OVERSIGHT—GAO REPORT ON U.S. FOREIGN MEDICAL GRADUATES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

QUALITY OF MEDICAL EDUCATION RECEIVED BY U.S. CITIZENS STUDYING ABROAD

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OVERSIGHT—GAO REPORT ON U.S. FOREIGN MEDICAL GRADUATES

FRIDAY, NOVEMBER 21, 1980

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 1:30 p.m. in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman, chairman, presiding.

Mr. WAXMAN. The committee will come to order.

This morning the subcommittee will receive testimony on a report, prepared by the U.S. General Accounting Office (GAO), on the quality of medical education received by U.S. citizens studying abroad. The study is the first of its kind and was originally requested by the subcommittee's ranking minority member, Dr. Tim Lee Carter.

It is well known that competition for admission to American medical schools is fierce. The United States is second to none in the quality and rigor of its medical education. However, it is also well known that many highly intelligent and socially motivated individuals are denied admission to U.S. schools and choose to leave the country to pursue an education in the healing arts.

While I have great personal sympathy for the thousands of American students studying abroad, maintaining the highest standard of medical care in this country is a critical public health priority. No individual, regardless how motivated, should be licensed to practice medicine absent a clear demonstration that they possess the necessary intellectual and practical skills essential to the practice of medicine. The practice of medicine is not a right but a privilege.

The GAO's report presents several troubling observations concerning a new breed of foreign medical school often operating for the sole purpose of attracting U.S. students. The GAO's recent investigation of six foreign schools seriously questions the scope and overall quality of this educational experience as preparation for graduate study or practice in the United States.

In addition, the report questions the adequacy of State licensing programs to detect graduates of foreign medical schools who may not—due to deficiencies in education and training—be qualified to practice medicine in this country.

In addition to the GAO, our witnesses this morning represent a wide range of scientific and professional organizations reponsible for the education and licensing of physicians. I look forward to

hearing their comments concerning this report and gaining the benefit of their views on this important issue.

Before we ask the witnesses from GAO to come forward to present their testimony, I would like to recognize Dr. Tim Lee Carter, the ranking member of the subcommittee, who was the initiator of this study.

Mr. CARTER. Thank you, Mr. Chairman.

I am very pleased to join you in holding this hearing concerning the quality of medical education in certain foreign medical schools, and the health policy questions which arise with the return of U.S. citizens who have received their medical training abroad.

As you know, the basis for this hearing is the GAO report which is being released today and which was requested by Chairman Staggers and myself last year.

We were interested in this issue for several reasons.

First, we had been aware of increasing numbers of U.S. students going abroad to study medicine, coupled with a recent proliferation of medical schools established in the Caribbean.

Second, concern had been expressed by various representative of the medical education and health care fields about the quality of education received by U.S. students attending many foreign schools.

Finally, because the Federal Government was supporting the education of U.S. students attending foreign schools through various loan programs administered by the Department of Education and the Veterans' Administration, we felt it was appropriate to request a thorough investigation of the quality of education at certain representative foreign schools.

I would like to emphasize, as does the GAO report, that there are indeed many first-rate medical schools in foreign countries which produce excellent physicians. Also many distinguished scholars from medical schools around the world come to this country as teachers and practitioners. Moreover, even though a medical school's education capabilities may be limited, some students will do well because of their ability and willingness to study and learn.

However, I believe that this report's findings provides the basis for serious concern about the quality of education received by U.S. students at the six schools GAO visited, particularly since GAO estimates that approximately half of all U.S. students studying medicine abroad are enrolled in these six schools.

Moreover, because most of these students plan to return to the United States to practice medicine, I feel there is a legitimate public policy concern to assure that these individuals demonstrate skills and knowledge comparable to U.S.-trained physicians before they enter the mainstream of American medicine.

The GAO report suggests several alternative to consider in accomplishing this objective. My own view at this point is that the second alternative, namely, the development of an appropriate testing mechanism, is the most viable approach. I would expect the medical profession and State licensing representatives along with other concerned groups to work together to address this situation. In my view, these organizations are best equipped to develop and carry out the necessary actions.

In closing, I want to commend the GAO staff for their excellent work on this project. In particular I want to mention Mr. Ahart, Dr. Murray Grant, Mr. Steve Schwartz, and Mr. Bob Wilson. With this undertaking, you have helped focus attention on a very important area of health policy.

I look forward to hearing the reactions and suggestions of our distinguished witness after GAO presents the report.

Mr. WAXMAN. Thank you, Dr. Carter.

Our first witnesses are from the General Accounting Office. They are Mr. Gregory Ahart, Director of the Human Resources Division. He is accompanied by Mr. Stephen Schwartz, Mr. Robert Wilson, and Dr. Murray Grant, who actually performed most of the work on the study.

I would like to join Dr. Carter in expressing my appreciation for the amount of work that went into this study over the past year. I am sure it will be useful to this committee and to all the other groups interested in this area.

Mr. Ahart, we have your prepared statement, which we will make part of the record. Please summarize some of your major findings so we will have the opportunity for questions. [See p. 10.]

STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY MURRAY GRANT, M.D., CHIEF MEDICAL ADVISER; STEPHEN SCHWARTZ, EVALUATOR; AND ROBERT WILSON, EVALUATOR

Mr. AHART. I certainly will. Dr. Grant is on my right. To my immediate left is Mr. Stephen Schwartz and Mr. Bob Wilson.

We are pleased to be here to discuss the results of the review requested by this committee of U.S. students attending foreign medical schools. As you mentioned, our final report was released today. I would mention that unfortunately we have very limited numbers of copies available. We will have more next week for those who might wish copies.

As you mentioned, questions have been raised about the quality of medical education in those foreign medical schools most willing to accept U.S. citizens, and the adequacy and appropriateness of that educational experience as preparation for practicing medicine in the United States.

As part of our work, between July and November 1979, we visited six foreign medical schools—three in the Caribbean, one in Mexico, and two in Europe, which had about 5,400 U.S. citizens studying medicine—about half of the total number we estimate were studying medicine abroad. During our visits, we met with school administrators and faculty to obtain 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 three Caribbean schools had a combined enrollment of about 4,100 medical school students, of whom about 3,100 were U.S. citizens. These schools did not exist 10 years ago, and two of them were established in the past 4 years. The Universidad Autonoma De Guadalajara was founded in 1935 and had about 7,500 medical school students, of whom about 2,100 were U.S. citizens. The Euro-

pean schools we visited had existed for hundreds of years and had relatively few U.S. citizens.

During our visits to these foreign medical schools, we learned that many U.S. citizen foreign medical school 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 get a better understanding of this training, 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 State medical licensing boards in these States to determine whether they were aware of these clinical training programs. Additionally, we discussed with New Jersey officials similar clinical training programs for foreign-trained U.S. citizens conducted in their State.

Throughout our work, our audit staff was assisted by Dr. Murray Grant, our chief medical adviser. Dr. Grant accompanied the staff on visits to the foreign medical schools, host country health and education organizations, U.S. hospitals, State licensing boards, and U.S. medical organizations.

The Liaison Committee on Medical Education is responsible for evaluating and accrediting United States and Canadian medical schools, including their clinical training programs. Because Canadian medical schools are evaluated and accredited by the Liaison Committee and the Association of Canadian Medical Colleges, they are not viewed as foreign medical schools for the purposes of our review. However, since the Liaison Committee does not have this responsibility for medical schools located in foreign countries other than Canada, it did not evaluate or accredit any of the schools we visited or the clinical training programs provided in U.S. hospitals for U.S. citizens attending foreign medical schools.

Before discussing what we found during our study, I want to highlight several items that we should keep in mind as we proceed. First, there are many first-rate medical schools in other countries that produce excellent physicians. Second, many distinguished scholars from medical schools around the world are welcomed to this country as teachers and practitioners and do make a valuable contribution. And third, 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.

I want to reemphasize that we visited only six foreign medical schools that were selected primarily because large numbers of U.S. citizens either had studied or were studying there. Because it was generally believed that the goal of U.S. citizens attending foreign medical schools was to return to this country 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.

The foreign medical schools we visited differed considerably, and the merits or problems of each must be viewed separately. However, in our opinion, none of these foreign medical schools 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 generalize about the adequacy of the foreign medical schools in all of these areas, a serious shortcoming at each foreign medical school was the lack of adequate clinical training facilities. In no instances did the foreign schools have access to the same range of clinical facilities and numbers and mix of patients as a U.S. medical school.

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

As I mentioned earlier, the Liaison Committee on Medical Education accredits U.S. medical schools, including their clinical training programs which are conducted in hospitals approved for teaching purposes. However, no such organization is responsible for overseeing all undergraduate clinical training which U.S. citizen foreign medical school students receive in U.S. hospitals.

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 their State.

U.S. citizens we talked to who were studying at foreign medical schools said their goal was to return to the United States and practice medicine. Four routes are available to them:

One, transfer with advanced undergraduate standing to U.S. medical schools;

Two, participate in the fifth pathway program—1 year of clinical training in the United States under the supervision of a U.S. medical school;

Three, enter graduate medical education in the United States; and

Four, obtain a license to practice medicine from a jurisdiction authorized to license physicians.

Those 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 since it is also required for licensure in most States.

To enter graduate medical education, U.S. citizen foreign medical school graduates must pass the Educational Commission for Foreign Medical Graduates examination. 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—that is, as a test of the readiness for graduate medical education and 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 the visa qualifying examination. 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 even though they may have attended the same foreign medical school.

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 United States 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 a candidate for licensure has an adequate medical education and is eligible to take the State licensing examination.

During our study we learned that the National Board of Medical Examiners was working on a new medical examination—the comprehensive qualifying examination. This examination 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 which involves developing two examinations, referred to as FLEX I and FLEX II.

FLEX I would be administered to all United States and foreign medical school graduates before they begin graduate medical education. Since the National Board of Medical Examiners is presently developing a similar examination, known as the comprehensive qualifying examination, the federation would adopt this as its FLEX I.

FLEX II would be a clinically oriented examination designed to measure the fitness of an individual 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.

It is anticipated that the federation would 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, its timing would be at the discretion of the individual State licensing boards.

I would like to turn now to the kind of Federal assistance the Government gives to students studying 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. Together, these agencies are providing financial assistance to several thousand U.S. citizens studying medicine abroad, including hundreds enrolled at four of the six foreign medical schools we visited.

Before U.S. citizens can receive guaranteed student loans, the Department of Education is required by law to make a determination that the education and training provided by the foreign medical school is comparable to that available at a U.S. medical school. The Administrator of Veterans' Affairs may deny or discontinue

educational benefits if such enrollment is determined not to be in the individual's or the Government's best interest.

We have several observations concerning the Department of Education and Veterans' Administration policies and procedures for approving foreign medical schools and the management of their programs.

The Department of Education and the Veterans' Administration determined that foreign medical schools were comparable to U.S. medical schools almost exclusively on the basis of 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.

Mr. Chairman, based on our work, we believe that the recent proliferation of foreign medical schools established to attract U.S. citizens who are unable to gain admission to medical schools in this country is cause for concern.

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 what steps can be taken to better assure that students who attend 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 for either graduate medical education or medical practice.

We believe a number of alternatives exist for evaluating the education and training received in foreign medical schools.

Alternative 1: Worldwide accreditation of medical schools;

Alternative 2: Establish a better examination to test students before permitting them to enter graduate medical education or receive medical licensure in the United States; and

Alternative 3: Establish an accrediting body, either by the private sector or by the Department of Health and Human Services, responsible for determining whether students who attend foreign medical schools are properly prepared to receive graduate medical education or licensure in the United States.

We believe that the Congress should 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 insure 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.

The alternatives we have presented, as well as those proposed by others, should be considered. We also believe that the Secretary should work with the same groups to address the current practice

whereby students from foreign medical schools receive part or all of their undergraduate clinical training in U.S. hospitals.

We further believe that the Secretary of Education should issue regulations establishing procedures and criteria for implementing the legislative requirement that the department insure 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. This is required by law but has not been done.

The Administrator of Veterans' Affairs should 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.

Finally, we believe that the Secretary of Education should insure that the Government's interest in outstanding guaranteed student loans at foreign medical schools is adequately protected by properly identifying the status of all U.S. citizens with outstanding loans and initiating repayment were appropriate.

Summaries of our observations on their medical education and training programs were sent to each of the six foreign medical schools we visited. All schools responded, and their comments have been incorporated as appropriate and recognized in appendices II through VII of the report. The University of Central del Este was the only school that disagreed with what we had observed at the time of our visit.

The Department of Health and Human Services, the Federation of State Medical Boards, the Association of American Medical Colleges, and the American Hospital Association generally agreed with our findings, conclusions, and recommendations regarding the need to insure 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 our 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 estabishing 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.

We do not agree that adequate safeguards exist. Also, the Department of Health and Human Services, the Federation of State Medical Boards, and other members of the medical profession reached different conclusions than the association on this issue. Moreover, we did not recommend that the Federal Government assume responsibility for program accreditation or licensure.

Our report recognizes that this responsibility rests with State licensing bodies and the medical profession. At the same time, however, we believe the Department of Health and Human Services 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 insure 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 on our draft report.

The Department of Education agreed with our findings and recommendation regarding the need to issue regulations for assessing comparability to determine eligibility for the guaranteed student loan program. However, the Department 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. The Department of Education agreed with our recommendation to protect the Government's interest in outstanding guaranteed student loans for U.S. citizens studying medicine abroad.

The Veterans' Administration said it has no objection to our 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. It stated, however, that its legislation and attendant regulations would have to be considered when evaluating the adequacy of any new Department of Education standards.

Department of State officials had no disagreement with our draft report.

Mr. Chairman, this concludes my statement. We will be happy to answer any questions that you or other members of the subcommittee might have.

[Testimony resumes on p. 34.]

[Mr. Ahart's prepared statement follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

STATEMENT OF

GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION

BEFORE THE

HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

ON

U.S. CITIZENS ATTENDING FOREIGN MEDICAL SCHOOLS

Mr. Chairman and Members of the Subcommittee:

We are pleased to appear here today to discuss the results of our congressionally requested study of U.S. citizens attending foreign medical schools.

BACKGROUND

There has been a great deal of concern 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 foreign medical schools most willing to accept U.S. citizens, and the adequacy and appropriateness of that educational experience as preparation for practicing medicine in the United States.

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 returning to the United States to ultimately practice medicine--even though some estimate there will be a surplus of physicians in this country by 1990. The exact number of U.S. citizens studying medicine abroad is not known. However, we estimate that the number approximates 10-11,000.

WHAT WE DID

As part of our work, we held discussions with officials at the headquarters offices of the Department of Health and Human Services, the Department of Education, the Department of State, and the Veterans Administration. We also met with

representatives of the various organizations responsible for the education, testing, and licensure of physicians in the United States.

