the Educational Commission for Foreign Medical Graduates and the Fifth Pathway.

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This proposal is founded on the concept that this country has special obligations to remedy the educational deficiencies of graduates of foreign schools. The AAMC believes that no such obligation exists and that the expenditure of scarce resources on such an effort is not justifiable at a time when the possibility that the nation will have an excess number of physicians is becoming a policy issues:

The Association recommends:

- That all graduates of foreign medical schools be required to meet the same standards for entry into graduate medical education and licensure in this country.
- That State Medical Boards be encouraged to establish uniformly high standards for licensure in all jurisdictions and develop rigorous practical clinical examinations for graduates of foreign schools.

EFFECTS OF GMENAC'S RECOMMENDED REDUCTION IN FIRST YEAR ENROLLMENT

| Fully-Accredited Medical Schools | 1978[1] 1st Year Enrollment | 1982 Projection[2] 1st Year Enrollment | 10% Reduction[3] 1978 1st Year Enrollment | Projected 1982[4] 1st Year Enrollment Reduced by 18% |
|---|---|---|---|---|
| Alabama | 169 | 170 | 152 | 139 |
| Alabama, South | 70 | 70 | 63 | 57 |
| Albany | 128 | 128 | 115 | 105 |
| Albert Einstein | 186 | 188 | 167 | 154 |
| Arizona | 88 | 89 | 79 | 73 |
| Arkansas | 138 | 145 | 124 | 119 |
| Baylor | 167 | 169 | 150 | 139 |
| Boston University | 141 | 139 | 127 | 114 |
| Bowman Gray | 107 | 113 | 96 | 93 |
| Brown | 62 | 60 | 56 | 49 |
| U. California, Davis | 102 | 100 | 92 | 82 |
| U. California, Irvine | 106 | 109 | 95 | 89 |
| U. California, Los Angeles | 145 | 146 | 131 | 119 |
| U. California, San Diego | 129 | 129 | 116 | 106 |
| U. California, San Francisco | 159 | 159 | 143 | 130 |

[1]Source: AAMC Medical School Admission Requirements, 1980-81.

[2]For fully-accredited medical schools 1979 first year enrollment was used as a projection for 1982 first year enrollment. For provisionally-accredited schools the 1982 first year enrollment projection was based on figures from Medical Schools of the U.S.A., Status of Accreditation, June 20-21, 1980.

[3]GMENAC's recommendation is for a 10% aggregate decrease in based on 1978 entering class size.

[4]An 18% reduction from 1982 first year enrollment is required to meet GMENAC's recommendation for a 10% aggregate decrease from 1978 first year enrollment figures.



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| Fully-Accredited Medical Schools | 1978 1st Year Enrollment | 1982 Projection 1st Year Enrollment | 10% Reduction 1978 1st Year Enrollment | Projected 1982 1st Year Enrollment Reduced by 18% |
|---|---|---|---|---|
| U. Southern California | 136 | 144 | 122 | 118 |
| Case Western Reserve | 147 | 146 | 132 | 120 |
| Chicago Medical | 120 | 119 | 108 | 98 |
| U. Chicago--Pritzker | 104 | 104 | 94 | 85 |
| Cincinnati | 199 | 198 | 179 | 162 |
| Colorado | 128 | 129 | 115 | 106 |
| Columbia | 150 | 149 | 135 | 122 |
| Connecticut | 83 | 82 | 75 | 67 |
| Cornell | 96 | 105 | 86 | 86 |
| Creighton | 109 | 113 | 98 | 93 |
| Dartmouth | 67 | 65 | 60 | 53 |
| Duke | 120 | 119 | 108 | 98 |
| Emory | 115 | 112 | 103 | 92 |
| Florida | 116 | 117 | 104 | 96 |
| Florida, South | 96 | 99 | 86 | 81 |
| Georgetown | 205 | 206 | [illegible] | 169 |
| George Washington | 155 | 152 | 140 | 125 |
| Georgia | 181 | 185 | 163 | 152 |
| Hahnemann | 192 | 190 | 173 | 156 |
| Harvard | 167 | 166 | 150 | 136 |
| Hawaii | 68 | 68 | 61 | 56 |
| Howard | 139 | 143 | 125 | 122 |
| Illinois | 344 | 354 | 310 | 290 |
| Illinois, Southern | 74 | 73 | 67 | 60 |





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| Fully-Accredited Medical Schools | 1978 1st Year Enrollment | 1982 Projection 1st Year Enrollment | 10% Reduction 1978 1st Year Enrollment | Projected 1982 1st Year Enrollment Reduced by 18% |
|---|---|---|---|---|
| Indiana | 320 | 318 | 288 | 261 |
| Iowa | 175 | 177 | 156 | 145 |
| Jefferson | 235 | 223 | 212 | 183 |
| Johns Hopkins | 121 | 120 | 109 | 98 |
| Kansas | 202 | 202 | 182 | 166 |
| Kentucky | 110 | 110 | 99 | 90 |
| Loma Linda | 149 | 150 | 134 | 123 |
| Louisiana, New Orleans | 183 | 192 | 165 | 157 |
| Louisiana, Shreveport | 106 | 104 | 95 | 85 |
| Loyola--Stritch | 153 | 152 | 138 | 125 |
| Maryland | 181 | 181 | 163 | 148 |
| Mayo | 41 | 41 | 37 | 34 |
| Meharry | 149 | 156 | 134 | 128 |
| Miami | 144 | 180 | 130 | 148 |
| Michigan State | 117 | 110 | 105 | 90 |
| U. Michigan | 247 | 244 | 222 | 201 |
| Minnesota--Duluth | 48 | 48 | 43 | 39 |
| Minnesota--Minneapolis | 243 | 251 | 219 | 206 |
| Mississippi | 154 | 153 | 139 | 125 |
| Missouri, Columbia | 113 | 111 | 102 | 91 |
| Missouri, Kansas City | 83 | 84 | 75 | 69 |
| Mount Sinai | 102 | 103 | 92 | 84 |
| Nebraska | 152 | 154 | 137 | 126 |
| Nevada, Reno | 49 | 49 | 44 | 40 |



