

The Origin and Future of Offshore Medical Schools in the Caribbean

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ABSTRACT

The Flexner Report of 1910 concluded that there were too many medical schools in the United States of America (USA). In the wake of this conclusion, Flexner recommended higher admission and graduation standards for medical schools, the expected impact being fewer medical schools and graduates. One unintended consequence of this recommendation was a male-only policy by some universities to accommodate the smaller numbers of males.

There were privately owned medical schools, unaffiliated to any college or universities which were run primarily for profit. Degrees were usually obtained after only two years of study and laboratory and dissection exercises were not part of the training.

The adoption of Flexner's recommendation resulted in medical education becoming more expensive; it also created opportunities for persons without the financial means or the matriculation requirements to find alternative training programmes among those "medical schools" which did not adopt Flexner's recommendations.

This paper traces the further development of these "medical schools" to facilitate the need for more doctors in the context of global maldistribution of doctors which has resulted in many medically underserved areas, more so in developing countries (1).

Keywords: Caribbean, offshore, medical school

Origen y Futuro de las Escuelas de Medicina Offshore en el Caribe

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RESUMEN

El Reporte Flexner de 1910 concluyó que había demasiadas escuelas de medicina en los Estados Unidos de América (EE.UU.). Luego de esta conclusión, Flexner recomendó elevar los estándares para el ingreso y la graduación en las escuelas de medicina, esperando que el impacto fuera menos escuelas de medicina y menos graduados. Una consecuencia imprevista de esta recomendación fue una política de permitir sólo a varones por parte de algunas universidades, y a la vez dar ingreso a un menor número de estudiantes varones. Hubo escuelas de medicina privadas – sin afiliación a ninguna facultad o universidad – organizadas fundamentalmente para con fines lucrativos. Por lo general los títulos se obtenían después de sólo dos años de estudio, sin que las prácticas de laboratorio, y los ejercicios de disección fueran parte del entrenamiento. La adopción de la recomendación de Flexner trajo como resultado que la educación médica se hiciera más costosa. Por otra parte, también creó oportunidades para que las personas sin recursos financieros o sin los requisitos para matricularse, encontraran programas alternativos de entrenamiento en las "escuelas médicas" que no adoptaron las recomendaciones de Flexner. El presente trabajo examina el desarrollo ulterior seguido por estas "escuelas médicas" para hacer frente a la necesidad de más doctores en el contexto de la mala distribución global de doctores, que ha traído consigo la existencia de muchas áreas de insuficiente servicios médicos, particularmente en los países en desarrollo (1).

Palabras claves: Caribe, offshore, escuela de medicina

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INTRODUCTION

The primary purpose for establishing medical schools is to increase the number of physicians. There must, however, be a context to the training of physicians to avoid the exercise being an end in itself. Following the Flexner Report of 1910 (1) and some of the unintended consequences, *viz*, persons and “medical schools” unable/unwilling to accept Flexner’s recommended standards for admission and graduation, there was an unmet demand for medical training which created a “space” for this other “level” of training which was also less expensive by nature of their omission of what Flexner deemed mandatory, *eg* dissections and an appreciation for laboratory testing as a critical support service for clinical medicine.

The World Health Organization (WHO) recognized that need to “evolve systems of education different from the traditional ones” (2). The WHO Study Group of 1975 (3), in considering their terms of reference, considered the importance of medical training being “fit for purpose” *ie*, to contribute to the solution of national health problems through exposure to the “wider concept of centres for health sciences” and as a forerunner of the Alma-Ata Declaration in 1978 (4), as part of a health development strategy.

The Group thus advanced the following as some of the reasons for establishing medical schools:

- To increase the number of physicians
- To train doctors in the local environment
- To create a merger of an integrated system of comprehensive healthcare for the entire population with academic responsibility for medical education
- To provide a focus for the development and maintenance of high professional standards

This formula, it was felt, will define the goals of the institution and the functions it will perform. Graduates from such an institution will be able to contribute to better health coverage to meet the community health needs and demands.

More recently, the General Medical Council (GMC) of Britain issued an important documentation in 1993 which promoted high standards of medical education and its coordination of all its stages (5). An appreciation of public health was cited as being important in the medical undergraduate curriculum, particularly so, for general practice and community care.

In terms of accreditation, medical schools are assessed particularly in terms of:

- The institutional objectives.
- The quality and quantity of research undertaken.
- Opportunities for staff training.
- The medical schools’ development committees which should be concerned with the development of buildings and equipment, budgetary and financial matters and relationships with other institutions.
- Curriculum development.
- Evaluation of the educational programme in terms of an internal audit of the effectiveness of its pro-

grammes, the teaching staff and the courses offered – these activities being coordinated by a resource/learning/educational unit.

Standards are used as a means for providing assurance that graduates meet comparable standards with fellow graduates from other accredited medical schools. To ensure the achievement of these standards, the above-mentioned parameters must be constantly reviewed to ensure that the dynamic nature of all the environments of the young graduate practice are reflected with particular reference to the WHO’s definition of health and the bio-psychosocial model of health and well-being.

This approach to accreditation endorses the three purposes espoused by Abrahamson (6) for medical education, *viz*:

- To prepare students for the practise of medicine in a particular society.
- To enable graduates to help to solve the health problems of individuals in a particular society.
- To ensure that the objectives of medical education were directly responsive to the health needs of a society, and in accordance with scientific methods and principles.