Between July and November 1979 we 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 were studying medicine abroad. During our visits, we met with school administrators and faculty to obtain 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 and their locations follow:

Caribbean:

Universidad Central del Este--located in San Pedro de Macoris, Dominican Republic.

Universidad Nordestana--located in San Francisco de Macoris, Dominican Republic.

St. George's University School of Medicine--located in Grenada, West Indies.

Mexico:

Universidad Autonoma De Guadalajara--located in Guadalajara, Mexico.

Europe:

Universita Degli Studi Di Bologna--located in Bologna, Italy.

Universite de Bordeaux, II--located in Bordeaux, France.

The three Caribbean schools had a combined enrollment of about 4,100 medical school students, of whom about 3,100 were U.S. citizens. These schools did not exist 10 years ago, and two of them were established in the past 4 years. The Universidad Autonoma De Guadalajara was founded in 1935 and had about 7,500 medical school students, of whom about 2,100 were U.S. citizens. The European schools we visited had existed for hundreds of years and had relatively few U.S. citizens.

During our visits to these foreign medical schools, we learned that many U.S. citizen foreign medical school 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 get a better understanding of this training, 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 State medical licensing boards in these States to determine whether they were aware of these clinical training programs. Additionally, we discussed with New Jersey officials similar clinical training programs for foreign-trained U.S. citizens conducted in their State.

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Throughout our work, our audit staff was assisted by Dr. Murray Grant, our Chief Medical Advisor. Dr. Grant accompanied the staff on visits to the foreign medical schools, host country health and education organizations, U.S. hospitals, State licensing boards, and U.S. medical organizations.

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. Subsequently, the school moved to the Caribbean island of Montserrat.

The Liaison Committee on Medical Education is responsible for evaluating and accrediting U.S. and Canadian medical schools, including their clinical training programs. Because Canadian medical schools are evaluated and accredited by the Liaison Committee and the Association of Canadian Medical Colleges, they are not viewed as "foreign" medical schools for the purposes of our review. However, since the Liaison Committee does not have this responsibility for medical schools located in foreign countries other than Canada, it did not evaluate or accredit any of the schools we visited or the clinical training programs provided in U.S. hospitals for U.S. citizens attending foreign medical schools.

Before discussing what we found during our study, I want to highlight several items that we should keep in mind as we proceed. First, there are many first rate medical schools in other countries that produce excellent physicians. Second, many distinguished scholars from medical schools around the world are welcomed to this country as teachers and practitioners and make a valuable contribution. And third, 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.

I want to reemphasize that we visited only six foreign medical schools that were selected primarily because large numbers of U.S. citizens either had studied or were studying there. Because it was generally believed that the goal of U.S. citizens attending foreign medical schools was to return to this country 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.

WHAT WE FOUND

The foreign medical schools we visited differed considerably, and the merits or problems of each must be viewed separately. However, in our opinion, none of these foreign medical schools 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 generalize about the adequacy of the foreign medical schools in all of these areas, a serious shortcoming at each foreign medical school was the lack of adequate clinical training facilities. In no instances did the foreign schools have access to the same range of clinical facilities and numbers and mix of patients as a U.S. medical school.

A report 1/ provided to the Congress on May 13, 1980, by the Secretary of Health and Human Services identified similar deficiencies in the education of U.S. citizens who attended foreign medical schools and later transferred to U.S. medical schools.

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 under arrangements made by either the foreign medical school or the student. However, the type, length, and extent of training received at most U.S. hospitals that we visited participating in these arrangements varied greatly and generally was not comparable to that provided to U.S. medical school students.

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

Moreover, most of the hospitals that we visited were not affiliated with U.S. medical schools and had little assurance that U.S. citizens from foreign medical schools were adequately and properly prepared for clinical training.

As I mentioned earlier, the Liaison Committee on Medical Education accredits U.S. medical schools--including their clinical training programs which are conducted in hospitals approved for teaching purposes. However, no such organization is responsible for overseeing all undergraduate clinical training which U.S. citizen foreign medical school students receive in U.S. hospitals.

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 their State.

Alternative Routes for Entering the American Medical System

U.S. citizens we talked to who were studying at foreign medical schools said their goal was to return to the United States and practice medicine. Four routes are available:

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

--Participate in the Fifth Pathway Program (1 year of clinical training in the United States under the supervision of a U.S. medical school).

--Enter graduate medical education in the United States.

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

Those 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 since it is also required for licensure in most States. The American Medical Association's Center for Health Services Research reports that about 2,300 U.S. citizen foreign medical school graduates were in U.S. graduate medical education training programs in 1979.

To enter graduate medical education, U.S. citizen foreign medical school graduates must pass the Educational Commission for Foreign Medical Graduates examination. 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--that is, as a test of the readiness for graduate medical education and 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 the Visa Qualifying Examination. 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 even though they may have attended the same foreign medical school.

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 jursidictions 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 a candidate for licensure has an adequate medical education and 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. 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.

Emerging Developments

During our study, we learned that the National Board of Medical Examiners was working on a new medical examination--the Comprehensive Qualifying Examination. This examination could affect the routes by which graduates of foreign medical schools enter the U.S. medical system.

In 1973, the Committee on Goals and Priorities of the National Board 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 medical 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 the public of the physician's competence to provide such services resides with the States. 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 Liaison Committee on Medical Education's accreditation process which assures quality medical education in U.S. medical schools.

Additionally, the Federation of State Medical Boards is considering a new concept to achieve a uniform assessment procedure for licensure which involves developing two examinations, referred to as 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 the National Board of Medical Examiners is presently developing a similar examination, known as the Comprehensive Qualifying Examination, the Federation would adopt this as its FLEX I.

FLEX II would be a clinically oriented examination designed to measure the fitness of an individual to practice medicine independently. FLEX II would be offered to all medical school graduates, U.S.- and foreign-trained. A passing score would be required to obtain a license to practice medicine. It is anticipated that the Federation would 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, its timing would be at the discretion of the individual State licensing boards.

Federal Financial Assistance for 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. Together, these agencies are providing financial assistance to several thousand U.S. citizens studying medicine abroad, including hundreds enrolled at four of the six foreign medical schools we visited.

Before U.S. citizens can receive guaranteed student loans, the Department of Education is required by law to make a determination that the education and training provided by the foreign medical school is comparable to that available at a U.S. medical school. The Administrator of Veterans Affairs may deny or discontinue educational benefits if such enrollment is determined not to be in the individual's or the Government's best interest.

We have several observations concerning the Department of Education and Veterans Administration policies and procedures for approving foreign medical schools and the management of their programs.

--The Department of Education and the Veterans Administration determined that foreign medical

schools were comparable to U.S. medical schools almost exclusively on the basis of 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.

--Nevertheless, regulations establishing procedures and criteria for making comparability determinations have not been published by either agency even though the programs were enacted years ago. The Department of Education, however, issued proposed rules in April 1979 but has not finalized them.

Over the past 10 years, the Department of Education's records show that it guaranteed about 21,500 loans for over $45 million, and the Veterans Administration disbursed $5.6 million to 997 veterans, their spouses, and their dependents to attend foreign medical schools. Based upon Department of Education records, we estimate that the interest subsidies, defaults, and other expenses of the guaranteed loans have cost the Federal Government about $12.4 million during this period. However, we were unable to determine precisely the program's cost because the Department's accounting system does not provide accurate and complete information on the number or amount of guaranteed student loans and defaults.

ACTION NEEDED

Mr. Chairman, based on our work, we believe that the recent proliferation of foreign medical schools established to attract U.S. citizens who are unable to gain admission to medical schools in this country is cause for concern.

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 what steps can be taken to better assure that students who attend 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 for either graduate medical education or medical practice.

We also believe that 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.

We believe a number of alternatives exist for evaluating the education and training received in foreign medical schools.

Alternative 1

The Liaison Committee on Medical Education or some other body established for this purpose could be given responsibility for visiting foreign medical schools, with the foreign 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 medical 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 medical 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.

--There would be national and international political implications, pressures, and possible legal actions which 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 to obtain graduate medical education or licensure in the United States.

When previously asked, the Liaison Committee on Medical Education 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 examinations were developed, it could be many years before they 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 the Department of Health and Human Services, 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 which 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 attended 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. After the period of additional hospital training specified by the accrediting body, the hospital program director would certify to the accrediting body whether the applicant 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 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 training 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.

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We believe that the Congress should 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. The alternatives we have presented as well as those proposed by others should be considered. We also believe that the Secretary should work with the same groups to address the current practice whereby students from foreign medical schools receive part or all of their undergraduate clinical training in U.S. hospitals.

We further believe that the Secretary of Education should issue regulations establishing procedures and criteria for implementing the legislative requirement that the Department 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. The

Administrator of Veterans Affairs should 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.

Finally, we believe that the Secretary of Education should ensure that the Government's interest in outstanding guaranteed student loans at foreign medical schools is adequately protected by properly identifying the status of all U.S. citizens with outstanding loans and initiating repayment were appropriate.

Comments of Schools, Federal Agencies, and Others

Summaries of our observations on their medical education and training programs were sent to each of the six foreign medical schools we visited. All schools responded, and their comments have been incorporated as appropriate and recognized in appendixes II through VII of the report. The University of Central del Este was the only school that disagreed with what we had observed at the time of our visit.

The Department of Health and Human Services, the Federation of State Medical Boards, the Association of American Medical Colleges, and the American Hospital Association generally agreed with our findings, conclusions, and recommendations 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 our 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.

We do not agree that adequate safeguards exist. Also, the Department of Health and Human Services, the Federation of State Medical Boards, and other members of the medical profession reached different conclusions than the Association on this issue. Moreover, we did not recommend that the Federal Government assume responsibility for program accreditation or licensure. Our report recognizes that this responsibility rests with State licensing bodies and the medical profession. At the same time, however, we believe the Department of Health and Human Services 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 on our draft report.

The Department of Education agreed with our findings and recommendation regarding the need to issue regulations for assessing comparability to determine eligibility for the Guaranteed Student Loan Program. However, the Department 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. The Department of Education agreed with our recommendation to protect the Government's interest in outstanding guaranteed student loans for U.S. citizens studying medicine abroad.

The Veterans Administration said it has no objection to our 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. It stated, however, that its legislation and attendant regulations would have to be considered when evaluating the adequacy of any new Department of Education standards.

Department of State officials had no disagreement with our draft report.

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Mr. Chairman, this concludes my statement. We will be happy to answer any questions that you or other members of the Subcommittee might have.

Mr. WAXMAN. I thank you very much for your summary of the report. Let me ask a few questions of you and your colleagues.

The basic conclusion of your study is that these schools do not provide education comparable to that of U.S. medical schools. What, in your judgment, is the most serious weakness? Is it the faculty and/or the clinical training facilities?

Mr. AHART. I think the most common shortcoming is the lack of adequate clinical training facilities.

I would like Dr. Grant to respond in more detail to other shortcomings.

Dr. GRANT. Mr. Chairman, I think Mr. Ahart has stated accurately, as we see it, that the most serious shortcomings we noted in the six schools related to their lack of clinical training facilities.

Just to give an example, the average medical school in the U.S. has a total student body of some 500 and has available to it some 3,100 hospital beds for training purposes. If you use the figure of 6 to 1, which that represents, Universita Degli Studi Di Bologna, which has 13,000 medical students, would need some 78,000 beds. In fact, they have 2,300.

This is the kind of situation that we found in most of the schools that we visited: that the number of students, as compared to their available clinical training facilities, did not match.

There were some deficiencies in the basic science program, limited equipment and supplies, but the biggest problem we found related to lack of clinical training facilities.

Mr. WAXMAN. Many of these schools are new, having opened in the past 5 years. In your judgment, were they established principally to recruit U.S. students?

Dr. GRANT. We believe that some of the schools we visited were clearly established in order to cater to U.S. students who were not able to gain admission to U.S. medical schools. That is not true of all the schools we visited. Some schools had been established for many, many years.

Mr. WAXMAN. How can we assure that only qualified physicians practice in the United States?

Dr. GRANT. We feel that the most significant step that needs to be taken is that which was expressed in Mr. Ahart's statement. We feel that for those U.S. students that travel abroad to study medicine, it would be reasonable to expect that their medical knowledge and skills should be demonstrated to be reasonably equivalent to those of their U.S.-trained counterparts before they enter into the U.S. health care delivery system. We feel that is most important.

Mr. WAXMAN. Do you think the student has the ability to catch up and supplement that education?

Dr. GRANT. I think in many instances there is. As a matter of fact, the evidence is clear that many of the students who went through the cotrans system, by which I mean those students who gained admission to U.S. medical schools after they had spent 2 years or more in foreign schools, after going through the training in U.S. medical schools, were able to catch up.

But we are not talking about all students. We are talking about those that were able to gain admission to advanced study, and that represents a very small proportion.

The answer, I think, to your question is yes, in some instances they could, but we have no way of knowing for certain whether that is true of the majority of the students who travel abroad to study.

Mr. WAXMAN. Of course, the concern would be the fairness to those students who so desperately want to become doctors that they are willing to study in a foreign school even under a foreign language and want to apply themselves to whatever discipline will be necessary for them to achieve this professional status. If we were to have a testing program for the foreign medical school students, would we in effect, be saying to them they really won't have an opportunity to become physicians in this country?

Dr. GRANT. I don't think so, Mr. Chairman. I think we share your view of the desirability of providing opportunities to those students. But I think we have to consider two aspects of the problem. One is that, as you said, many of them are highly motivated, and many would make excellent physicians. But, on the other hand, we have to also ensure that the health of the American public is appropriately safeguarded by ensuring individuals so trained are properly qualified to cater to the health needs of the American public.

Mr. WAXMAN. In your report you focus on the Department of Education and VA student assistance programs as the principal Federal programs relating to these students. You are fairly critical of the administration of these programs. Is that correct? If it is, what steps do you think should be taken to improve the situation?

Mr. AHART. First of all, we spell out in the report we feel that the Department of Education has to take a harder look at the carrying out of its responsibilities for only approving guaranteed student loans for studying at institutions that do provide education comparable to that which can be received in the United States. Thus far, they rely largely upon a listing of these medical schools listed in the World Health Organization publication and the listing does not signify endorsement but only that that school has been recognized by the government of the country in which it is located as being a medical school.

That doesn't provide very much assurance as to the quality of that medical education.

There were proposed regulations issued at one time. They were withdrawn. They have not been issued so that right now for those students studying abroad there is basically only that one credential: their listing.

We feel that is very important.

In addition, not only in foreign medical schools—although the problem is exacerbated there—but in some other schools as well, the Department of Education has not done a good job of keeping track of the status of students to make sure assistance going to students in good standing and pursuing an education.

The Veterans' Administration was a little different in that the Administrator is given the authority to deny or discontinue benefits where he reaches a judgment that the program is not in the best interest of either the student or the United States.