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| Fully-Accredited Medical Schools | 1978 1st Year Enrollment | 1982 Projection 1st Year Enrollment | 10% Reduction 1978 1st Year Enrollment | Projected 1982 1st Year Enrollment Reduced by 18% |
|---|---|---|---|---|
| New Jersey Medical | 154 | 179 | 139 | 147 |
| Rutgers | 114 | 110 | 103 | 90 |
| New Mexico | 75 | 73 | 68 | 60 |
| New York Medical | 180 | 181 | 162 | 148 |
| New York University | 171 | 173 | 154 | 142 |
| SUNY--Buffalo | 142 | 138 | 128 | 113 |
| SUNY--Downstate | 221 | 225 | 199 | 185 |
| SUNY--Stony Brook | 63 | 60 | 57 | 49 |
| SUNY--Upstate | 150 | 150 | 135 | 123 |
| North Carolina | 161 | 162 | 145 | 133 |
| North Dakota | 67 | 68 | 60 | 56 |
| Northwestern | 177 | 173 | 159 | 142 |
| Ohio, Medical College of | 133 | 142 | 120 | 116 |
| Ohio State | 251 | 258 | 226 | 212 |
| Oklahoma | 178 | 176 | 160 | 144 |
| Oregon | 117 | 116 | 105 | 95 |
| Pennsylvania, Medical College of | 102 | 104 | 92 | 85 |
| Pennsylvania State | 97 | 99 | 87 | 81 |
| U. Pennsylvania | 160 | 160 | 144 | 131 |
| Pittsburgh | 136 | 139 | 122 | 114 |
| Rochester | 101 | 97 | 91 | 80 |
| Rush | 122 | 120 | 110 | 98 |
| St. Louis University | 155 | 155 | 140 | 127 |
| South Carolina, Medical Univ. of | 169 | 167 | 152 | 137 |



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| Fully-Accredited Medical Schools | 1978 1st Year Enrollment | 1982 Projection 1st Year Enrollment | 10% Reduction 1978 1st Year Enrollment | Projected 1982 1st Year Enrollment Reduced by 18% |
|---|---|---|---|---|
| South Dakota | 68 | 66 | 61 | 54 |
| Stanford | 86 | 86 | 77 | 71 |
| Temple | 184 | 187 | 166 | 153 |
| U. Tennessee | 221 | 215 | 199 | 176 |
| U. Texas, Dallas | 207 | 207 | 186 | 170 |
| U. Texas, Galveston | 208 | 206 | 187 | 169 |
| U. Texas, Houston | 159 | 214 | 143 | 175 |
| U. Texas, San Antonio | 214 | 208 | 193 | 171 |
| Texas Tech | 62 | 84 | 56 | 69 |
| Tufts | 151 | 149 | 136 | 122 |
| Tulane | 150 | 151 | 135 | 124 |
| Uniformed Services | 108 | 129 | 97 | 106 |
| Utah | 102 | 100 | 92 | 82 |
| Vanderbilt | 104 | 106 | 94 | 87 |
| Vermont | 83 | 93 | 75 | 76 |
| Virginia, Eastern | 80 | 99 | 72 | 81 |
| Virginia, Medical College of | 168 | 168 | 151 | 138 |
| U. Virginia | 138 | 143 | 124 | 117 |
| Washington U. (St. Louis) | 128 | 124 | 115 | 102 |
| U. Washington | 175 | 181 | 158 | 148 |
| Wayne State | 256 | 257 | 230 | 211 |
| West Virginia | 88 | 89 | 79 | 73 |
| Wisconsin, Medical College of | 180 | 201 | 162 | 165 |
| Wright State | 79 | 106 | 71 | 87 |
| Yale | 102 | 102 | 92 | 84 |





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| Provisionally-Accredited Medical Schools | 1978 1st Year Enrollment | 1982 Projection 1st Year Enrollment | 10% Reduction 1978 1st Year Enrollment | Projected 1982 1st Year Enrollment Reduced by 18% |
|---|---|---|---|---|
| Morehouse | 27 | 64 | 22 | 52 |
| East Carolina | 37 | 64 | 33 | 52 |
| Northeastern Ohio | 49 | 100 | 44 | 82 |
| Oral Roberts | 25 | 48 | 23 | 39 |
| Puerto Rico, Ponce | 28 | 60 | 25 | 49 |
| Puerto Rico, Escuela de Medicine de Cayey | 80 | 80 | 72 | 66 |
| U. South Carolina | 37 | 64 | 33 | 52 |
| East Tennessee | 24 | 72 | 22 | 59 |
| Texas A & M | 32 | 96 | 29 | 79 |
| Marshall University | 26 | 48 | 23 | 39 |
| TOTALS | 16,501 | 18,151 | 14,851 | 14,883 |



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APPENDIX XXIII

AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE CHICAGO, ILLINOIS 60611 TELEPHONE [redacted]
TO CALL AMERICAN PHONE SERVICE 6412

September 26, 1980

Gregory J. Ahart
Director
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Ahart

I write in reply to your August 15, 1980 letter to Mr. McMahon requesting the comments of the American Hospital Association (AHA) on the draft of a GAO staff report: Policies Regarding U.S. Citizens Studying Medicine Abroad are in Need of Careful Review and Reappraisal. Staff members have reviewed the report in detail and we are pleased to respond to your request. Our comments are divided into three sections: first, general considerations in response to the substantive issues discussed in the report; second, some general editorial suggestions that offer ways in which the report might be revised to benefit the reader; and third, some detailed comments with specific page references.

I. General Considerations

The underlying problem which led to the writing of this report has been addressed by the AHA during the recent past. In brief, this problem can be defined as the infiltration into the health care delivery system of U.S. citizens, who having studied medicine abroad in unaccredited medical schools, return to the U.S. to complete medical training and thereby become practicing physicians without their credentials being subjected to the rigorous appraisal that is afforded to entrants into the medical profession who have been educated in the U.S. Aware of the problems created by anomalous loopholes in the screening of such medical students and the attendant threat to an appropriate standard of patient care, the AHA Board of Trustees took the following action in May 1979:

To alert member hospitals and medical staff members to the increasing number of requests from U.S. students in foreign medical schools for clinical clerkship positions in U.S. hospitals; further,

To urge that hospitals and physicians assess most carefully (1) the

CABLE ADDRESS: AMHOSP

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individual qualifications and educational backgrounds of the prospective participants, (2) the quality of the educational program at the individual's foreign medical school, and (3) the relative value of the clerkship experience to the participant, the hospital, and the public in reviewing such requests before making the institution's facilities and staff available for educational opportunities; and further,

To reaffirm the American Hospital Association's 1976 Guidelines on Mutual Responsibilities in Education Health Manpower.