International standards apply to Abrahamson’s three purposes in so far that all programmes of medical education should be built on a solid scientific foundation but should also reflect national standards (6). There is a contention that programmes which have to conform to “international standards” are unlikely to be relevant to people’s health needs, health policies and priorities, whereas national/regional standards have a better chance of being more responsive to educational innovation and change (7).

THE AMERICAN PHYSICIAN POPULATION POST WORLD WAR II

The marked growth in the American hospital-based system at the end of World War II created employment and training opportunities for foreign medical graduates. The Information and Educational Exchange Act of 1948 gave foreign physicians the means through which they could come to the United States of America (USA) for training (8).

The Educational Commission for Foreign Medical Graduates (ECFMG) was established in 1956 to promote quality healthcare for the public by certifying international medical graduates. The recognition of the need for more primary care physicians in the midst of an over-abundance of specialists influenced a decision in the 1960s to improve education and research in family medicine, this being seen as an opportunity to focus training on the health problems of the community rather than on serious illness requiring hospital-based care (9).

The adoption of Flexner’s recommendations resulted in the closure of medical schools which did not meet the accreditation standards. As a consequence, the shift towards training more family physicians was limited by the reduction in

the number of undergraduate training opportunities to meet the demand for the targeted number of physicians to achieve this transition from costly hospital care to “training family physicians as specialists in people rather than disease”(9).

Why does the USA need so many foreign doctors? Lack of places and funding have resulted in medical schools turning away many applicants; this situation can only be rectified by a massive medical school building programme to accommodate areas where there is an identified shortage, *eg* family physicians, and also to service the demand for health-workers in the context of health insurance reform (10). The Association of American Medical Colleges (AAMC) Centre for Workforce Studies Report (2005) by Jordon T Cohen predicted that America will face a shortage of doctors by 2020. He drew this conclusion on the evidence that the population was rapidly growing; there was an increasing number of the elderly, an ageing physician workforce, and a rising demand for healthcare. Based on this Report and the assumption that it can take up to 14 years from the time new doctors begin their education until they enter practice, the AAMC recommended a 30% increase in US medical schools enrolment by 2015 – this, hopefully, will provide an additional 5000 new doctors annually. This targeted output will require the establishment of new medical schools to complement the existing ones.

Figures obtained from an AAMC US Census Bureau prepared by the Centre for Workforce Studies (AAMC 2006) revealed that medical students’ enrolment per 100 000 population has been declining since 1980 – from 7.3 to 5.6 in 2005. If corrective measures were not taken immediately, the trend-line suggests that this rate will decline further to 5.0 by 2020.

The Organization for Economic Cooperation and Development ranks the USA at 13th position globally with 364 doctors per 100 000 people. Dr Ward Dean in an article which addressed the issue of solving the medical care crisis (11) proposed a free market approach wherein more graduates can be produced by building more schools and letting the system weed out those who cannot complete the curriculum or pass the licensing examination.

American offshore medical schools have taken up this challenge and at present there are many such schools. A recent survey found that approximately 20% of the physicians practising in the USA are international medical graduates, and Caribbean medical schools are now a favourite choice for US students seeking medical training (12).

Caribbean schools are less expensive than most US medical schools, their GPA and MCAT scores are lower and they have three application periods per year. These present advantages are countered by the fact that not all of these schools are accredited. Four US states: California, Florida, New Jersey and New York do not accredit most Caribbean medical schools. The clinical component of these schools curriculum is also a limiting factor in comparison to the options available to a student at a US medical school.

Since clinical rotations are considered more important than any other aspect of medical education, the wide variation in placements for these rotations among students attending Caribbean medical schools places them at a decided disadvantage.

MEDICAL SCHOOLS IN THE CARIBBEAN

These are usually four or six years teaching institutions. Offshore American medical schools in the Caribbean generally train American and/or Canadian students to be licensed to practise in the USA or Canada. The administrative offices of offshore American medical schools are located in the USA.

American and Canadian medical schools are accredited by the Liaison Committee on Medical Education (LCME) whereas offshore American medical schools accrediting bodies such as those in the Caribbean may be accredited by a variety of other internationally based non-profit accreditation bodies such as the Accreditation Commission on Colleges of Medicine. Unlike hospitals, there is no global body to accredit international medical schools; instead there are many independent accrediting bodies that may accredit the schools of one or several countries. Though WHO and the International Medical Education Directory (IMED) catalogue medical schools around the world, neither agency has authority to grant any form of recognition.

The current list of all Caribbean medical schools contains schools in the English, Spanish and Dutch-speaking islands, totalling 60 at last count (13). There has been substantial growth in the options for medical undergraduate training for Americans who are unwilling or unable to accept/access opportunities in the USA.

The American offshore medical schools in the Caribbean have grown in numbers since the late 1960s to early 1970s. While there is a projected need for more physicians in the USA than are being trained locally, there is a concern among the regulators of the profession in the USA about the level of competence that these offshore graduates are achieving in terms of their abilities to meet the requirements for local registration. The matter of accreditation is a key issue in that regard, and potential attendees are being strongly advised to ensure due diligence to establish the standing of particular offshore medical schools and their accreditation status.

The idea of surplus physician is strongly eschewed in the context of the free market approach and the demand/supply equation. Institutions and graduates who do not meet the requirements for registration and licensing will be excluded from the formal system. The global market, it seems, guarantees jobs for properly qualified physicians so there is no thought at present of limiting the training of medical undergraduates, only a concern for standards.

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