I think, in essence, it amounts to the same kind of determination that it is a quality education that is being supported with the

Federal dollar, and we have suggested that once a determination is made by the Department of Education, the Administrator of Veterans Affairs take judicial notice of that.

It is important. About $45 million has been guaranteed over 10 years through the Office of Education, and over $5 million in veterans' benefits have been paid to support the study of medicine abroad through the Veterans' Administration programs.

Mr. WAXMAN. You discuss the three options and seem to favor the third option, which would establish a new private sector accrediting body to administer a variety of programs to insure that all U.S. students, who attend foreign medical schools, are adequately prepared to practice in the United States.

Who would sponsor such a body? How could it be established? Where would the funds come from, and what role is there for the Federal Government in all of this?

Mr. AHART. I am not sure we have terribly good answers to all those questions. I think this is an area in which we feel with the Department of Health and Human Services facilitating or playing a catalytic role, these kinds of questions need to be discussed among the parties of interest in the private sector and in the State sector.

Certainly the State boards, the State jurisdictions who grant licensure, need to have a part in that, and be contributors to it.

The medical profession, itself, has a role and interest in this whole arena. The Federal Government has some interest. Just what the funding mechanism would be, I am not sure.

You stated that we tend to favor the third one. I would like to qualify that a little bit. I think that we view the third one as being the most comprehensive one. It is one that gets more directly at looking at the individual in terms of his experience or education, his own qualifications, using examinations, evaluation of experience and education altogether. So it is the most direct.

It does have problems with it. To some degree, parts of the others would be antecedents to it in the sense that in your evaluating an individual's education you would have to know something about the curriculum, facilities, and so on.

You would also have to have the results of the examinations in many cases, particularly for persons wanting to enter practice who had just finished their undergraduate training and could not have a record of experience. Even though it is the most direct and comprehensive, we don't find it as an exclusive type of thing. I think these three are not mutually exclusive either among themselves or with other proposals that might come forward.

Mr. WAXMAN. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I notice one of the schools visited was St. George's University of Medicine in Grenada. Is that correct?

Mr. AHART. That is correct.

Mr. CARTER. Who is the chancellor of this medical school?

Mr. AHART. Let me refer you to Dr. Grant.

Dr. GRANT. Mr. Charles Modica is the name of the chancellor of that school.

Mr. CARTER. Mister?

Dr. GRANT. Yes. I do not think he is a physician.

Mr. CARTER. He has had a little medical training, I understand.

Dr. GRANT. I do not believe so. Unless you are talking about very early on, I don't believe he has had.

Mr. CARTER. He had 1 year, I believe, in Calcutta.

Dr. GRANT. I think that is correct.

Mr. CARTER. I noticed that this school, in particular, didn't have any clinical material to work with. Usually in the latter part of the second year medical students begin some of their clinical work and continue it throughout the final 2 years. What sort of clinical material do they have in St. George's? Do they have an abundance of people with pathology so that students can recognize diseases?

Dr. GRANT. They have two things: In Grenada, not too far from where the medical school is located, there is a hospital which has about 300 beds, a tropical kind of hospital to which some of the students go for some work involving the history, and physicals, and physical diagnosis. Very few, however, actually visit this hospital.

There is a second facility in the neighboring island of St. Vincent, Kingston General Hospital, which is a 200- to 300-bed hospital similar to that which I have listed in St. George's, which is also used by the students in one semester to prepare them for the clinical training that will generally be carried out in hospitals in the United States.

That is the extent of the clinical training they have.

Mr. CARTER. I believe they have, or had, arrangements for "externships" in the United States. Is that correct?

Dr. GRANT. Yes, sir.

Mr. CARTER. In the United States the so-called extern student usually wants to earn extra money; and after a little teaching, uses cadavers and such things as that; is that not correct?

Dr. GRANT. I think generally the externships practiced in the U.S. facilities provide that students will actively participate in the workup and treatment planned for the patient.

Mr. CARTER. I don't believe they do very much. The interns do most of the basic work.

Dr. GRANT. That is certainly true.

Mr. CARTER. Let us go further. I believe these externs come to the United States for one semester's training. What do they pay?

Dr. GRANT. The extern doesn't pay anything to the hospital. He continues to pay his tuition to the medical school in Grenada. That amounts to about $5,000 a year.

Mr. CARTER. I have an article here that states students are charged $11,000 per semester for the externship.

Dr. GRANT. St. George's Medical School pays the hospitals for the externship program $1,000 per semester.

Mr. CARTER. There must be a misprint. According to this article in the American Medical News, the student has to; pay $11,000 for the externship.

Dr. GRANT. That must be a misprint.

Mr. CARTER. That is quite a sum of money. What is the usual tuition charged by schools such as Chancellor Modica's?

Dr. GRANT. Approximately $5,000 a year in tuition.

Mr. CARTER. If the school gets $11,000 for each year's externship—what would be the total costs, would you think?

Dr. GRANT. If that $11,000 were an accurate figure, of course the cost would be very large. Of course, I do not believe it is accurate.

Mr. CARTER. What about the quality of laboratory facilities and in particular, the anatomy labs in the different medical schools you visited?

Dr. GRANT. In some of the medical schools they had no cadavers at all. Some of them had some cadavers. Some of them had what we would consider to be an adequate number. One of them had cadavers which would be, in my judgment, rather difficult to work on because it was very difficult to identify the nerves and arteries, et cetera, because they were in a condition which made it very difficult to look at these materials.

Mr. CARTER. As I recall the cadavers that are used in medical schools, the arteries were usually projected with particular kinds of dye so you could recognize them. Did you find this at the schools you visited?

Dr. GRANT. In some of the schools we did, and in the one I am referring to, you could not tell.

Mr. CARTER. What was the level of training of the teachers in these schools, particularly those in the Caribbean?

Dr. GRANT. By and large, Dr. Carter, we found that the qualifications of the faculty were quite good. There were some exceptions, but, by and large, we would have to say their qualifications were reasonably good.

Mr. CARTER. I notice in the article St. George's School the professors seemed to have adequate educational backgrounds, yet they were not holding onto their jobs in the States because of age; is that correct?

Dr. GRANT. There were some who were on the faculty who were fairly advanced in years. There were others, however, who were not.

Mr. CARTER. And they did have adequate background so far as you could tell?

Dr. GRANT. At St. George's this was one of the schools in which we did not have access to the faculty vitae. So it is very difficult to judge, Dr. Carter, except from personal discussion with some of the faculty.

Mr. CARTER. Checking a list of three professors mentioned in this article about St. George's, I find one who is 70, one 72 and one 74. They might do extremely well. We have Supreme Court Justices who do a good job at 85, supposedly.

How about the quality of our facilities? You say as a usual thing the anatomy labs were inadequate.

Dr. GRANT. In some of the facilities.

Mr. CARTER. What part of them? What percentage?

Dr. GRANT. I would say about 50 percent of the ones we viewed were reasonably adequate, and the other 50 were not.

Mr. CARTER. Did the 50 percent that were adequate compare favorably with those in the United States?

Dr. GRANT. Reasonably so, except for one facet, the numbers of students in some of these medical schools were such that it would be very difficult to provide what U.S. medical schools do; namely, four to five students per cadaver. It would be unusual for the

school we visited to have that number of cadavers for the number of students.

Mr. CARTER. How many would they have?

Dr. GRANT. One we looked at had 10 cadavers for 300 students.

Mr. CARTER. When I attended medical school, I believe two of us dissected a cadaver. What about you?

Dr. GRANT. I had four.

Mr. CARTER. I remember having a beautiful cadaver—one that was really lean. I was very fortunate to have him. But bit by bit, he went away from me.

What do you recommend that we do about students who go to these medical schools?

Dr. GRANT. We feel that they should be given an opportunity to demonstrate that they have acquired knowledge and skills reasonably comparable to those of their U.S.-trained counterparts before they enter the U.S. health care delivery system.

Mr. CARTER. And that we should check them with a thorough examination.

Dr. GRANT. Yes.

Mr. CARTER. Our medical schools that numbered so few have grown to 126 at the present time and from 31,000 or 32,000 students to some 60,000 now. We have 450,000 physicians now, and by 1990 we will have nearly 600,000.

It seems that in this country that we now have an adequate number of medical schools. It is rather difficult to get accepted. Usually the applicant must have a 3.5 average. We have loan programs so even the poorest can go to school. What do you think about it? Should we insist that our students attend only the schools in this country, or go to others that are well recognized—and there are many of them?

Dr. GRANT. It is very difficult to answer that question because I guess one would have to take the position that anyone had the right to go wherever he wishes. I think the question really is: what happens when they complete their education? Can we permit them to practice medicine? That is the issue, it seems to me, that really needs to be addressed.

Mr. CARTER. You would address it by requiring passage of a very thorough examination before you would admit that physician to practice. Is that correct?

Dr. GRANT. That would certainly be one way by which we could attack the problem.

Mr. CARTER. What would be another?

Dr. GRANT. I would point out there are perhaps three objections we would have to the question of using just an examination. Those objections would be:

First, many would question the possibility of using the examination solely and having it substitute for the rigorous training program that normally goes on in a medical school, and that is what, in effect, we would be doing.

The second objection we would have would be that it may be possible for any student to be adequately coached and pass an examination, especially if he repeats it several times.

The third objection we haven't really mentioned in our report, but might be worthy of mentioning, is that one of the advantages

of the third alternative, even though it also has disadvantages, is that it would enable each student who was studying abroad to be treated as an individual so that distinguished scholars and outstanding students could go through the process very easily and come into the program without too much difficulty. If he were subject to an examination as provided for by alternative two, and assuming that distinguished scholar had been out of medical school 30 years, I think you would agree he would have some difficulty passing examinations in basic sciences and even in some clinical subjects. That would be a problem.

Mr. CARTER. I want to thank you gentlemen for an excellent report and an excellent presentation.

Mr. WAXMAN. Our second panel of witnesses are Dr. Leonard Fenninger, from the American Medical Association, and Dr. William Deal, from the Association of Medical Colleges. Together, the AMA and AAMC make up the liaison committee on medical education, which accredits the medical schools in the United States.

Dr. Fenninger, if you could begin by summarizing your statement. We are going to be limited in time. We have prepared statements from most of you, if not all of you. The prepared statements will be made part of the record in their entirety. We would like to ask that each witness, including this panel, restrict their statements to no more than 5 minutes.

STATEMENTS OF LEONARD D. FENNINGER, M.D., GROUP VICE PRESIDENT, GROUP ON MEDICAL EDUCATION, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY ROSS RUBIN, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION; AND WILLIAM DEAL, M.D., ON BEHALF OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY AUGUST G. SWANSON, M.D., STAFF MEMBER

Dr. FENNINGER. We are very pleased to have the opportunity to offer a statement this afternoon, and I will be brief because we have already submitted a more extensive statement to the committee. [See p. 43.]

Based on the opportunity that we had to comment on a draft of the report prepared by the General Accounting Office—we do appreciate their sending us this draft—our comments are based on that draft and not on the final report which has only been released today.

I would like to speak to two points particularly. One is the roles of the public and private sectors in assuring that individuals attending nonaccredited foreign medical schools obtain necessary medical education to protect the public. The second is the proper use of public funds.

The GAO's report renders a valuable public service by providing onsite information concerning selected foreign medical schools and in outlining the current status of U.S. citizens who seek a medical education in schools outside the United States and Canada. The report correctly recognizes this subject as an issue of increasing magnitude, since there is a greater number of U.S. citizens who desire medical education than there are places in U.S. medical schools.

Mr. Chairman, in our view the public interest in the quality of medical education received in foreign medical schools falls within two basic categories—the need to protect the public health and safety by allowing only those individuals who have demonstrated appropriate knowledge and skills to pursue graduate medical education or to practice medicine, and the need to assure that public funds are used appropriately.

Protection of the public health through minimum standards of education and knowledge has traditionally been the responsibility of State governments and the private sector. States have accepted this responsibility by establishing licensure and registration requirements.

The private sector, specifically the medical profession, has acted to assure quality through programs for accreditation of medical schools and graduate medical education programs and participation in the Educational Commission for Foreign Medical Graduates—ECFMG. This successful cooperative activity has established a level of medical training and medical skills that are unsurpassed in the world.

In comparison, the Federal Government's interest in the "comparability" of foreign medical education has its basis in assuring the proper use of public funds. When enacted, the requirement that a foreign educational institution be "comparable" to a domestic institution was to be applied to all educational institutions and programs for the purpose of a U.S. national obtaining a guaranteed student loan. Neither the statute nor its legislative history indicated a special concern regarding the quality of medical care. Instead, the 1966 amendment to the guaranteed loan program was viewed as expanding the benefits to U.S. nationals attending foreign education institutions in any discipline.

GAO has set forth three alternatives and a series of recommendations that, if implemented, would establish for the first time a national standard for entry into graduate medical education programs and for licensure to practice medicine in the States, albeit for the limited population of foreign educated physicians.

Such involvement by the Federal Government 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 and supervision of patient care that are sufficient to insure the safety of the patients in the institution and the educational benefit of the program. Furthermore, prior to admission to an accredited residency program, foreign educated candidates must be certified by the ECFMG.

The ECFMG does significantly more than just administer an objective test of language and clinical skills. ECFMG also verifies the credentials of an applicant to determine whether that candidate meets the standards to practice medicine in the country of training.

We also believe that the State legislatures and medical licensing authorities should not be preempted by Federal standards from setting individual standards for licensure. Each State has affirmatively accepted the responsibility to insure that those licensed to

practice meet locally established standards to practice medicine. There appears to be no reason for Federal action in this area, and GAO has not presented any data indicating that incompetent practitioners are being licensed by any States.

We would suggest that GAO, the Congress, the Department of Education, and the Veterans' Administration concentrate Federal efforts toward assuring the proper use of public funds under the guaranteed student loan program and the VA education benefit program. In this regard, we would encourage these agencies to develop uniform criteria for determining comparability of educational programs.

These criteria should be general and apply to programs in all disciplines, as required by law, 20 U.S.C. 1085(a)(3), and not specific to medical education programs only. We do agree with GAO that it is absolutely necessary for development and implementation of a system to monitor attendance of all students who are recipients of Federal education assistance.

In closing, we would like to commend the GAO and this committee for instigating this discussion concerning education available at certain foreign medical schools. However, we cannot support recommendations that would establish Federal criteria and standards for entry into medical practice and graduate medical education programs. Such criteria are best left to the States and the private sector, whose records in this regard are enviable, and whose activities should be encouraged and supported.

Mr. Chairman, we will be pleased to answer any questions the subcommittee may have.

[Testimony resumes on p. 52.]

[Dr. Fenninger's prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

BY LEONARD D. FENNINGER, M.D.,
GROUP VICE PRESIDENT, GROUP ON MEDICAL EDUCATION

Re: Report of the General Accounting Office
"Policies Regarding U.S. Citizens Studying
Medicine Abroad are in Need of Careful
Review and Reappraisal"

November 21, 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.