(For your information I append the policy document referred to in the final part of the action.)

In the debate that preceded the adoption of this motion, members of AHA's policy making bodies identified a need for collaboration in solving a complex problem. The many bodies with legitimate interest in standard setting for medical education will need to develop mechanisms jointly while remaining sensitive to the rights of individuals. The AHA as a representative of many hospitals that provide the locus of clinical training for both undergraduate and graduate medical education will be willing to work collaboratively with private sector and public governmental bodies to reduce [illegible] U.S. citizen foreign medical school students who seek to receive all or part of their clinical training in U.S. hospitals. Individual hospitals are not equipped to determine the quality of medical education but as the site for educational experiences hospitals have a legitimate claim to participate in the process. The AHA is in broad agreement with the major conclusions identified in the central paragraph of page 71 but when, on page 74, the parties which may develop solutions are identified, we believe that hospitals should be included.

In response to the elaboration of alternative evaluation mechanisms, the AHA does not believe the first alternative to be a plausible solution. The second and third alternatives each have advantages in that the second would introduce parity for all medical students--U.S. and alien--whether trained abroad or within the U.S., and the third would focus specifically on those students currently giving rise to the problem. We do, however, advise caution with respect to the third suggestion since in a climate of extreme fiscal stringency and with a projected surplus of U.S. educated physicians, the motivation to implement a new credentialing mechanism requiring extensive collaboration will not be high. This motivation may be further reduced by the recommendations expected to emanate from the report to the Secretary of Health and Human Services by the Graduate Medical Education National Advisory Committee.

II. General Editorial Suggestions

While the reader who is unfamiliar with the system of medical education will undoubtedly be better informed as a result of reading the report, we suggest that the introduction of some graphic materials would improve the text and enhance its clarity. For instance, in the passages describing alternate pathways flow charts would help the reader, and where statistics are extensively used graphs and histograms would be a useful addition.

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Furthermore we find that the report is frequently repetitious in that material essentially dealing with the same topic occurs in several different places. Some compression and editorial excisions would increase the cogency of the report.

III. Detailed Remarks

1. Chapter 1 page 1 line 7

   Although 10,000 - 11,000 is an approximate figure, it would assist the reader to know what the basis was for this estimate. In the absence of accurate data, the source of an estimate is important.

2. page 1 line 15

   The opening of the third paragraph would be strengthened if the individuals or organizations expressing concern and raising questions were identified. It is left for the reader to assume that the concern and question ultimately translate into a threat to the safety and welfare of the public.

3. page 7 lines 1-6

   Insofar as this paragraph addresses undergraduate education, it is substantially correct. However, the term teaching hospital is generally used to refer to hospitals that participate in programs of graduate medical education, and the assertion in the final sentence is not true of all hospitals with graduate medical education programs.

4. Chapter 2 page 22

   The discussion following the heading "Clinical Training for U.S. Citizen Foreign Medical School Students in U.S. Hospitals" seems to blur the distinction between credentialing individuals by licensure, a function of state medical licensing boards, and credentialing of educational programs, a function of an approved accrediting body.

5. page 24 final paragraph

   This sentence is extremely obscure since the New York State officials are not identified by title. The reader needs to know under what statutory authority these officials took the action.

6. page 27 line 7-10

   It would be helpful to the reader if the screening examination referred to was more definitively identified. Was this the ECFMG examination or one devised by an individual hospital for the purpose?

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7. page 29

Under the heading "Curriculum", there is not sufficient distinction made between the two types of clerkship. Since the five basic clinical specialties identified are listed under both programs, it appears to the reader that length of program rather than content is the substantive issue. Was this the intention?

8. page 30 lines 18-20

We find the final sentence of the second paragraph obscure in that medical student notations rarely become part of the patient record. The purpose of documenting medical student history and physical examinations is its educational value for the student; such records are not routinely considered part of patient care unless carried out under supervision and countersigned by the physician responsible for patient care.

9. page 31 lines 7-10

Many physicians without medical school teaching appointments participate in teaching programs for U.S. students.

10. Chapter 3 page 33

The exposition of the four separate routes for the entry of U.S. FMGs would be enhanced if all five routes to the practice of medicine were identified. We assume that graduates of U.S. schools is the first pathway. The term "fifth pathway" could then be described in fifth position.

Where ambiguities have been identified, we have discussed them as they occur in the main body of the text without referencing them in the digest. I hope that this response is helpful to you. If your staff would like further clarification of any of the points raised in this letter, please contact Thomas Atchison (312-280-6449) or Ada Mary Gugenheim (312-280-6421). Thank you for the opportunity to review the draft.

Sincerely yours

Tita D. Corpuz
Vice President

mm

APPENDIX XXIV

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 751-6000 • TWX 9' 221-0300

JAMES H. SAMMONS, M.D.
Executive Vice President
(751-6200)

September 15, 1980

Gregory J. Ahart
Director
Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The American Medical Association is pleased to have been offered the opportunity to provide its comments on the draft of GAO's proposed report "Policies Regarding U.S. Citizens Studying Medicine Abroad Are in Need of Careful Review and Reappraisal." This report renders a valuable public service by providing on-site information concerning selected foreign medical schools and in outlining the current status of U.S. citizens who seek a medical education in schools outside of the United States and Canada.

It is our view, as indicated in the attached comments, that although the federal government has a valid interest in assuring proper usage of tax dollars for higher education loan guarantees and VA education benefits, the federal government should not become involved with program accreditation or in establishing prerequisites for licensure or graduate medical education in the U.S. The report does not adequately recognize existing safeguards through state responsibilities for licensure to practice medicine that in general are based on:

1. character of the applicant;
2. an examination;
3. completion of an appropriate educational program.

Likewise, admission standards to graduate medical education programs are determined by the program director and medical staff to assure that the participant benefits from the program and that patients in the institution are protected. In addition, the report fails to emphasize that undergraduate clinical education should be an experience provided under the most stringent academic supervision in order to fully protect the patient.

With these safeguards for licensure to practice medicine already established at the state level and entry to graduate medical education established through voluntary actions of the private sector, we believe that it is inappropriate to institute further federal regulation.

Very truly yours,

James H. Sammons, M.D.

JHS/dap
Attach.