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.

Many highly motivated and competent individuals choose 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 knowledge 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 knowledge and skills for foreign medical graduates, certification by the Educational Commission for Foreign Medical Graduates (ECFMG), completion of an accredited residency, and in at least one state, specialty board certification. Physicians educated outside the U.S. and Canada are not unusual to many states. For most of our history some U.S. citizens have obtained all or part 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 medical profession has also exercised its leadership in assuring the quality of medical education, both undergraduate and graduate, through the accreditation activities of the Liaison Committee on Medical Education and the

Liaison Committee on Graduate Medical Education. In order to deal with individuals who receive their medical education in foreign medical schools, the AMA, along with other organizations, sponsors the Education Commission for Foreign Medical Graduates (ECFMG). Organized in 1958 this organization was established to screen the credentials and qualifications for foreign educated physicians to determine their ability to benefit from and participate in residency programs. As well as objectively testing English language and clinical knowledge, the ECFMG verifies the credentials of the candidate as meeting the requirements to practice medicine in the country of education. This voluntary private sector activity has, in our view, worked well at meeting its goal of providing an adequate screen for foreign educated physicians to enter accredited residency programs.

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 methodology 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 education 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 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 achievement of minimal 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 principal defined geographic site under the direct supervision of selected 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 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. Clinical clerkships offered by U.S. and Canadian medical schools 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.

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 and loss of continuity for the medical student.

The remainder of our comments will be directed at providing our views concerning the alternatives and recommendations found at the end of the report.

Alternatives and Recommendations

The report 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 for licensure, the federal government's concern should be limited to item one which is based on the deter-

mination 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 I

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 and supervision of patient care that are sufficient to ensure the safety of the patients in the institution. 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 graduates come to the U.S. for residency training so that they can develop additional skills for practice on returning to their home countries. This alternative would irrevocably damage this type of educational opportunity and the important role it plays in maintaining good international relationships for the U.S.

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 into the U.S. of alien foreign medical graduates whether or not they participate in Graduate Medical Education programs. 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 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 educational residency programs. 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 as a means of assuring the proper use of government funds.

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 (including ECFMG certification) to assure that the concerns of patient care and safety are met. We do not view this as an area appropriate to or in need of Congressional involvement. The calling of this hearing, by focusing 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 disucss with the Secretary 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 in all disciplines.

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 the medical profession through medical school faculties and hospital medical staff in supervising graduate medical education residency programs to ensure quality patient care and a meaningful educational experience. Nor does it properly recognize ECFMG and its important and successful role of certifying individuals who attend foreign medical schools and have achieved accepted standards of medical education (including English language and clinical success) to enter into accredited residency programs in the U.S.

Mr. WAXMAN. Thank you very much.
Dr. Deal, if we could hear from you.

STATEMENT OF WILLIAM DEAL, M.D.,

Dr. DEAL. Thank you, Mr. Chairman and Mr. Carter.

My name is William Deal, dean and associate vice president for clinical affairs, University of Florida College of Medicine.

I am accompanied by Dr. August Swanson, who is a staff member of the Association of American Medical Colleges, whom I am representing today.

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to comment on this important report of the Government Accounting Office entitled, "Policies Regarding U.S. Citizens Studying Medicine Abroad Are in Need of Careful Review and Reappraisal" which calls for a careful review and reappraisal of policiies related to U.S. citizens studying medicine abroad. The association is the voice for the Nation's 126 operating medical schools and their students, for over 70 academic societies representing their faculties and for more than 400 teaching hospitals, all of which are deeply involved in medical education, in biomedical and behavioral research, and in patient care.

The association applauds the committee's decision to explore the question of whether the foreign medical schools, to which U.S. citizens predominantly have access, provide an education comparable to that accorded students in our domestic schools.

The striking finding presented by the GAO report is that none of the 5,400 U.S. citizens enrolled in the schools they visited are

offered a medical education comparable to that available in the United States. These six schools alone enroll one-half of all U.S. citizens studying medicine abroad, according to the GAO estimate.

The problem before the committee is not whether U.S. citizens should study medicine abroad, but whether the Congress should continue to make available guaranteed student loans and VA educational benefits to support citizens who are being exploited by a few entrepreneurial, profitmaking schools.

Advocates for continued support will claim that the intense competition for positions in our own schools has denied admission to a large number of qualified U.S. students. This claim needs to be examined from two aspects.

First, the intensity of competition during the past decade has been overstated. During the peak years of 1974–76, there were 2.8 applicants for each position; that ratio has now fallen to only 2.1.

Second, admissions committees select applicants they believe possess the requisite intellectual and personal qualities for a career in medicine. In doing this, they particularly scrutinize the large pool of graduating college seniors each year, but they invariably go beyond this pool to fill their classes.

The GAO notes, and the association concurs, that there are many meritorious foreign medical schools whose graduates have contributed significantly to the advancement of medicine. Graduates of foreign schools are valued faculty members of many of our institutions. But it should be noted that such meritorious schools are not easily accessible to our citizens.

More than 70 percent of the 1,600 registrants for last June's medical sciences knowledge profile examination were from only 10 foreign schools; primarily located in Mexico and the Caribbean. Few were enrolled in the distinguished medical education institutions in the United Kingdom or northern Europe.

The schools cited are representative of those to which our citizens predominantly have access.

In a free society, individuals should have the right to aspire to the career of their choice. But the citizens of a free society have an equal right to subsidize only those who pursue their aspirations in ways which insure that their contributions to society will be of benefit to the citizenry. Our citizens also have the right to require that those who practice medicine demonstrate that they are capable. The issues before the committee today must be examined from these perspectives.

In the 1960's a shortage of physicians was predicted and expansion of our domestic accredited medical schools was started. In 15 years the number of entering students more than doubled. While the number admitted rose, so did the absolute number of those not admitted. This large group provided an enticing target-of-opportunity to profiteering.

Medical schools, with totally inadequate educational programs and facilities, began to burgeon in the 1970's. Because these so-called medical schools lacked the prime facilities needed for medical education; namely, clinical teaching facilities, students who voluntarily enrolled in these institutions have turned to U.S. hospitals to gain clinical experience. By providing such experiences, our health care system is further subsidizing the profiteers.

Mr. Chairman, at a time when the Graduate Medical Education National Advisory Committee has advised that domestic medical school enrollment should be curtailed, continuation of subsidies to students studying medicine abroad in whatever form and by whatever means cannot be justified.

The GAO, in its report, presents three alternatives.

First, it examines having a U.S. agency accredit foreign medical schools and finds such a course infeasible. We agree.

Second, it examines requiring the same examination for entry into graduate medical education and licensure for all students, both foreign and domestic. The report correctly states that it is doubtful that a written examination could be developed which would substitute for the rigorous supervised training that students in the United States undergo.

Third, it suggests establishing a mechanism through either the Department of Health and Human Services or the private sector to screen foreign medical graduates, identify those with deficiencies, and provide the opportunity for those who are deficient to take further training in designated U.S. hospitals.

This latter alternative is totally unacceptable. It would institutionalize the policy that U.S. citizens voluntarily enrolling in foreign schools should have special privileges accorded them for rehabilitation after they have voluntarily opted to attend inadequate institutions.

Mr. Chairman, the association strongly opposes the continuation of further subsidies to the study of medicine abroad by U.S. citizens. The Graduate Medical Education National Advisory Committee has recommended the discontinuation of all guaranteed student loan and scholarship support for the study of medicine abroad. We endorse that advice.

We also oppose the provision of any rehabilitation program, such as proposed by the GAO, and would urge discontinuation of any private sector efforts of similar type.

Finally, we would emphasize that, as the GAO points out, no written examination can substitute for the extended observation and evaluation to which students in our domestic schools are subjected by our faculties.

Therefore, we recommend that the Federal Government urge the Federation of State Medical Boards to work with its constituent licensing jurisdictions to develop policies which will require that foreign medical graduates be scrutinized directly in a practical, hands-on clinical examination as part of the licensure requirements for physicians who are not graduates of accredited, domestic medical schools.

Thank you for the opportunity to present our views. The association believes strongly that all sectors of our society with responsibilities and concerns for preserving the quality and integrity of medical education and medical care in this country should work together to deter the unseemly exploitation documented in this report.

I would be happy to try to answer any questions that have occurred to you.

Mr. CARTER [presiding]. Thank you, Doctor. I enjoyed your remarks very much.

Really, I don't believe that the GAO in its report actually recommended a Federal examination. I think the idea really was that the State should perhaps conduct their own. Certainly I believe, as you have mentioned, that it should not be just a written examination.

You state the physician should undergo a clinical examination, too, to evaluate his ability to diagnose. What advice would your organization give to students who have not been accepted to U.S. medical schools and who are contemplating studying abroad?

Dr. FENNINGER. We, of course, have a great many inquiries and, as a matter of fact, members of the American Medical Association, as well as members of its staff, speak on many occasions to parent groups and students who are considering the possibility of studying medicine or taking their medical education abroad.

I think we have been very realistic in discussing with them all of the problems, the differences in the educational experiences, the problems of acculturation in a different culture, studying in a different language, and the problems of trying to return to the United States with an education which is quite different from that conducted in the accredited schools in the United States.

I personally was involved in this long before I was associated with the American Medical Association and gave such advice to students and, frequently, as an individual not representing any organization at all, advised them to think about other careers which they could contribute to the health and well being of the citizens of the United States.

Despite such advice, there are people who still have a strong enough urge to attend medical schools in other countries which are educationally quite different from those of the accredited U.S. schools.

One then is faced with a very important and fundamental question of the person who has devoted time, energy, and resources, and really wishes to be a physician practicing in the United States and has the right as a citizen to return, to prepare that person to practice medicine in the United States, if he is admitted to practice by meeting the standards established by each of the States through licensure, to be as well prepared to give safe, effective, and timely care.

In a sense, that is where the dilemma lies.

Dr. SWANSON. The association annually publishes a handbook which is used by most students applying to medical school. In this book, called the Medical School Admissions Requirements Handbook, there is a chapter devoted to the unaccepted applicant with good advice.

The important first step in advising such students is that they should really assess what their motivations were with medicine, they should look at other career options. We are very, very explicit about the hazards of opting to voluntarily go to foreign nations, pointing out that the chances for disappointment are very great.

We also respond to many, many inquiries where similar advice is provided.

Mr. CARTER. Yes, sir.

Dr. DEAL. Speaking about my own institution, if I may, we advise these young men and women and carefully review their record to see where they may be deficient and advise them perhaps they

may need more formal undergraduate training in specific areas and encourage them to reapply.

About 1 out of 4 of our medical students has applied to medical school more than one time so eventually many of these young men and women who are turned down the first time do gain entrance into a U.S. medical school.

Being denied admission the first time around is not the end of the world.

Mr. CARTER. Why do we have this growing number of American students studying abroad? Is it because they are turned down here in this country or because it is easier for them to graduate and get a degree from some of these foreign schools—or both reasons?

Dr. SWANSON. The absolute number of people rejected by medical schools when they apply has increased because the total number of applicants has increased. Therefore, there are a larger total number of disappointed applicants, but I think the interesting thing is that we had a large number of disappointed applicants in the 1940's when the returning veterans gave us the biggest competitive bulge we ever had.

At that time there were 3.3 applicants per position in the United States. The difference between 1940 and 1970 was that we did not have schools operating outside of U.S. jurisdictions catering to and recruiting U.S. students of the kind that we have seen demonstrated in the GAO report.

Those schools are one of the major reasons why we see this large number.

Mr. CARTER. I certainly agree with you; I don't think that we should subsidize students going to certain schools. However, if they are going to schools such as Heidelberg or Edinburgh, schools that are recognized throughout the world as being the best, there is quite a difference.

But who makes that judgment? We can't really designate a foreign school as being acceptable, or can we? Should we attempt to do that?

Dr. FENNINGER. Dr. Carter, I think that question may have two parts. One is the current statutory responsibility of the Department of Education to determine comparability, which is one type of comparability and one type of obligation. The second is the ability of any agency or any group, public or private in the United States, to make judgments about education in other nations.

It should be recalled that medical education is at the end of education in almost all nations throughout the world and, therefore, it relates to the whole culture and the whole educational system within the nation where the medical education is being given.

One is really making a judgment about only one segment of education in the cultural experience. As a practical matter, it should be recognized that the American Medical Association in the early 1950's, following the passage of the Hays-Fulbright Act and the interest in having exchange students among nations, particularly U.S. students going abroad and students from other nations coming to the United States, recognized that there were going to be people from the United States who would wish to study medicine

in other nations and wish to return and initiate a program to accredit foreign medical schools.

After a very substantial trial, it turned out not to be feasible to accredit the end of an educational system in another nation for many reasons.

Mr. CARTER. Yes, sir.

Dr. SWANSON. To follow up on that, Dr. Carter, I think the universities such as Heidelburg, Edinburgh, Oxford, are relatively unavailable to U.S. citizens to study medicine in larger numbers.

Mr. CARTER. That is quite true.

Dr. SWANSON. We found in our analysis of the examinees last June, of those who were seeking advanced placement from schools around the world, that there were 130 medical schools around the world that contributed to that examining population, but 107 contributed one or two each. The big bulk were with seven schools located in Mexico and the Caribbean.

Mr. CARTER. What would you say is the purpose of these schools examined in the GAO report?

Dr. DEAL. The purpose——

Mr. CARTER. Is it to really educate the physician or is it a sort of a mill to turn out physicians with diplomas?

Dr. DEAL. I referred to some of these schools as profiteering, entrepreneurial enterprises, and I believe many of them are.

Mr. CARTER. What do you think about a school that requires $11,000 for a semester's externship for one of its students, sir?

Dr. DEAL. I don't think much of that, sir.

Mr. CARTER. Well, do you think that the Veterans' Administration or the Department of Education should make loans to students to attend these schools? Surely, we could find some criteria, or set up some standard.

Dr. DEAL. Mr. Chairman, as I testified earlier, I don't believe it is appropriate that we should support these students with our tax dollars to go to noncomparable institutions.

Mr. CARTER. Yes, sir, but who is going to determine what is comparable. I am sure there are some, but when I read about those in this report I found the situation very depressing. It seems to me they are nothing more than diploma mills.

Dr. SWANSON. I think the committee should give serious consideration to the question of whether studying medicine abroad should be further subsidized by guaranteed student loans or veterans' benefits.

We seem to be facing a more than adequate supply of physicians from our domestic medical schools, and I do believe trying to set up comparability standards will be extremely difficult. The committee should really consider the possibility of just saying for studying medicine abroad we do not provide federally guaranteed loans or veterans' benefits.

Mr. RUBIN. If I could add, the GAO report is absent in acknowledging how the Department of Education and VA has been determining comparability for other nonmedical disciplines such as law or engineering.

We would hope that any kind of criteria developed to evaluate medical schools would be on the same basis as Government support for educating any U.S. national in a foreign institution and discriminatory standards not be developed for medicine.

One could say that there are too many lawyers in the United States as well, but as a law student I could go to any law school meeting comparability standards and receive Federal assistance as well.

Mr. CARTER. Have you been contemplating going to Leningrad?

Mr. RUBIN. No; I haven't personally.

Mr. CARTER. Thank you.

When these students come back, what are we going to do with them? Doctor?

Dr. FENNINGER. Mr. Carter, as members of the committee, you know in 1958, a means of screening persons who had their medical education abroad was developed prior to their entering into possible doctoral or residency education.

It was developed in cooperation among the Association of American Medical Colleges, the Federation of State Medical Boards and the AMA in recognition that all of these groups have a significant role to play in education, and in the rights and privileges for the practice of medicine.

This means of screening was only for admission to an accredited residency in the United States. It did not have anything to do with licensure. ECFRG screening includes an examination and review of the credentials presented by the individual to verify the fact that those credentials were reliable and accurate, and that the person had indeed met the standard established within the nation where he undertook his study of medicine, to meet the necessary requirements for practice in the nation where the education was received. It also includes a test of English.

Since that time, that screen device has continued, and as a matter of fact, the standards both of the scientific and clinical scientific, as well as the English portions, have been changed. I am sure others will speak to that.

A screening mechanism has been in place. Much of the criticism which has been directed at the Educational Commission for Foreign Medical Graduates in its screening mechanism has failed to understand three things.

First, there is more than a scientific examination involved in the certification of candidates; second, that the certification is for entrance into graduate medical education in the United States, not for entrance in independent practice. It is anticipated that during the course of graduate medical education, the foreign medical graduate will acquire, under supervision, the clinical skills necessary to be a safe, effective practitioner.

A third factor is that that screen, which was put in place in 1958, was designed to review a limited number of individuals. However, the Congress in 1965 and 1970 changed the size of the pipe over which that screen was in place by amending the Immigration and Naturalization Acts, and suddenly expanding the opportunities for persons, citizens of other nations to enter the United States.

No matter what the size of the mesh or the effectiveness of that screen, if it remains a 4-inch screen designed for a 4-inch pipe. The Congress increased the size of the pipe to 8 or 12 inches while the screen remained the same size, fairly sizable objects can fit through the screen, even if it is a solid plate.

That is what has happened, and there is considerable misunderstanding about the events that occurred quite properly and legally allowing foreign medical graduates to come to the United States, bypassing this screening mechanism which had been put in place by the private sector of medicine.

Mr. CARTER. Any other comment? Gentlemen, I want to thank you for your helpful presentation and responses.

Our next witness will be Dr. Harold Jervey, executive director of the Federation of State Medical Boards.

STATEMENTS OF HAROLD E. JERVEY, JR., M.D., EXECUTIVE DIRECTOR/SECRETARY, FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.; RAY L. CASTERLINE, M.D., EXECUTIVE DIRECTOR, EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES; AND WILLIAM D. HOLDEN, M.D., CHAIRMAN, NATIONAL BOARD OF MEDICAL EXAMINERS, ACCOMPANIED BY EDITHE LEVIT, M.D., PRESIDENT

Dr. JERVEY. It looks like it is getting down to a one-on-one situation now.

I am Harold Jervey, executive director of the Federation of State Medical Boards of the United States.

Mr. CARTER. Excuse me, Dr. Jervey. Suppose we call all the other witnesses up at the same time.

Doctor, you wouldn't mind?

Dr. JERVEY. I would love to have company.

Mr. CARTER. You will still be first.

Dr. William D. Holden, accompanied by Dr. Edithe Levit, and Dr. Ray Casterline.

If you would summarize.

Dr. JERVEY. My name is Harold E. Jervey, Jr., M.D. I am executive director of the Federation of State Medical Boards of the United States, Inc., which was founded in 1912.

The membership consists of the medical licensing boards of the 50 States and the District of Columbia, together with Puerto Rico, Guam, and the Virgin Islands. We used to have the Canal Zone, but they left us. In addition, 8 independent boards of osteopathy are members and the 10 Canadian Provincial licensing authorities are affiliate members.

A primary reason for establishing the federation was to advance the adoption and maintenance of adequate and uniform standards for licensure in medicine. This includes a quality licensing examination which all jurisdictions could accept.

With the establishment of FLEX in 1968 and its adoption by all member boards in 1979, this goal has been achieved. In addition is the need for adequate and uniform standards to determine the quality of the medical education of the candidate for licensure.

With the excellent accreditation system that is now in place in the United States and Canada, this is no problem for United States and Canadian graduates.

Of course, the Congress has addressed the alien physician immigrant in Public Law 94-484 and its amendments. This gives some assurance that only reasonably competent physicians can enter the U.S. health care system.

However, the phenomenon of the seventies, whereby large numbers of U.S. citizens went abroad to obtain their medical education in schools of questionable quality, has not been resolved.

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 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.

All alternatives proposed in the GAO report for evaluating the education and training received in foreign medical schools are reasonable but, as the report notes, each has problems.

The federation supports alternative No. 2, and considerable progress has been made in developing the FLEX I–II concept. When this is in place, all United States, as well as alien and U.S. foreign medical graduates, will be required to pass FLEX I prior to entering a postgraduate training program.

This is a few years away, however. Even with this in place, there remains the need to evaluate the quality of education the students receive.

The licensing boards are in urgent need of documented information and guidelines. For this reason, the federation strongly believes that the needs of the boards and the American public can best be achieved by the Commission to Evaluate Foreign Medical Schools.

The commission has met and reviewed in great detail the accreditation system in the United States. It has discussed various ways to carry out its charge. After deliberation, it concluded that, to achieve a uniform standard, the methodology used must be comparable to the evaluating procedures used in the United States.

It has not finalized its plan to implement the system, but will do so in the very near future. This will not be an accreditation system, but rather a reliable information gathering system. With documented facts, the medical boards can exercise their lawful responsibility in a judicious manner.

This approach to evaluating foreign medical schools will become operational in a short period of time. The federation recognizes that the major obstacle to fully implementing this system is personnel and money.

The federation will require assistance from both the private and governmental sectors. If the American public is to be protected

from the inferiorly trained physician, it is essential that the commission's work be supported.

The medical licensing boards of this country are composed of knowledgeable and dedicated men and women who give freely of their time to assure the public of competent medical care. They need assistance in deciding who is qualified to practice medicine.

The American public expects to receive their medical care from adequately trained, capable physicians. This they must have. With your support, they will.

Thank you for permitting me to testify before you today. I would be happy to respond to any questions which you may have.

I might say that the federation right now has the only game in town, and we would hope that everyone could support us in what we are attempting to do.

Mr. CARTER. Dr. Jervey, I want to commend you on your presentation.

Dr. JERVEY. Thank you.

Mr. CARTER. There will be questions later.

We will proceed with you, Dr. Casterline.

STATEMENT OF RAY L. CASTERLINE, M.D.

Dr. CASTERLINE. I am Ray L. Casterline, executive director of the Educational Commission for Foreign Medical Graduates.

Mr. Chairman and members of the subcommittee, ECFMG appreciates this opportunity to appear before you, to comment about the ECFMG examination and certain other testing instruments. I have submitted a prepared statement, which I wish to have become part of the record of my testimony. [See p. 63.]

References in the GAO report citing the alleged low level of difficulty of the ECFMG examination are based on outdated reports prepared before the content and scoring standards were modified with the 1976 examination.

The ECFMG examination was restructured so that one-sixth of the questions are derived from the basic medical sciences, national board part I material and five-sixths from the clinical sciences. The minimum passing levels are comparable to the national board, part I and part II exams.

The ECFMG English test was strengthened in 1974 with the cooperation of the language program of the Educational Testing Service. The English test is a modified test of English as a foreign language, known as TOEFL.

TOEFL is the best of the English language testing programs. Following the introduction of the "modified TOEFL," the ECFMG English test pass rate dropped sharply, thus providing a significant hurdle. The ECFMG English test is also utilized to meet the English language prerequisite to take the visa qualifying examination.

A statement in the report infers that the ECFMG examination is given only "to U.S. citizen foreign medical school students." A preponderance of alien FMG's still take the ECFMG exam.

The statement that the ECFMG examination "was not designed to assess capacity for problem solving, attitudes, behavior or clinical skills," is of course true. However, neither national board part I or part II examinations, nor the VQE, assess those particular traits or skills.

The statement in the report regarding the visa qualifying examination is incomplete. Public Law 94-484, which created the need for the VQE, states that medical school graduates entering the United States either to perform medical services or for graduate medical education or training are required to pass the VQE.

The VQE is longer than the ECFMG examination and contains approximately 1,000 items with nearly equal numbers of questions from the national board part I and part II examinations.

When comparing the VQE and ECFMG pass rates, it should be understood that VQE applicants are required to have prequalified in English, whereas the ECFMG applicant population takes the ECFMG English test with the science examination.

It should be emphasized that the purpose of the visa qualifying examination is to obtain a visa to enter the United States and not necessarily to enter graduate medical education or training.

In summary, the ECFMG examination is a standardized, multiple choice objective examination that has been subjected to intense psychometric scrutiny. It has been consistently reliable and is a high-quality examination instrument.

Relatively low, but consistent pass rates, provide assurance that the ECFMG examination performs an important screening function.

In comparing pass rates of examinees who take ECFMG examinations and the VQE with those of U.S. medical school graduates, a number of factors must be considered, such as the length of time between the examinations and examinees' completion of formal medical education, the number of times they may have taken—and failed—previous ECFMG examinations, their native languages, their cultures, and a number of other factors that could substantially influence their performance on the examinations.

Foreign medical graduates who obtain ECFMG certification have met all of the educational requirements for licensure in the country in which they received their medical education.

Many of them have had experience as interns and residents in training programs in their own countries. Others have had a number of years experience in practice before coming to the United States to receive training in one of the recognized specialties.

USFMG's also are required to meet the educational requirements for licensure in the country in which they receive their medical education.

Mr. CHAIRMAN. I want to thank you for inviting ECFMG to testify before the subcommittee about the GAO reports.

[Dr. Casterline's prepared statement follows:]

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

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POLICIES REGARDING U.S. CITIZENS STUDYING MEDICINE ABROAD ARE IN NEED OF CAREFUL REVIEW AND APPRAISAL

A Report Prepared by the Staff of the United States General Accounting Office

Testimony of Ray L. Casterline, M.D.

Executive Director

Educational Commission for Foreign Medical Graduates

Before the Sub-Committee on Health and the Environment of the Committee on Interstate and Foreign Commerce of the United States House of Representatives

November 21, 1980

Mr. Chairman and members of the subcommittee, the Educational Commission for Foreign Medical Graduates (ECFMG) appreciates this opportunity to appear before you to comment on the United States General Accounting Office report "Policies Regarding U.S. Citizens Studying Medicine Abroad Are in Need of Careful Review and Appraisal" ("GAO Report").

ECFMG will limit this statement to comments regarding sections of the report that relate to the ECFMG examination and certain other testing instruments that are administered to students and graduates of foreign medical schools (FMGs). Most of the applicants take these examinations in the course of qualifying for entry into programs of graduate medical education in the United States.

From its initial administration as the American Medical Qualifying Examination in March 1958, the questions for ECFMG examinations have been selected from the National Board of Medical Examiners (NBME) pool of calibrated test items in the basic and clinical sciences (National Board Part I and National Board Part II materials).

Initially, 90% or more of the ECFMG examination was drawn from the traditional clinical sciences of medicine, surgery, obstetrics and gynecology, pediatrics and public health. Less than 10% of the ECFMG examination was derived from the traditional basic sciences.

From the beginning, the scores of FMGs on questions on the ECFMG examination have been based on a comparative analysis of the results obtained when a standard reference group of American and Canadian medical students and graduates answered the questions that make up the examination. Approximately eleven to twelve percent of the members of the reference group fail the NBME Part I (basic science) examination and approximately two percent fail the NBME Part II (clinical sciences) examination. The minimum passing standard score on the NBME clinical sciences (Part II) examination is 290. The minimum pass level in the Basic Science is a great deal higher. Until the mid 1970's, the entire ECFMG examination was scored as if it consisted entirely of Clinical Science items that are scored with a much lower minimum pass level (MPL = 2.1 standard deviations below the mean).

In 1975, the ECFMG Board of Trustees formed a committee to study the question of the minimum passing standard score on ECFMG examinations. The Board adopted the committee recommendation that the ECFMG examination be restructured so that one-sixth (approximately 16%) of the questions would be derived from the basic sciences (NBME Part I) material and five-sixth (approximately 84%) from the clinical sciences. Furthermore, the minimum passing standard score on the basic science questions was set at 1.2 standard deviations below the mean and the minimum passing level on the Clinical Sciences at 2.1 standard deviations below the mean.

Although the minimum passing scale score on the ECFMG examination remained at 75, the changes in content and the method of scoring both basic and clinical science items resulted in a much more difficult examination than had been administered by ECFMG during the preceding seventeen years.

The ECFMG examination contains fewer questions than the NBME Part I and Part II examinations. However, since 1976, the scoring standards for the ECFMG examination have been comparable to those used in scoring National Board Part I and Part II examinations.

Many references citing the alleged low level of difficulty of the ECFMG examination are based on out-dated data and reports prepared before the content and scoring standards were modified, beginning with the 1976 examination.

The ECFMG English test was strengthened in 1974 with the close cooperation of the language program section, Educational Testing Service, Princeton, New Jersey. The ECFMG English test is a modified Test of English as a Foreign Language (TOEFL). TOEFL is considered to be the best of the English language testing programs. As could be expected, following the adoption of the modified TOEFL as the ECFMG English test, the pass rate on that test dropped sharply, thus providing a significant hurdle for students and graduates of foreign medical schools. The ECFMG English test is also utilized for physicians to meet the English language requirement, as specified in Public Law 94-484 and as a prerequisite to take the Visa Qualifying Examination.

The ECFMG examination, a uniform screening mechanism, is a standardized objective examination which is not the only criterion utilized for ECFMG certification and for admission into a residency training program in the United States. Foreign medical graduates who obtain ECFMG certification have met all of the educational requirements for licensure in the country in which they received their medical education. Many of them have had experience as interns and residents in training programs in their own countries. Others have had a number of years experience in practice before coming to the United States to receive training in one of the recognized specialties.

United States citizen foreign medical school graduates also are required to meet the educational requirements for licensure in the country in which they receive their medical education.

Under the sub-heading "Examinations for Graduate Medical Education," on page 43 and following pages, the statement infers that the ECFMG examination is given only "to U.S. citizen foreign medical school students". The ECFMG examination is taken by a preponderance of applicants who are not U.S. citizens.