APPENDIX XXIV

COMMENTS

of the

AMERICAN MEDICAL ASSOCIATION

to the

General Accounting Office

Re: "Policies Regarding U.S. Citizens Studying Medicine Abroad are in Need of Careful Review or Appraisal"

September 15, 1980

The AMA is pleased to have been offered the opportunity to comment on the above referred report. The report correctly recognizes this subject as an issue of increasing magnitude since there is a greater number of U.S. citizens who desire a medical education than there are places in U.S. schools. The report points out that there are many high quality foreign medical schools primarily concerned with education of their own nationals which do not seek enrollment of U.S. citizen students. The report centers on the fact that in recent years there has been a steadily increasing number of foreign schools specifically developed to encourage U.S. citizens to attend.

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While the number of positions in U.S. medical schools has risen dramatically in the last two decades, this increase has not kept pace with the number of students who desire to attend. Competition for space has been extraordinary with many well-qualified individuals having failed to gain admission. Many of these highly motivated and competent individuals chose foreign education in the hope of returning to the U.S. (through the fifth pathway programs, advanced standing transfer, or graduate medical education) for a career in medicine. It should be pointed out that some foreign schools have no admissions requirements and, therefore, may accept students who would not be eligible for admission to a U.S. medical school even with space available.

In our view, the interests of the federal government concerning foreign medical education should be synonymous with its interests concerning any foreign higher education program entered into by its citizens. Since medical licensure is a purely State function, the competence and skills necessary to practice medicine in a jurisdiction are established by the State licensing authorities and are not in direct federal domain. No jurisdiction allows the practice of medicine without proof that an individual meets its established criteria for licensure. States have met their responsibility by accepting certain objective indicators of competence for foreign medical graduates, such as passage of the ECFMG examination, completion of an approved residency, and in at least one state, Specialty Board Certification. Foreign-trained physicians are not unusual to many states. For most of our history some U.S. citizens have obtained all or part

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of their medical education in other countries. What is different in recent years is the situation described in the report--increasing numbers of U.S. citizens receiving educations abroad.

The federal government does have a valid interest in assuring that tax dollars are being properly spent. This interest specifically relates to the use of higher education loans and VA education benefits. Therefore, the report is significant in pointing out the failure of the Department of Education (ED) in following through on attendance verification requirements for students at foreign schools as well as determining comparability of educational programs with U.S. programs. The report notes ED's failure to determine standards of comparability for medical education programs, yet it is surprisingly silent on methadology used in determining comparability of foreign educational programs offering non-medical training. The report also fails to address how the Veterans' Administration (VA) evaluates non-medical foreign training programs.

Finally, the report does not address the critical questions relating to comparability of "What is a medical school?" and "What is the meaning of an M.D. degree?" In the United States a medical school is an academic institution. It is not a vocational school for teaching technical skills only. The student matures in a milieu of thought and investigation under the guidance of a faculty carefully chosen for their abilities and skills, and capable of devising an integrated curriculum (didactic and clinical), presenting it, monitoring it, and evaluating it, as well as evaluating the progress of the student. That faculty is responsible for certifying that

APPENDIX XXIV

the student has satisfactorily completed the curriculum under its direction through the granting of the M.D. academic degree. In the United States and Canada all undergraduate medical education programs are accredited by a single agency to ensure standards of curriculum, faculty, and resources as well as to assure the student and the public that such standards are met. The educational program is usually provided in one defined geographic site under the direct supervision of selected faculty and occasionally at a remote site also under the direction of full time faculty. Clinical components of the curriculum are accredited only as a portion of the whole program and not separately. The Liaison Committee on Medical Education, the nationally recognized agency for accreditation of programs in medical education leading to the M.D. degree, does not recognize programs in the basic sciences alone unless the institution has established its intent to provide a complete program. Nor does it recognize clinical programs alone.

The GAO report notes that there is a lack of clinical facilities at all six schools visited and that, to a great extent, so called "clinical rotations" must be arranged by the students themselves. These "clinical rotations" are analogous in intent to the core clinical clerkships of U.S. and Canadian medical schools. The core clerkships are, however, an integral part of the U.S. total curriculum, usually its third year, and are monitored by carefully chosen faculty of the school and provided in a medical care institution where the educational programs are supervised by the school's faculty. During the fourth year or final period of an accredited program students may be permitted to select an elective course or experience at

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another institution. In no case, however, is responsibility for the students' education vested in another totally unrelated institution.

The report (Alternative 3) suggests that a mechanism be devised for approval of U.S. hospitals to provide undergraduate clinical training to students in foreign schools. This in essence would create clinical schools of medicine in the U.S. outside of a total academic program and could encourage further development of foreign basic science proprietary schools targeted at U.S. citizens. Separation of the responsibility for the clinical experience from the institution providing the rest of the academic program may lead to a reduction in the quality of the educational process.

The remainder of our comments will be directed at providing our views concerning the alternatives and recommendations found at the end of the report. We have also prepared detailed technical comments on items in the report as an appendix to these comments.

Alternatives and Recommendations

The report (pages 74-79) presents three alternatives for consideration designed to establish a method for readily determining whether the medical education provided by a foreign medical school meets a minimum standard for (1) continued U.S. government funding through ED loan guarantees and VA benefit programs, and (2) whether the individuals so trained should be allowed to enter into graduate medical education or practice in the U.S. As we have stated above, it is our view that because of State responsibility

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for licensure the federal government's concern should be limited to item one which is based on the determination of comparability of educational programs. Addressing such comparability may be unfeasible if not impossible because of differences in tradition, educational evolution, curriculum, resources, requirements for admission, etc.

Alternative 1

This alternative suggests that the Liaison Committee on Medical Education or other recognized accrediting body, should accredit foreign medical schools. Only graduates of accredited schools could qualify for undergraduate clinical training in U.S. hospitals, graduate medical education, or licensure in the U.S.

In addition to the problems outlined in the report there are three additional factors that would militate against its adoption. First, the alternative fails to recognize that establishment of entrance standards for a graduate medical education program is the proper responsibility of the program's director and the medical staff of the institution. An accredited residency program must have admission standards that are sufficient to ensure that the safety of the patients in the institution is assured. Suggestions that federal standards for admission to an education program in a state or private institution be imposed is unprecedented. Second, the alternative does not properly recognize the right of the States to establish the level and type of education required for licensure. Finally, it must be remembered that a large number of alien foreign medical come to the U.S. for residency training so that they can develop additional

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skills for practice on returning to their home countries. This alternative would irrevocably damage this type of educational opportunity.

Alternative 2

This alternative suggests that a new, more comprehensive standardized examination be created--with passage a prerequisite to graduate medical education and licensure in the U.S.

While a sponsoring organization of the Educational Commission for Foreign Medical Graduates, AMA will defer to it to provide definitive comments on the quality and reliability of the ECFMG's program for verifying the credentials of foreign medical graduates. However, we will address three points. First, the ECFMG exam, the VQE and FLEX examinations are all prepared by the same agency and draw from the same pool of questions. Second, the VQE exam was developed primarily as a mechanism to address the entry of alien foreign medical graduates. Finally, determination of the qualifications for an individual to obtain a license rests with the States and to enter a graduate medical education program rests with the institution responsible for the safety of patients and in whom the quality of care delivered is vested.

Alternative 3

This alternative would establish within the Department of HHS, or a private agency, a bureaucracy to evaluate the credentials of each foreign medical graduate.

We believe this alternative is the least desirable of those suggested. First, it improperly places the federal government in the role of accrediting

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programs for undergraduate medical education in the U.S. (i.e., clinical clerkships). It also inappropriately establishes federal prerequisites for licensure and for entry into graduate medical training. Finally, it fails to recognize the fact that the ECFMG was established as a voluntary private sector program to do just such a screening of candidates.

In summary, both alternatives 2 and 3 address qualifications for entering U.S. medical practice and fail to address the federal question of comparability which in our view is the major federal interest.

Recommendations to Congress

This section suggests that the Congress should direct the HHS Secretary to work with representatives of the medical profession and state licensing authorities to develop and implement mechanisms to ensure that all foreign medical graduates demonstrate skills comparable with those of U.S. medical graduates in the practice of medicine.

As we have stated earlier, it is the view of the American Medical Association that the qualifications for the practice of medicine are appropriately set by State licensing authorities. Each State has accepted the responsibility to ensure that those licensed to practice medicine meet certain standards. Likewise, entry into graduate medical education is now regulated both by the States (through requirements for limited licensure or registration of residents) and by the programs themselves to assure that the concerns of patient care and safety are met. We do not view this as an

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area appropriate to or in need of Congressional involvement. The publication of this report, by calling attention to this issue has been an important Congressional response to the issues of concern.

Recommendations to the Secretary of HHS

This section recommends that the HHS Secretary, in cooperation with the medical profession and State licensing authorities, should address the current practice whereby students in some foreign medical schools receive clinical training in the U.S.

We believe that the report raises a valid concern for review and the AMA would be pleased to participate in any forum for discussing this issue.

Recommendations to the Secretary of Education

This section recommends that the Secretary of Education issue regulations as necessary to carry out its statutory duty to ensure that foreign medical schools are comparable to U.S. medical schools (as part of the requirements for the guaranteed student loan program) and for the Secretary to implement necessary procedures to verify the attendance of U.S. citizens at foreign medical schools.

We believe that these recommendations clearly focus on a valid interest of federal concern. We would suggest that the Secretary first determine if the criteria used to determine the eligibility for guaranteed student loans to students in non-medical disciplines attending foreign universities would be acceptable for the purposes of medical education. If not acceptable, the AMA would be pleased to discuss with the Secretary

APPENDIX XXIV

and other interested parties, possible mechanisms for meeting the statutory mandate.

We concur with the GAO in the second recommendation for proper accountability of U.S. students attending foreign medical schools.

Recommendation for the Administrator of the VA

This recommendation calls upon the VA to accept the Department of Education's finding of comparability of foreign medical schools for the purpose of eligibility for VA benefits.

We concur with this recommendation.

Conclusion

In closing, the AMA believes that this report has provided a valuable benefit by emphasizing the issues related to U.S. citizens seeking undergraduate medical education at foreign medical schools. We agree that the Secretary of Education and the Administrator of the VA should be properly accountable for the tax dollars that are being used for education of U.S. citizens at foreign schools.

We do, however, believe that the report fails to recognize the important role that the States have in ensuring quality medical care through their conditions for licensure. Likewise, the report makes no reference to the role of medical school faculties and hospital medical staff in supervising graduate medical education residency programs to ensure quality patient care and a meaningful educational experience.

APPENDIX XXV

NATIONAL BOARD OF MEDICAL EXAMINERS

3930 CHESTNUT STREET PHILADELPHIA PENNA 19104

TELEPHONE AREA CODE 215 349 6400 · CABLE ADDRESS NATBORD

September 8, 1980

OFFICE OF THE PRESIDENT

Gregory J. Ahart
Director
Human Resources Division
United States General Accounting Office
Washington, DC 20548

Dear Mr. Ahart:

On behalf of the National Board of Medical Examiners, I wish to express our appreciation for the opportunity to comment upon the GAO draft of its proposed report to the Congress on U.S. citizens studying medicine abroad. This comprehensive, well documented draft report clearly delineates the complex issues relative to education in foreign medical schools and the subsequent implications this has for entry into the U.S. educational and health care system.

While we have reviewed the entire report with great interest, please note that the National Board's comments and suggestions are confined to those segments of the report that relate to NBME programs and activities. To facilitate your review, our comments and suggested modifications are provided on individual pages identified with the page and paragraph numbers in the draft report. Suggested changes and/or additions have been underlined for your ready consideration. Also, copy of the corresponding page from the draft report is attached to each NBME comment. The enclosures represent comments on pages 33, 34, 35, 36, 40, 41, 42, 44, 45, 46, 47, 49, 50, 51, 52, 74-81, 84, 85, 153, 157, 159, 160, and 161 of the GAO draft report. 1/

As noted in the comments on pages 35 and 50, we would suggest that the GAO Report be updated with respect to the MSKP Program. At the time that the GAO staff was gathering information and data for this report, the MSKP Program was in a developmental stage. In view of the fact that this program has become operational, with the first examination administered in June 1980, it would seem appropriate for the GAO Report to include the results of this examination as well as an additional appendix to describe the MSKP Program. We are enclosing the following informational materials for your consideration:

(1) The NBME Annual Report for 1979, with excerpts providing the background and rationale for the introduction of this new program to replace the COTRANS Program which involved the use of the Part I examination (see pages 14-15); and a description of the objectives and the content of the MSKP examination (see page 24). 1/

(2) Copy of the Bulletin of Information for the MSKP Examination which was provided to applicants; and 1/

(3) Copy of a brochure on interpretation of scores provided to individual examinees along with their score reports.