Near the bottom of page 43, the statement that the ECFMG examination "was not designed to assess capacity for problem solving, attitudes, behaviour or clinical skills", is, of course, true. However, neither National Board Part I or Part II examinations, nor the VQE assess those particular traits or skills.

The task force report described at the top of page 44 was prepared prior to the previously- discussed changes in the content and increased difficulty of the ECFMG examination.

The statement regarding the Visa Qualifying Examination, beginning at the top of page 45, is incomplete. The VQE is taken by alien physicians who have graduated from foreign medical schools and may seek to obtain a visa to enter the United States. However, Public Law 94-484, which created the need for the Visa Qualifying Examination, states that medical school graduates entering the United States to perform medical services or for graduate medical education or training are required to pass National Board Part I and Part II examinations or an equivalent examination -which the VQE is considered to be.

The Visa Qualifying Examination is longer than the ECFMG examination and contains approximately 1,000 items with approximately equal numbers of questions from the National Board Part I and Part II examinations. When comparing the VQE and ECFMG pass rates, it should be understood that VQE applicants are required to have prequalified in English, whereas the ECFMG applicant population take the ECFMG English test with the science examination.

It should be emphasized that the purpose of the Visa Qualifying Examination is to obtain a visa to enter the United States and not necessarily to enter graduate medical education or training.

On page 48 the expected eligibility of graduates of the American University of the Caribbean on the island of Montserrat, for medical licensure has been noted. Importantly, graduates of that medical school, as of all other foreign medical schools, in most states, are required to obtain ECFMG certification or, at least, pass the ECFMG examination and receive a year or more of graduate training, before they can become eligible to take the examination for licensure.

In summary,

1. The ECFMG examination is a standardized, multiple choice objective examination that has been subjected to intense psychometric scrutiny. It is consistently reliable and is a high quality examination instrument.

2. Relatively low, but consistent pass rates provide assurance that the ECFMG examination does perform an important screening function.

3. In comparing pass rates of examinees who take ECFMG examinations and VQE with those of U.S. medical school graduates, a number of factors must be considered, such as the length of time between the examinations and examinees' completion of formal medical education, the number of times they may have taken (and failed) previous ECFMG examination, their native language(s), their culture(s), and a number of other factors that could substantially influence their performance on the examinations.

Ray L. Casterline, M.D.
Executive Director,
Educational Commission for
Foreign Medical Graduates

November 21, 1980

Mr. CARTER. Thank you very much.

STATEMENT OF WILLIAM D. HOLDEN, M.D.

Dr. HOLDEN. I am William D. Holden, chairman of the National Board of Medical Examiners, and with me is Dr. Edithe Levit, president of the National Board of Medical Examiners. We both will be pleased to respond to questions later on.

I would like to say at the very beginning of this statement that the national board in its written testimony [see p. 70], as well as in the statement that I have at the present time, addresses only those aspects of the GAO report that have a relationship to the National Board of Medical Examiners.

The national board is not concerned with the accreditation process at any level of medical education whatsoever. It has no responsibility for it. Its sole responsibility and function is the preparation of examinations to evaluate the capabilities of individuals, either students or physicians.

The purpose of all examinations, irrespective of where they are given or at what time in a medical career is directed to the quality of medical care I think we have to bear that in mind constantly. This is the bottom line of all the different things we do in terms of both accreditation and examination processes.

Examinations, however, as it has been stated several times today already, alone cannot serve the purpose of assuring the quality of medical care. It can do this only partially.

It is important I think for everyone concerned with this very serious issue that we are confronted with today to appreciate the fact that examinations must be constructed so that they have relevance to the purpose for which the examinations are administered if validity of a particular assessment instrument is to be achieved.

As an example, examinations that are being prepared for licensing purposes must address those capabilities that are required for the care of patients.

On the other hand, examinations that are prepared to assess the educational achievement of a student who wishes to transfer from one school to another or who wishes to enter the arena of graduate medical education must be prepared differently.

With licensing examinations, one starts out by identifying those particular tasks that are going to be required by a physician practicing medicine. In the first year of graduate medical education or in a practice situation. From those, criteria are developed upon which the examination is constructed.

With an educational achievement examination, the single criterion that has to be employed is the educational content of the program through which the examinee has just passed. These can vary enormously in terms of the different items that are introduced into an examination.

There is need, however, for the continuing assessment of the educational program which is done by accreditation, and also a need for the continuing assessment of students. This is best done over a long period of time by a faculty that has the opportunity to observe a student in multiple different settings confronted with a variety of intellectual and clinical problems.

The national board recognizes this. Its certification process does not consist solely of passing the parts I, II, III examinations. The certificate is issued only after those examinations have been completed successfully, the MD degree is issued by a school that is accredited by the Liaison Committee on Medical Education, and the individual has completed successfully 1 year of graduate medical education.

The national board recognizes that examinations are only one factor that can be employed in the justifiable assessment of an individual in terms of his or her capability to practice medicine in this country.

When the quality of an educational program, however, cannot be assessed effectively, then greater reliance must be placed upon the examination system. That essentially is what the GAO report has enunciated in that there is no adequate accreditation system for many of these schools in foreign lands today. At least we do not recognize an adequate accreditation system. Therefore, great emphasis must be placed upon the examination system to determine whether any particular individual who wishes to come to this country has in fact achieved a certain amount of educational progress and also the capability to care for patients.

There are multiple variables that do not permit the aggregate performance on examinations of a class or a school to be used as a reliable and valid assessment of the educational program being conducted in that school.

It would be very helpful if we could merely examine the performance of an aggregate number of students in the school and then classify that school according to the capability and effectiveness of the educational program. We cannot do that, however, because there are so many variables other than the performance of a group of students or physicians on an examination.

The examinations for the entry of foreign medical graduates and U.S. nationals in foreign medical schools to medical schools in this country or to graduate programs in the teaching hospitals in the United States does determine insofar as examinations can whether the applicant's educational achievement is such that they have a sufficient fund of knowledge to continue with their education in a U.S. institution.

These examinations: the ECFMG examination, the VQE, and the medical science knowledge profile tests have no relationship whatsoever to licensing examinations. They are not intended to evaluate individuals coming into the U.S. health care system in terms of their capability to take care of patients. They are screening examinations to determine whether individuals have in fact achieved a certain degree of education so that they are capable and can benefit from the pursuit of additional educational programs.

If the examinations do demonstrate, however, that the applicant educational achievement has been obtained, and that they are admitted to a U.S. institution, they should be required, as Dr. Jervey has just stated, to meet the same standards for licensure that are required of all United States and Canadian graduates. The Federation of State Medical Boards has proceeded a considerable distance toward the development of a uniform licensing system

that can be applied to all physicians who are about to assume the responsibility for the care of patients.

Thank you, Dr. Carter.

[Testimony resumes on p. 77.]

[Dr. Holden's prepared statement follows:]

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TESTIMONY OF

WILLIAM D. HOLDEN, M.D.

CHAIRMAN

NATIONAL BOARD OF MEDICAL EXAMINERS

To: The Chairman of Subcommittee on Health - The Honorable Henry Waxman

The National Board of Medical Examiners (NBME) is grateful for the opportunity to comment upon the report issued by the General Accounting Office (GAO) which is entitled "Policies Regarding U.S. Citizens Studying Medicine Abroad Are in Need of Careful Review and Reappraisal." The report, which includes a large amount of material and data, has been assembled in an effective fashion. The major thrust of the report is embodied in its title.

The NBME confines its comments and suggestions to only those sections of the report that relate to the programs and activities of the NBME.

As a principle fully endorsed by the NBME, any examination should be viewed as an episodic and isolated assessment of an individual's knowledge and capabilities and should be weighted proportionately with the continuing evaluation of a medical student or physician by instructors and supervisors over an extended period of time. Physicians who have attended U.S. or Canadian medical schools and who have passed the NBME's Parts I, II, and III examinations are certified to the state medical boards not only because they have completed the examinations successfully but also because they have received an M.D. degree from a medical school that has been carefully and fully accredited by a reputable agency, the Liaison Committee on Medical Education, representing the national medical organizations responsible to the medical profession and the public for the quality of medical education. They have also completed one year of accredited graduate medical education.

A second principle espoused by the NBME is that an examination or any type of assessment procedure must have a specific objective, and the content and

format of the examination must be constructed according to the purpose it is intended to serve. An examination may be devised to measure the knowledge acquired by an individual during a defined educational experience. Under these circumstances the criteria employed in constructing the examination will be the factual content of the educational program. On the other hand, an examination may be devised to assess the capabilities of an individual to perform certain tasks. Such an assessment procedure must define the tasks to be performed and the abilities required to carry them out in an acceptable fashion. The capabilities to be evaluated may include essential knowledge, ability to solve problems, the demonstration of judgment, and to some extent skills in communication and interaction with others and the employment of psychomotor skills.

The NBME is committed heavily to the design and development of examinations for the purpose of licensing physicians. These consist of the Parts I, II, and III examinations of the National Board and FLEX, which is an examination of the Federation of State Medical Boards (FSMB). Many of the National Board's resources are also used to assist other agencies in developing evaluation procedures to assess the competence of individuals in special areas of medical practice. All of the examination services provided by the NBME, with the exception of its own Parts I, II, and III examinations, are designed for the use of other agencies. Policies concerning the administration of the examinations are formed and implemented by the other agencies and not by the NBME.

The process of evaluating U.S. and foreign medical students in foreign medical schools seeking transfer to U.S. medical schools should be separated from the evaluation of U.S. and foreign medical graduates seeking entry into accredited programs of graduate medical education in this country. Both, however,

if possible, require an acceptable method and process of accreditation of the foreign medical schools. The GAO report identified not only the absence of an effective accrediting mechanism but also the existence of significant deficiencies in the few foreign medical schools it surveyed. With the ultimate goal of having all physicians who are to be licensed to practice medicine in the U.S. meet at least minimally acceptable standards of medical education and training, both the means and process of accreditation of foreign schools and the evaluation of individuals seeking entry into the United States medical educational system should be addressed. The argument has been made repeatedly that students in foreign medical schools, whether U.S. or foreign nationals, are treated differently than students in the U.S. and Canadian medical schools. The fact is that the vast majority of them are different because of the quality of medical education which they have experienced. This is supported by the GAO report.

If an accreditation process could be developed and applied to foreign medical schools that employed the same standards and intensity of scrutiny that are characteristic of the Liaison Committee on Medical Education, a single uniform process of individual evaluation would be appropriate for all students seeking transfer to a U.S. medical school or entry into accredited graduate medical educational programs. Numbers of foreign medical graduates admitted would be determined by immigration quotas for temporary and permanent visas. Lacking, however, any comparable accreditation process that assures an acceptable quality of medical education, more attention must be devoted to the methods of evaluating individual applicants with procedures and standards that reflect the capabilities of U.S. students and medical graduates if the ultimate quality of medical practice is to achieve an acceptable standard.

Since the NBME has no responsibility for and is not involved in any process of institutional accreditation but is exclusively committed to the provision of examinations to evaluate capabilities of medical students and physicians, the following comments are addressed solely to the issue of individual evaluation.

At the present time the NBME has a responsibility for preparing three different examinations designed primarily to evaluate students and graduates of foreign medical schools: the Medical Science Knowledge Profile examination (MSKP), the ECFMG examination, and the Visa Qualifying Examination (VQE). These relate to the transfer of students from one medical school to another or to the entry of graduates of foreign medical schools into programs of graduate medical education in the United States. None of these examinations is a licensing examination. Each is described in the GAO report (pages 50, 152, and 154).

The Medical Science Knowledge Profile examination (MSKP) is sponsored and administered by the Association of American Medical Colleges (AAMC). It is open to any individual who wishes to take the examination and may be required of U.S. citizens in foreign medical schools who desire to transfer with advanced standing to an accredited medical school in the United States. The MSKP examination is designed to assess the knowledge of applicants wishing to transfer into U.S. medical schools who have completed an education in the basic medical sciences and the elements of physical diagnosis, subjects customarily taught in U.S. medical schools during the first two curricular years. Candidates who perform effectively could be considered for transfer with advanced standing to U.S. medical schools. Final decisions concerning the acceptability of candidates for transfer with advanced standing are made by the schools of medicine; performance on the MSKP examination is but one of several qualifications considered.

The ECFMG examination, which consists of items extracted from the NBME's pool of questions, is administered by the Educational Commission for Foreign Medical Graduates. It is provided as a screening examination for entrance into a graduate medical educational program for graduates of foreign medical schools, and, in addition, it is the principal assessment procedure used for U.S. citizens desiring to enter a Fifth Pathway Program. It is also administered to foreign medical graduates who desire ECFMG certification but are not seeking a visa to enter this country. The ECFMG examination assesses both the basic and clinical sciences. The performance of a candidate on the examination is but one of several qualifications considered by the institution to which the candidate is applying.

The Visa Qualifying Examination (VQE), as the name implies, was developed to meet requirements established in federal legislation (PL 94-484) for the issuance of visas to foreign medical graduates. The VQE is accepted as equivalent to the NBME Parts I and II examinations for this stated purpose and is administered by the Educational Commission for Foreign Medical Graduates. Satisfactory performance on an English language test is also required of foreign medical graduates seeking U.S. visas. Successful completion of the VQE is accepted as meeting one of several qualifications required for ECFMG certification which is necessary for entrance into graduate medical programs in the United States.

None of these three examinations is a part of the licensing process in this country. The NBME, as noted earlier, includes in its process of certification to the state medical boards not only successful passage of its Parts I, II, and III examinations but also receipt of an M.D. degree from a school of medicine accredited by the Liaison Committee on Medical Education, whose standards are

universally recognized as exemplary, and completion of one year of accredited graduate medical education. It is axiomatic that the integrity, thoroughness, and completeness of the educational program itself is as important as performance on one or more examinations. The combination of a thorough education in an accredited school of medicine and the evaluation of an individual's capabilities required for the assumption of responsibility for the care of patients provides the public with considerable assurance for the quality of medical practice in this country.

In the absence of an effective method for accrediting foreign medical schools, of necessity, greater reliance has been placed upon evaluation procedures applied to individuals.

The NBME, over the course of seven and one half years, has been developing a Comprehensive Qualifying Examination (CQE) which is well described on pages 51 and 52 of the GAO report, except that a greater emphasis is to be placed upon the integration of the basic medical sciences into the clinical sciences than is noted in the report. The primary purpose of the examination is to evaluate the capabilities of physicians to care for patients under supervision at a time when they are initially entering a graduate setting. As such, it is designed to become a part of the licensing system and at the discretion of the state medical boards may be required of all physicians assuming new responsibilities for the care of patients in a supervised setting. The Federation of State Medical Boards (FSMB) has endorsed the concept of a uniform two-stage licensing examination system entitled FLEX I and II (page 53). With further development of the CQE prototype examination, it is anticipated that it may be adopted to serve as FLEX I. A joint committee of the FSMB and the NBME is now addressing the subject of the FLEX II examination in order to provide coordination and integration of

these two examinations leading to independent licensure. Successful passage of FLEX II, which will address in depth clinical knowledge and skills in the whole field of medicine, will provide, at the discretion of the state medical boards, a license for independent practice.