1/This material has been deleted from their comments.

APPENDIX XXV

I hope that the enclosed comments and informational materials will be helpful to you. Should you have any questions concerning these materials or if we can be helpful in providing any clarification or further information, please let me know.

Again, our thanks for the opportunity to review and comment upon this important document.

Sincerely,

Edithe J. Levit

Edithe J. Levit, M.D.
President and Director

EJL:kh
Enclosures

APPENDIX XXV

General Comments Concerning Alternatives and Recommendations

(Pages 74-81 of GAO Draft Report)

The three alternatives as presented seem to propose mutually exclusive strategies for evaluating the education and training received in foreign medical schools. These present problems conceptually in that there is not a clear recognition of the separate and distinct functions and responsibilities of accreditation on the one hand, and the assessment of individual capabilities on the other. The accreditation process is concerned with evaluating the quality of an educational program or institution, but it cannot assure the competence and capabilities of each individual who has participated in a given educational program. An examination system on the other hand is directed toward assessing the knowledge and competence of individuals, and as such, the examination system cannot assure the quality of the educational program itself. Because of the separate and distinct purposes, both procedures are required in order to assure the qualifications and demonstrated competence of physicians to provide health care to the public.

Another distinction that needs to be clarified within this section of the report relates to the separate mechanisms and needs of qualifications for entry into educational programs (whether at the undergraduate or graduate level) as opposed to the qualifications and mechanisms for achieving licensure for independent practice. As with the issue of accreditation and examination noted above, these also appear to be comingled in the discussion of the various alternatives.

As now presented in the report, alternative 1 proposes a mechanism for accreditation of foreign medical schools, but does not propose the mechanism for assessment of individuals either for entry into U.S. educational programs or entry into the practice of medicine via licensure in this country.

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Alternative 2 proposes a uniform examination system that would apply to both U.S. and foreign medical graduates, with appropriate acknowledgement that such an examination in the case of foreign medical graduates could not substitute for the rigorous supervised training which U.S. graduates undergo. However, this alternative does not propose any mechanism for assessing the quality of the educational program of these foreign medical school graduates.

Alternative 3, like alternative 1, proposes a mechanism for accreditation of foreign medical schools but has comingled this responsibility with the responsibility of assessing individual medical school graduates. Also, alternative 3 does not recognize that different mechanisms might be needed for different levels of entry into the U.S. system, e.g., entry into undergraduate clinical training (in this section, confusingly referred to as "additional hospital training"), entry into graduate medical education, or entry into the practice arena via independent licensure.

APPENDIX XXV

# INTERPRETATION OF SCORES
# MEDICAL SCIENCES KNOWLEDGE PROFILE EXAMINATION

Prepared by the National Board of Medical Examiners
in cooperation with the
Association of American Medical Colleges

The Medical Sciences Knowledge Profile (MSKP) is a program of the Association of American Medical Colleges (AAMC) for its member schools. It uses an examination developed specifically for the MSKP program by the National Board of Medical Examiners (NBME). Additional information about the program and a description of the content of the examination is provided in the NBME publication, "Bulletin of Information and Description of the Examination of the Medical Sciences Knowledge Profile - 1980". A copy of that publication was provided to each MSKP applicant prior to the examination and one is included with the Composite Score Roster that is provided to each medical school that requests a roster.

## MSKP - An Advance Placement Examination

The MSKP is intended for use as an advance placement examination. Consistent with this use, the scores provide a profile of the examinee's knowledge in each of eight areas of the test. No overall assessment is provided. There is no total test score or overall average and no pass/fail or cut-off score is set by the AAMC or the NBME.

The Introduction to Clinical Diagnosis subtest was included because this area is in the curriculum prior to the beginning of the third year in United States medical schools. The score on this subtest should be helpful to schools in determining the placement level of students in reference to their knowledge in this area. It should be kept in mind that in this subtest as well as for the entire MSKP examination, it is knowledge that is being tested. The test does not assess the use of skills.

## Stanine Score Profile

An examinee's raw score in each of the eight areas of the test is converted to a stanine (standard nine) type scaled score. This scaling of the eight MSKP scores makes them comparable to each other and provides for easy and meaningful interpretation. The stanine scale places individuals having slightly different raw scores together into a single stanine score. This feature of the scale is desirable for an advanced placement examination like the MSKP where small differences in raw score do not reflect true differences in the amount of knowledge possessed by different examinees and should not be critical in any decisions based in part on test scores.

However, information about the precision with which the current MSKP subtests measure the examinees' knowledge indicates that the odds are at least 2:1 that a difference of one point on the stanine scale represents a true difference in knowledge, and the odds approach 100:1 that a two point difference in stanine scores represents a true difference.

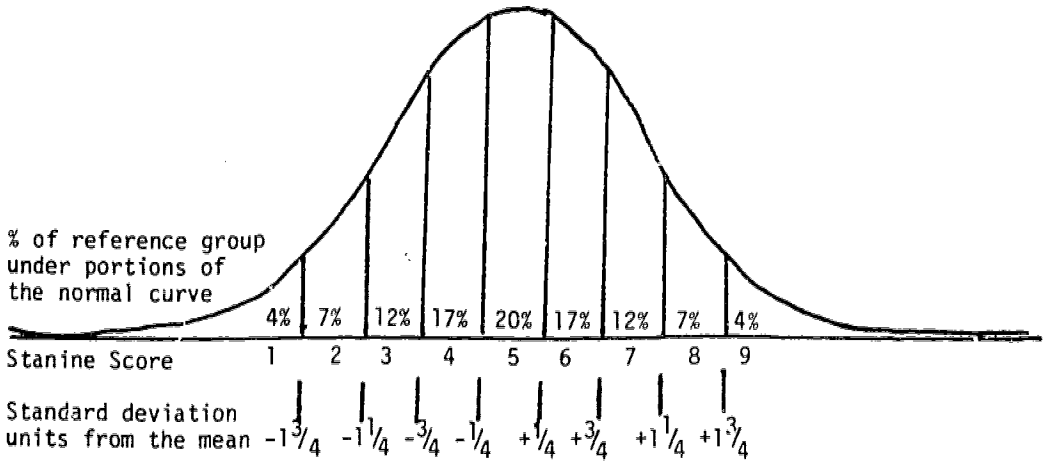
The stanine scores are based on the performance of the MSKP reference group which is made up of all MSKP examinees who reported on their application that they:

(1) are currently enrolled in a medical school; and
(2) are pursuing or have completed courses in anatomy, biochemistry, microbiology, pathology, pharmacology, and physiology.

Stanine scores range from 1 through 9 and the average score for the reference group is 5. Each score level from 2 through 8 represents a band (range) of raw scores that is one-half a standard deviation in width. Thus, a score of 5 includes the average raw score of the reference group and all raw scores from one-fourth standard deviation below to one-fourth standard deviation above the average. All very low or very high scores are scaled to 1 or 9 respectively. Figure A provides the information needed to interpret stanine scores assuming a normal distribution of raw scores for the reference group and breakpoints in the distribution at specified positions. The MSKP reference group does not meet these conditions with total precision (which is usually the case with any distribution) so stanine score norms are also provided for each of the eight subject scores for the MSKP reference group.

Figure A

Interpretation of Stanine Scores




1980 Norm Data: MSKP Reference Group and U.S. Medical Students

The June 1980 MSKP examination was taken by 1,794 persons, 1,296 of whom met the criteria of the reference group as described above. The norm tables allow the comparison of any MSKP score with those of the MSKP reference group (Table A) and with the predicted performance of a sample of students from U.S. medical schools (Table B).

The U.S. student group contains approximately 1,000 second-year students from six U.S. medical schools that administered portions of the MSKP to their second-year classes in a field test which was conducted in the late spring of

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1980. These students also took the National Board Part I examination in June 1980.[1] Because MSKP questions have appeared either in Part I examinations or in the Spring 1980 field test, it is possible to predict the performance of this particular U.S. student group on the current MSKP.

To use either of the tables, locate a score in the Stanine Score column and note the corresponding entries in the two columns for the appropriate subject. For example, assume a score of 6 in Anatomy. To determine how this score compares with those of the MSKP reference group, locate "6" in the score column of Table A and note the entries in the two Anatomy columns. The first figure (18.1) is the percentage of the group that received a score of 6. The 58.0 in the second column is the percentage of the group that obtained scores lower than 6. The same procedure is used for the remaining columns of Table A and for Table B.

Tables A and B also list the average and standard deviation of the stanine scores for the MSKP reference group and U.S. sample respectively. As shown by a comparison of the mean scores, the predicted performance of the U.S. sample on the MSKP examination is higher than the performance of the MSKP reference group. The greatest differences are for behavioral sciences and introduction to clinical diagnosis. A comparison of the standard deviations shows that the spread of stanine scores is smaller for the U.S. sample than for the MSKP group. These findings are further indicated in the norm data of Tables A and B. For the MSKP reference group, 10 to 15 percent score at the 1 and 2 levels and another 10 to 15 percent at the 8 and 9 levels. When the same scaling procedure is applied to the U.S. sample, essentially none of the group scores at the 1 or 2 levels while 20 to 45 percent score at the 8 and 9 levels.

[1]The sample of U.S. medical students is not, and should not be confused with the National Board Part I reference group that was used to standardize the June 1980 Part I Examination. The Part I performance of the U.S. sample indicates that it is reasonably representative of all U.S. medical students taking Part I for the first time.

TABLE A

Percentage of the 1980 MSKP Reference Group
(Approximate N = 1,300) Scoring At or Below Each Stanine Score

| | Anatomy | | Beh. Sci. | | Biochem. | | I.C.D. | | Micro. | | Pathology | | Pharm. | | Physiology | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | At | Below | At | Below | At | Below | At | Below | At | Below | At | Below | At | Below | At | Below |
| 9 | 4.6 | 95.4 | 2.0 | 98.0 | 4.2 | 95.8 | 2.9 | 97.1 | 2.8 | 97.2 | 3.1 | 96.9 | 3.5 | 96.5 | 2.8 | 97.2 |
| 8 | 5.3 | 90.1 | 6.3 | 91.7 | 7.6 | 88.2 | 8.3 | 88.8 | 9.5 | 87.7 | 8.8 | 88.1 | 8.5 | 88.0 | 7.2 | 90.0 |
| 7 | 14.0 | 76.1 | 15.8 | 75.9 | 14.8 | 73.4 | 12.6 | 76.2 | 12.3 | 75.4 | 12.0 | 76.1 | 12.3 | 75.7 | 14.2 | 75.8 |
| 6 | 18.1 | 58.0 | 19.1 | 56.8 | 14.3 | 59.2 | 16.7 | 59.5 | 16.9 | 58.5 | 15.1 | 61.0 | 18.1 | 57.6 | 18.1 | 57.7 |
| 5 | 15.9 | 42.1 | 20.5 | 36.3 | 15.9 | 43.2 | 20.8 | 38.7 | 17.4 | 41.1 | 20.6 | 40.4 | 18.5 | 39.1 | 17.7 | 40.0 |
| 4 | 19.0 | 23.1 | 14.4 | 21.9 | 20.4 | 22.8 | 15.4 | 23.3 | 14.7 | 26.4 | 17.7 | 22.7 | 16.2 | 22.3 | 15.9 | 24.1 |
| 3 | 11.5 | 11.6 | 11.7 | 10.2 | 11.2 | 11.6 | 11.4 | 11.9 | 15.4 | 11.0 | 11.3 | 11.4 | 10.9 | 12.0 | 11.6 | 12.5 |
| 2 | 8.2 | 3.4 | 4.5 | 5.7 | 7.9 | 3.7 | 7.9 | 4.0 | 7.0 | 4.0 | 6.7 | 4.7 | 7.9 | 4.1 | 8.1 | 4.4 |
| 1 | 3.4 | 0.0 | 5.7 | 0.0 | 3.7 | 0.0 | 4.0 | 0.0 | 4.0 | 0.0 | 4.7 | 0.0 | 4.1 | 0.0 | 4.4 | 0.0 |
| Avg. | 5.0 | | 5.0 | | 5.0 | | 5.0 | | 5.0 | | 5.0 | | 5.0 | | 5.0 | |
| S.D. | 2.0 | | 1.9 | | 2.0 | | 2.0 | | 2.0 | | 2.0 | | 2.0 | | 2.0 | |