The CQE (FLEX I) is not being designed to measure educational achievement, but rather the capabilities of physicians to care for patients. In the absence of an adequate accreditation process for foreign medical schools and in the interests of preserving the quality of medical care, it appears desirable and even essential to utilize a screening examination to determine that graduates of foreign medical schools have the background knowledge required to proceed with further education. Such a screening examination would not be directed to an assessment of capabilities to care for patients, which would be encompassed in the CQE, and would not be a part of the licensing process. An examination having the general properties of the Visa Qualifying Examination might be suitable, but additional thought should be devoted to this subject.

An individual successfully passing the screening examination and meeting other qualifications required for entrance into a graduate medical educational setting would then proceed through the educational and licensing processes as would any graduate of a U.S. or Canadian medical school. In short, having determined as well as current technology permits, that a graduate of a foreign medical school - U.S. or foreign citizen - has reached a defined measure of educational achievement required to pursue a program of graduate medical education, the subsequent process of education and licensing would be identical for both U.S. and foreign medical graduates.

A society such as ours is extremely sensitive to avoiding discrimination. In the context of providing medical services to the public, however, the pursuit

of nondiscriminatory actions must be equated with a clear and deliberate goal of high quality medical services. The report of the General Accounting Office demonstrates without equivocation that little is known about the quality of undergraduate medical education in most foreign medical schools and that for those schools which have been surveyed it would not meet the standards required of U.S. and Canadian medical schools. Unless an effective and politically palatable and cost effective process of accreditation of foreign medical schools can be devised, this country is essentially dependent upon the evaluation system applied to individuals to insure a level of acceptable quality for the delivery of medical services. The NBME is committed to the development and use of the most scientific methods available in order to assess the capabilities of an individual for whatever purpose and together with the Federation of State Medical Boards is in the process of developing uniform licensing examinations that at the discretion of the state medical boards may be applied universally to all physicians wishing to practice in the U.S.

William D. Holden, M.D., Chairman
National Board of Medical Examiners

November 17, 1980

Mr. CARTER. Thank you, Dr. Holden, for an excellent presentation.

Dr. Levit?

Dr. LEVIT. I have nothing to say, sir.

Mr. CARTER. I am very pleased to hear you gentlemen speak about this problem that confronts all of us today in this country.

How many U.S. foreign-trained students return to practice medicine by taking only the FLEX examination with no graduate medical education, Dr. Jervey?

Dr. JERVEY. I am not sure I understand your question exactly, but I think what you said was how many students return to this country and take only the FLEX examination for licensure?

Mr. CARTER. Yes, sir.

Dr. JERVEY. I would not want to go on record right now with a definite figure. I would be glad to submit a written answer to that.

Mr. CARTER. I believe there are still three States which do not require graduate medical education as a condition of licensure.

Dr. JERVEY. I don't know the number of students.

Mr. CARTER. Yes, sir, Doctor, do you believe it is desirable for all States to have identical requirements for licensure?

Dr. Casterline?

Dr. CASTERLINE. This question is somewhat beyond the scope of ECFMG Speaking as an individual however, I agree that the educa-

tional requirements for licensure and examinations for cognitive knowledge should be comparable in each of the States.

Mr. CARTER. I am sure you feel the same way, Dr. Holden.

Dr. HOLDEN. Yes. I think the licensing of physicians must be a discriminating process. That is what licensing is all about—to find out who those physicians are who can effectively care for the public in this country. However, it should not be discriminatory. It should be made available to all individuals who meet the eligibility requirements and it should be a single process.

Mr. CARTER. What enforcement procedures do you or other groups use to insure that those who practice medicine are properly licensed?

Dr. JERVEY. Well, the Federation of State Medical Boards represents the licensing boards, and they are empowered under law of the various States to enforce whatever those laws might be in regard to the standards of medical care there. And one of the big deficiencies that has been in existence and well recognized is the lack of resources for some of the boards to carry out provisions of the law.

But certainly I think right now, in this enlightened time, the legislatures of the various States have improved the laws and they have improved the resources to the boards and I think the boards are acting very effectively now. There is certainly room for improvement.

Mr. CARTER. Thank you, Doctor.

What is your reaction, Dr. Holden, to the proposal of the New York Board of Regents to accredit foreign medical schools?

Dr. HOLDEN. I am not thoroughly conversant with all of the details of the proposed program of the regents of the State of New York. However, from what I do understand, I think it would be a very difficult thing to do effectively.

Mr. CARTER. Yes, sir.

Dr. HOLDEN. As I understand it, it does not amount to real accreditation; that is, the process will not be employed in the same context, and with the same standards that are applied to United States and Canadian schools. It will be essentially a questionnaire. Having been a program director for several decades, I recognize that surveyors come around to visit you for 3½ days. At least four people visit a medical school. In the graduate arena surveyors are around for 1 or 2 days. They question all the people involved in the program. I do not think questionnaires can give you the kind of information they elicit.

Mr. CARTER. Thank you.

I thank you very kindly for your answers.

I want to commend the entire panel. I don't know when I have enjoyed hearing a panel any more than I have this one.

Thank you.

The committee will be adjourned.

[The following statements were received for the record:]

COMMENTS BY THE PARENTS AND FRIENDS OF
OF THE AUTONOMOUS UNIVERSITY OF GUADALAJARA, INC.
ON THE
CONTROLLER GENERAL'S REPORT
TO THE CONGRESS ENTITLED
"POLICIES ON U.S. STUDENTS STUDYING
MEDICINE ABROAD NEED REVIEW AND REAPPRAISAL"

Prepared by:

Robert Lane, M.D.	President, New York Parents Association, U.A.G.
Marvin Wertheim, M.D.	Consultant
Gerald Light	Member of the Board of Directors of The Parents and Friends of the U.A.G., Inc.

The Parents and Friends of the Autonomous University of Guadalajara, Inc. is an organization consisting of the parents and friends of the students presently enrolled in the medical school of the Autonomous University of Guadalajara and the Alumni physicians practicing medicine and teaching medicine in the United States. There are currently over 3,000 practicing physician graduates of the Autonomous University of Guadalajara in the United States, 1,850 undergraduate students and about 500 students in the Fifth Pathway or Social Service programs that are represented within The Parents and Friends of the Autonomous University of Guadalajara, Inc.

HISTORY OF THE UNIVERSITY

The Autonomous University of Guadalajara (U.A.G.) was founded in 1935 during a time when the national universities had been radicalized to the left. The University has long been known for its pro-free enterprise outlook and its friendship with the United States. The U.A.G. is a non-profit institution that is

directed by a board of trustees composed of highly respected public-spirited individuals who have no financial interest in the University, its medical school or the affiliated hospitals. There are over 20,000 students at the University from 43 countries studying in the 14 schools of the University in over 50 different career areas. The University is constantly in development and has received loans and grants from the Agency for International Development (AID), The Rockefeller Foundation, The Ford Foundation and others.

When the history, facilities and non-profit status of the U.A.G. are understood, a conclusion can be stated that:

> Any study that groups the U.A.G. with new schools, particularly those established for profit with minimal teaching facilities and faculty or older schools that differ in the basic philosophy of medical education, is in error and does a disservice to the U.A.G., its faculty and students, and the practicing physicians in the United States that were educated at the U.A.G.

As a first attempt at beginning a process of gathering information concerning foreign medical schools for the establishment of future standards of quality control, we both applaud and support this initial step. Certainly the limited period given to respond to the statements and conclusions is inadequate, but we will attempt to provide our comments so they may serve as a further base of information and hopefully provide insight and a balanced approach to this phenomenon being studied.

The schools being reviewed have exceedingly wide ranges of facilities and faculty as well as differences in curriculum and

approach. A careful review of each of the appendices dealing with the schools would lead to the conclusion that there are three different groups: the U.A.G., the two European schools and the three offshore schools. We who are knowledgeable of the Autonomous University of Guadalajara, its faculty, administration, curriculum, students and facilities, believe that most of the criticisms and negative conclusions do not apply in any way to the U.A.G. Further, as stated, we believe that the method used in presenting the conclusions does a gross disservice to the U.A.G. However, if the document is intended to impune all foreign medical schools reviewed, then we suppose the most effective way would to be lump them together, using the weaknesses of some to destroy the credibility of all.

We suggest that it is the presence of 1,850 U.S. citizens at the U.A.G. Medical School which constitutes the major reason for the supposed lack of comparability with U.S. institutions. There seems to be an inability on the part of some segments of the U.S. medical establishment to believe that a modern, sophisticated foreign medical school can successfully prepare U.S. citizens for entry into graduate medical education in the U.S. in this magnitude. We seriously question the motives for the criticism of the medical school of the U.A.G. The setting up of separate standards for licensure of U.S. citizens studying abroad versus U.S. citizens studying at U.S. medical schools is reminiscent of the "separate but equal" educational attitude so prevalent in the United States of two decades ago.

We oppose any attempt by organized medicine, specifically the AAMC, or any governmental body to set up a system which unfairly discriminates against qualified U.S. citizens and attempts to prevent them from taking their rightful place in their chosen career. We applaud the philosophy of the FLEX I and FLEX II approach to the licensing of physicians. We believe that our students should and must be allowed to take the same exams as their U.S. counterparts for the purposes of entering graduate medical education and securing licensure. Any attempt to prevent them from access to these same opportunities must be viewed not only as discriminatory but also as evidence the U.S. medical system is fearful that there may be a different but successful approach to teaching medicine that can produce a medical practitioner more efficiently.

On page 2 of the GAO Report, a statement is made that,

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

We would like to point out that at no time was the U.A.G. made aware that foreign medical schools were being compared to specific U.S. medical schools, and that the guidelines and standards used by the GAO were by nature very general and usually called upon personal opinion rather than hard data. These conclusions concerning comparability as it involves the Autonomous University of Guadalajara may be questioned as very subjective

opinions by a team of individuals consisting of one physician, an economist and an accountant. We sincerely doubt that any recognized approving body would rely on that technique in their accreditation process or in an investigation of foreign medical schools for the purposes of establishing comparisons. The GAO team, made up of two members with strong financial background and only one with medical education experience leads us to suspect that the real purpose of the visit was to substantiate conclusions already reached based upon data provided on student guaranteed loans and VA loans. Further, it could be speculated that the establishment of a data base for the purpose of comparability conclusions was an afterthought brought on by the need to provide sufficient arguments for the cut-off of these loans to the foreign medical students.

The GAO report correctly states that:

> "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 . . . affiliations may be major or limited."

It is known that many teaching hospitals, health service facilities and ambulatory clinics in the U.S. are counted by more than one medical school in calculating the number of available beds. Most "limited institutions," although counted in total in the bed ratio afford teaching exposure for a very limited number of students. It can be correctly concluded that American medical

schools exaggerate their bed/student ratios.

The GAO report then states:

> "None of the foreign schools had access to the range of clinical facilities and numbers and mix of patients as a U.S. school."

We should state that the administration and faculty of the U.A.G. expressed grave concern over the minimal time permitted for the review of our affiliated teaching hospitals. These hospitals represent 10,583 beds available to our students. Only minimal reference was made to the beds available in the United States "which have the range of clinical exposure in numbers and mix of patients" to meet LCME standards.

In conclusion, if a careful review were made of all the facilities available to the U.A.G. and its students, the range of clinical facilities and numbers and mix of patients would be closely comparable to U.S. medical schools.

The inclusion in the report of the recommendations of the GMENAC report leads us to the conclusion that many of the attacks on foreign medical schools are motivated by a desire to set artificial standards of supply of medical manpower in the U.S. rather than relying on a free market philosophy to regulate and control physician manpower and medical costs. We cite a March 13, 1980 article in The Wall Street Journal on the San Francisco-area in

which a supposed oversupply of physicians has caused the leveling off of costs and an improvement of patient/physician contact and relationship, just the opposite of the GMENAC conclusions. The GMENAC report has also come to the attention of the American Bar Association and brings serious questions to mind concerning federal trade rules and regulations. Could it be that the real reason for the UAG's inclusion in the GAO report is because we presently rank 13th in the number of graduates being placed in U.S. residencies, thus competing rather heavily with U.S. medical schools for those same positions? In fact, our graduates are chosen in preference to graduates of a number of LCME accredited medical schools testifying to the comparability of their education.

The following statements will provide, we hope, additional insights into the University's attitudes concerning the conclusions in the report dealing with admissions, faculty, facilities and equipment, curriculum and clinical instruction.

The GAO report states:

"None of the foreign medical schools had (admissions) requirements as stringent as those of U.S. Medical Schools."

A review of the admission policies of the six foreign schools would reveal that only the U.A.G.'s policies closely parallel the standards of admission of U.S. medical schools. So certainly our standards must be considered comparable. If the use of the

word "stringent" means a higher Grade Point Average (GPA) as is a frequent parameter in selecting medical students, then the GAO should be aware that recent studies completed by the University of Missouri Medical Schools concludes that:

> "Those students who were judged by admissions interviewers to have high levels of maturity, non-academic achievement, motivation or rapport were approximately two to three times as likely to receive outstanding internship recommendations as those without such personal characteristics. Undergraduate grade-point average had a smaller but nevertheless significant relationship with clinical success as measured by internship letters. These data suggest that additional emphasis during selection upon applicants' personal characteristics would have enhanced the clinical success of these students."

The report criticized our policy of making admission exceptions on occasions; however, we would point out that the U.S. medical schools do the same. The U.A.G. does not make exceptions, however, for large contributions to an endowment fund, a practice of many U.S. medical schools widely reported by the United States press. Nor does there exist a Deans's discretionary admission appointments at the U.A.G. We also do not discriminate against any minority or majority -- a commonplace occurrence in U.S. medical schools. Certainly the word "stringent" could not measure motivation. There is no recognized way to measure motivation and motivation is one factor accepted by most educators as the prime criterion for student success.

The general statement of page 14 of the GAO report states:

> "During the tour 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."

We would like to point out that all 800 plus faculty vitae at the U.A.G. were made available for the GAO review -- it was the team's decision based on their time restrictions to only look at a limited number. Here is a perfect example of the problem of placing all the schools in a single program. It should be noted that the major thrust of our faculty's time is devoted to teaching. The ratio of faculty to students for the clinical areas is 1 to 5.4. Although on face value this ratio would appear to be significant when compared to a U.S. medical school, we believe the statistics contained in this report with respect to U.S. faculty/student ratios are skewed by including clinical faculty who do little or no teaching and faculty that are primarily involved in research or large private practices. It is a fact that U.S. medical schools frequently appoint attending physicians at affiliated hospitals to faculty positions at no compensation. They perform minimal at best teaching responsibilities but receive the additional prestige for their private practice by such appointments. Again, faculty listed by the UAG are full time educators.

FACILITIES

The GAO report in regard to the facilities states:

> "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."

While the GAO report correctly evaluated the U.A.G. facilities as being "modern and highly sophisticated," the conclusion of the report was written in such a way that all of the schools visited were grouped together, giving the general impression that all had facility deficiencies. It is unfair to compare the U.A.G. facilities with those of the other foreign medical schools visited. When compared to U.S. medical schools, the U.A.G. facilities are at least adequate and in many cases superior and more efficiently utilized.

CURRICULUM

Since the Autonomous University of Guadalajara is a fully accredited medical school under the laws of Mexico, the curriculum and medical education programs must meet minimum standards set by the National Autonomous University of Mexico, and the U.A.G. exceeds, in all categories, their requirements. Changes in curriculum must be approved by the National Autonomous University of Mexico and we believe that there are ample quality control systems presently in operation. Nevertheless, a review of the curriculum would indicate that it closely parallels the U.S. medical schools with few and minor exceptions. We believe that the complete program is comparable.

The GAO report states:

"Clinical training programs differ and most are not comparable to U.S. medical schools."

Probably the one area where the difference in educational philosophies between our University and U.S. medical schools is in the area of clinical instruction. The U.A.G. approach is to prepare the student for the general practice of medicine while the American schools by and large prepare the student for specialty areas of medicine.

It is not surprising to note that in recent years the U.S. has been encouraging more and more of its graduates to enter into the field of family practice. If we look to the future, we can see that the U.A.G. and the U.S. medical schools are on a converging course wherein their philosophy on clinical education will soon coincide. At the present time, the major difference is students of the U.A.G. receive more emphasis on out-patient clinical than do their U.S. counterparts. Greater emphasis is placed on home treatment and preventive medicine as well as the solving of environmental medical problems in Mexico compared to the U.S. Mexico is a developing nation. The poverty levels encompass two-thirds of the population. The vast majority of Mexican citizens do not have any kind of hospitalization insurance and for 80% of the population, there is no such thing as sick leave from their jobs.

The building of vast numbers of hospitals for the purpose of serving the indigent is probably an impossible task. Although a great many technologically advanced hospitals exist, the brunt of the health care system depends upon an out-patient approach. Hospitalization of the vast number of the population seeking medical help is impossible. Expensive and extensive laboratory and diagnostic machine tests are impractical.

It is our belief that the U.S. student at the U.A.G. has a unique opportunity for integrating two types of medical experience. The U.A.G. clinical programs in the U.S. were not completely understood, in our opinion, by the GAO team. Since the students in the Cooperative Medical Education Program (COOP) are entering their fourth year of training, the tendency on the part of the GAO is look upon them as senior/final year medical students. It needs to be clarified that the UAG is a six year medical school and the educational goals of the 7th and 8th (fourth year) semester program are much more modest than assumed in the GAO report. All of the U.A.G. students, whether entering into a Fifth Pathway or "Internado" receive a more in depth experience in the clinical services during their 9th and 10th (fifth year) semester. Medical students at the Autonomous University of Guadalajara begin their patient contact in the very first semester but generally not in the hospital environment. This contact continues throughout the first four years of

medical education. It is important to point out that the pathology of the patients our students see and the seriousness of their illnesses is comparable to the same patients who, in the U.S., would be hospitalized. It is difficult for individuals who lack knowledge of medicine in developing nations to understand or appreciate the teaching possibilities that exist under these circumstances.

Previously, under the COTRANS Program, students transferred from our University with advanced standing into their third year at an American medical school. They then entered into clinical experiences side-by-side with their U.S. counterparts. The GAO report states that U.S. medical schools feel they are able to make up for any "deficiencies" during the next two years training. It is significant that in a report by Barry Stimmel, Associate Dean of Mt. Sinai School of Medicine, appearing in the New England Journal of Medicine that not only did the students coming into the program have higher grades on Part I of the Boards (explained away by their motivation to leave the foreign medical school) but that on Part II of the Boards their scores also exceeded their U.S. counterparts, an accomplishment that was not explained and that has been virtually ignored.

The Cooperative Medical Educational Program is dynamic and is still in the developmental stages. The concept of providing a clinical experience at widely scattered sites is not new. The problem with quality control and supervision is realized, and the U.A.G. is constantly working to improve on that factor.

On the other hand, an article by George Engle, M.D., University of Rochester School of Medicine, featured in JAMA, August 1976, aims criticism at the U.S. medical system and its clinical teaching programs. This article only serves to point out that all medical schools have the same problem. An interesting statement of Dr. Engle's is that after making inquiries of the medical students at more than fifty U.S. medical schools visited he met few who could remember being monitored in the interviewing and physical examination of more than one or two patients. He goes on to say that a surprising number appeared to have been awarded their M.D. degree without ever having been properly supervised in the complete clinical data collecting process of even one patient. We do not pretend to use this as a defense that we should be satisifed with supervision that is less than adequate. However, we would remind the U.S. system that when pointing one finger at a foreign medical school, that three fingers point back at themselves. It is a problem for all of us and we all need to do a better job.

In closing, the U.A.G. and the Parents and Friends of the Autonomous University of Guadalajara, Inc. would like to compliment the GAO on this first step toward solving the dilemma posed by the proliferation of "med schools" seeking only to avoid the accrediting process in the U.S. We concur that standards should be adopted on a state by state basis to protect both the students and the citizenry from possible exploitation by entrepreneurs who seek to capitalize on the dilemma of the qualified applicant unable

to find a place in a U.S. medical school. It must be pointed out again that the U.A.G. is a non-profit, multi-disciplined University offering a complete six year education in medicine. The school has grown over the years through cooperation with the National Autonomous University of Mexico and with universities from around the world. Our student body is drawn from over forty-three different nations, and we have participated in 73 programs with U.S. universities, ranging from business, language, education, architecture, engineering, to law. It is only in medicine and specifically with the AAMC that we have encountered resistence to our repeated requests for cooperation and mutual respect. It is fascinating to us that this one career has become so sacrosanct in the U.S., that the medical schools in the United States are in the forefront of an attack on a sister university across the border. The question must be asked, "What is the motivation? Does the U.S. system seek to create a profession so elite, so restrictive, so guaranteed of financial reward, that numbers of qualified citizens are denied the opportunity to secure an education leading to the practice of medicine. The United States must not become an educational island to the exclusion of different approaches leading to the same goal, quality physicians. Surely it is possible to see through the smoke screen and to recognize that medicine is a profession like many others, demanding the very best from its practitioners but not bestowing any robes of royalty.

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
OF THE
HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE
ON THE DRAFT REPORT BY
THE GENERAL ACCOUNTING OFFICE (GAO)
ENTITLED, POLICIES REGARDING U.S. CITIZENS STUDYING
MEDICINE ABROAD ARE IN NEED OF CAREFUL REVIEW AND REAPPRAISAL
December 19, 1980

The American Hospital Association, which represents over 6,100 hospitals and health care institutions as well as more than 30,000 personal members, is pleased to have this opportunity to provide its comments on the report prepared by the General Accounting Office (GAO) entitled, Policies Regarding U.S. Citizens Studying Medicine Abroad Are In Need of Careful Review and Reappraisal. The final version of the report was issued on November 21, 1980.

The report identifies five major issues that are related directly to United States foreign medical students (USFMSs): (1) foreign medical schools do not offer an education comparable to medical schools in the United States; (2) United States citizens in foreign medical schools often obtain clinical training in hospitals in the United States and the quality of this experience varies; (3) foreign-trained United States citizens can enter the American medical system in four ways, each of which involves different standards and criteria; (4) foreign medical students who are citizens of the United States can obtain direct federal financial assistance from the Department of Education and the Veterans Administration; and (5) United States citizens continue to

study abroad and return to the United States to practice medicine despite the fact that the Congress, the Department of Health and Human Services, and the Graduate Medical Education National Advisory Committee have recommended reductions in the number of physicians being trained in the United States.

We will limit our comments to the first three issues, which are of more direct interest and concern to the hospital industry.

Foreign Medical Schools Do Not Offer Education Comparable to U.S. Schools

As a part of its study, the GAO visited six foreign medical schools, selected primarily because they enroll large numbers of United States citizens. According to the report, none of these schools offered a medical education comparable to that available in the United States because of deficiencies in admission requirements, facilities and equipment, faculty or curriculum; a serious shortcoming at each school was the lack of adequate clinical training facilities. In short, the quality of the educational experience received by students varies considerably, and there is no entity with overall responsibility for evaluating foreign schools.

Medical schools, in the United States, by contrast, must undergo a stringent accreditation process under the auspices of the Liaison Committee on Medical Education (LCME). Guidelines related to curriculum content, program administration, faculty qualifications, and educational facilities are used to ensure that accredited schools meet appropriate national standards of medical education.

In its report, the GAO suggests that a similar accreditation program could be

initiated for foreign schools in order to provide a basis for evaluation of the credentials of their graduates. We do not believe such a program to be a workable solution for two reasons. First, accreditation of foreign schools would be costly in terms of both time and money. Second, it is quite likely that many foreign schools, especially those with international reputations, would not accede to such a program, thus penalizing students who would otherwise be able to enter this country as physicians.

Clinical Training in U.S. Hospitals

Because of the limited clinical training offered by many foreign schools, it is not uncommon for USFMSs to arrange clinical clerkships in hospitals in the United States. Often, however, these hospitals are not teaching institutions, and the type, length, and extent of the training they provide varies. Moreover, hospitals participating in such programs have little assurance that applicants are adequately and properly prepared for the clinical phase of medical education.

Aware of problems encountered by hospitals in the screening of such students and the attendant questions relating to appropriate standards of patient care, the AHA Board of Trustees took an action in May, 1979 which reads, in part:

> "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 to the participant, the hospital, and the public in reviewing such requests before making the institution's facilities and staff available for educational opportunities ...."

In our opinion, mechanisms are needed not only to enable hospitals to assess the qualifications of students applying for clerkship positions, but also to

enable the students to assess the quality of the clinical training offered by individual hospitals. To achieve the former objective, we would suggest that foreign students seeking clinical training in the United States be encouraged to take the Medical Sciences Knowledge Profile (MSKP) examination, which has been designed by the National Board of Medical Examiners (NBME), and which evaluates the student's knowledge and comprehension of the basic sciences curriculum. One way to achieve the latter objective would be to coordinate clinical clerkships for USFMSs through an independent agency such as an Area Health Education Center, which has been authorized under the Public Health Service Act to arrange and support educational opportunities for medical and other students.

Entry into the American Medical System

Aside from clinical clerkships, foreign-trained citizens of the United States can enter the American medical system in four ways: (1) transfer with advanced undergraduate standing to medical schools in the United States; (2) participate in a Fifth Pathway program; (3) enter postgraduate medical education in the United States, or (4) obtain a license to practice medicine from a jurisdiction authorized to license physicians.

All four routes require foreign-trained individuals who pass screening examinations that are designed to measure medical knowledge and proficiency. For example, USFMSs applying for advanced standing in medical schools in the United States must take the Medical Sciences Knowledge Profile exam (prior to 1980 Part I of the National Board Medical Examination was used). Fifth Pathway students are required to pass a screening examination satisfactory to the medical school in the United States sponsoring the program; generally, the test sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG)

is used for this purpose. Foreign-trained applicants to graduate medical education programs in the United States must achieve passing scores on either the ECFMG exam--if they are citizens of the United States--or the Visa Qualifying Examination (VQE)--if they are foreign-nationals. And finally, to obtain unrestricted medical licenses, foreign-trained physicians must achieve passing scores on the Federation Licensing Exam (FLEX), sponsored by the Federation of State Medical Boards.

These requirements for entry into the various stages of medical practice for foreign-trained physicians vary considerably from those for individuals educated in the United States. Medical students in the United States take Part I of the National Board Exam after their basic sciences education, Part II at the completion of medical school, and Part III after having obtained at least six months of graduate medical education. An individual who has achieved satisfactory scores on all three parts of the exam is eligible for medical licensure by certification.

In the opinion of the American Hospital Association, such fragmentation in the application of educational and licensure standards is neither desirable nor acceptable; rather, it promotes dual standards of medical practice. Moreover, it is generally believed that foreign medical graduates in the United States must meet the least stringent requirements, thus indirectly encouraging citizens of the United States to enroll in foreign schools. Although this country cannot and should not prohibit its citizens from studying abroad, it has no obligation to facilitate entry into practice for those who do study abroad by maintaining less stringent requirements for their admission to graduate medical education programs in the United States or for medical licensure.

We propose that all physicians--whether trained in the United States or foreign-trained--be required to meet the same high standards for entry into the practice of medicine. For example, the MSKP exam should be administered to medical students in the United States in lieu of Part I of the NBME, as well as to foreign students applying for advanced standing in United States schools or for Fifth Pathway programs. Moreover, a new examination currently being developed by the NBME, the Comprehensive Qualifying Examination (CQE), which is designed to assess the performance characteristics necessary to provide patient care under supervision, should be a prerequisite for entry into a graduate medical education program for United States medical graduates, foreign medical graduates in the United States, and alien foreign medical graduates, thus eliminating the need to use the ECFMG, and the VQE examinations for this purpose. And finally, we support a proposal made last year by the Federation of State Medical Boards for adoption of a new uniform licensing procedure that calls for two separate licensing exams--the FLEX I and FLEX II--and two categories of licensure--a restricted and an unrestricted status. The FLEX I, which could employ the CQE, would be administered prior to entry into graduate medical education as a prerequisite for a restricted license; FLEX II, an assessment of the skills needed for independent medical practice, would be administered after a predetermined period of graduate medical education in order to obtain an unrestricted license.

We are not, however, advocating a program of national medical licensure; occupational licensure is a function of the individual states. It is our intention that each of the 54 licensing jurisdictions in the United States would still have the prerogative of adding more stringent criteria if they so desire.

We wish to call to the Subcommittee's attention one further issue that is not

addressed in the GAO report. Many of our urban hospitals are unable to attract interested American physicians to their settings, and must rely on foreign physicians to provide primary care and specialty services to inner city residents. If these hospitals are to continue to provide such care, Congress must, during the transitional phase, continue to authorize the "substantial disruption" waiver. For the longer term however, other health service programs, such as the National Health Service Corps, must be expanded in order to enable these urban hospitals to fill housestaff positions that are left vacant as the number of FMGs declines.

Conclusion

We appreciate this opportunity to present our views on the draft GAO report and look forward to working with Congress, governmental agencies, and other private organizations in efforts to address these issues. We would be pleased to provide any additional information that the members of this Subcommittee may require.

[Whereupon, at 3:25 p.m. the hearing was adjourned.]

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