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TABLE 8

Predicted Percentage of a Sample of Second-Year U.S. Medical Students (Approximate N = 1,000) Scoring At or Below Each Stanine Score Level

| | Anatomy | | Beh. Sci. | | Biochem. | | I.C.D. | | Micro. | | Pathology | | Pharm. | | Physiology | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | At | Below | At | Below | At | Below | At | Below | At | Below | At | Below | At | Below | At | Below |
| 9 | 8.6 | 91.4 | 15.6 | 84.4 | 8.8 | 91.2 | 17.4 | 82.6 | 8.2 | 91.8 | 5.1 | 94.9 | 7.1 | 92.9 | 8.4 | 91.6 |
| 8 | 16.1 | 75.3 | 25.3 | 59.1 | 15.5 | 75.7 | 27.7 | 54.9 | 17.4 | 74.4 | 15.6 | 79.3 | 14.5 | 78.4 | 21.6 | 70.0 |
| 7 | 24.4 | 50.9 | 28.8 | 30.3 | 27.3 | 48.4 | 27.5 | 27.4 | 24.8 | 49.6 | 26.0 | 53.3 | 21.5 | 56.9 | 28.4 | 41.6 |
| 6 | 26.4 | 24.5 | 17.1 | 13.2 | 23.4 | 25.0 | 15.0 | 12.4 | 24.3 | 25.3 | 24.7 | 28.6 | 25.1 | 31.8 | 24.4 | 17.2 |
| 5 | 13.6 | 10.9 | 8.9 | 4.3 | 13.9 | 11.1 | 9.3 | 3.1 | 14.5 | 10.8 | 19.5 | 9.1 | 18.8 | 13.0 | 12.8 | 4.4 |
| 4 | 9.1 | 1.8 | 3.2 | 1.1 | 7.9 | 3.2 | 2.3 | 0.8 | 7.6 | 3.2 | 7.2 | 1.9 | 9.3 | 3.7 | 3.1 | 1.3 |
| 3 | 1.3 | 0.5 | 1.1 | 0.0 | 2.9 | 0.3 | 0.8 | 0.0 | 3.2 | 0.0 | 1.9 | 0.0 | 3.0 | 0.7 | 1.1 | 0.2 |
| 2 | 0.5 | 0.0 | 0.0 | 0.0 | 0.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.7 | 0.0 | 0.2 | 0.0 |
| 1 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Avg. | 6.5 | | 7.1 | | 6.4 | | 7.2 | | 6.5 | | 6.3 | | 6.2 | | 6.8 | |
| S.D. | 1.5 | | 1.5 | | 1.5 | | 1.4 | | 1.5 | | 1.4 | | 1.5 | | 1.3 | |



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Statistical Characteristics of MSKP Scores

Table C includes the matrix of correlation coefficients among the subtest scores and, for each subtest, the number of items, the reliability coefficient, and the standard error of measurement.

Except for the behavioral sciences subtest, the intercorrelations are in the .60's and .70's. The behavioral science correlations are held down a bit by the lower reliability of that subscore. The correlations indicate that there is a strong tendency for examinees to perform at a similar level in all of the subtests but that each subtest contributes some uniqueness of content.

Any test score has some lack of stability and precision. The reliability coefficients (on the diagonal of the correlation matrix of Table C) and the standard errors of measurement are indices of the stability and preciseness of the subject scores. The reliability of the behavioral science score would have been comparable to that of the introduction to clinical diagnosis score if the test had included as many items. The standard error of measurement is particularly useful for interpreting the reliability of the examination. Since the standard error of each MSKP subject score is 1.0 or less, it can be assumed that an examinee's "true" stanine score is within one of the obtained score. An examinee tested numerous times on the MSKP examination with no experience between testings that would be likely to affect his or her score would be expected to score the same as or within one point of the obtained score.

TABLE C

Intercorrelation Coefficients, Reliability Coefficients, Number of Items And Standard Error of Measurement for Subject Scores

1980 MSKP Reference Group

| | Anat. | Beh. Sci. | Biochem. | I.C.D. | Micro. | Path. | Pharm. | Phys. |
|---|---|---|---|---|---|---|---|---|
| Anatomy | .86* | .49 | .77 | .68 | .78 | .76 | .73 | .78 |
| Behavioral Sciences | | .74* | .51 | .57 | .53 | .57 | .52 | .55 |
| Biochemistry | | | .89* | .62 | .79 | .75 | .75 | .81 |
| Intro. Clin. Diag. | | | | .87* | .68 | .76 | .71 | .67 |
| Microbiology | | | | | .89* | .78 | .53 | .79 |
| Pathology | | | | | | .86* | .79 | .76 |
| Pharmacology | | | | | | | .85* | .75 |
| Physiology | | | | | | | | .87* |
| Number of items | 88 | 83 | 91 | 154 | 93 | 90 | 80 | 87 |
| Std. Error of Measurement | 0.7 | 1.0 | 0.7 | 0.7 | 0.7 | 0.7 | 0.8 | 0.7 |

*Coefficient Alpha Reliabilities

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**EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES**

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September 26, 1980

Gregory J. Ahart
Director
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

This is in response to your earlier request for comments regarding the United States General Accounting Office proposed report to the Congress, "Policies Regarding U.S. Citizens Studying Medicine Abroad Are In Need of Careful Review and Reappraisal."

The Educational Commission for Foreign Medical Graduates has reviewed the report but will comment only on certain technical aspects of the sections pertaining to ECFMG examination results, as follows:

The final paragraphs on pages 44 and 153, state, "Over the past five years (1975-79), the pass rate for U.S. citizens ranged from 34 to 48 percent." In this sentence, the "34" should be changed to "39".

In the same paragraph, "NBME estimated that, based on U.S. medical school performance on the NBME Parts I and II examinations, 97 to 98 percent of these students would pass the ECFMG examination if they took it."

I have discussed both sentences with members of the psychometric staff at the National Board of Medical Examiners, and they believe that the second sentence, also, should be changed to read (changes underlined), "The NBME estimated that, based on U.S. medical school performances on the NBME Parts I and II examinations, approximately 95 percent of these students would pass the ECFMG examination if they took it near the end of medical school."

Let me know if you have any questions about these comments.

Sincerely,

Ray L. Casterline, M.D.
Executive Director

RLC:leh

cc: Mr. Robert Wilson