Implications of off-shore medical schools in the Commonwealth Caribbean

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INTRODUCTION

The subject of planning of medical schools has attracted the attention of all those concerned with the training of medical personnel. In this, as in many other fields of health, the World Health Organization has provided valuable leadership through its Expert Committees. Partly as a result of their deliberations, a general consensus prevails among medical educators that medical education must be relevant to the needs of the society it is intended to serve. Moreover, the important factors of health profile, structure of health services, and methods of health care delivery must be applied in determining the broad goals of the education program. The modern medical school can no longer operate in isolation, but should be geared to the closest collaboration with the Government in its practical researches; such collaboration would provide the information needed to define policies for continuous improvement of the health services of the country (1).

While it was once assumed that sooner or later every country, with the possible exception of very small ones, should develop its own medical school, the value of cooperative and regional planning has been recognized as a rational and practical approach to meeting the requirements of medical education in a number of geopolitical situations.

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Even under such circumstances the commonly accepted, valid reason for a decision to plan and establish a new medical school is to train an increasing number of physicians from the local community, as a complement to the number and types of health personnel required to staff and implement the national health plan. Other considerations may include the introduction of new ideas and patterns in medical education; provision of a focus for the development and maintenance of high professional standards; social pressures resulting from an excess of eligible students wishing to study medicine; and, alas, political influence related to prestige (2).

On the other hand, a number of situations are also recognized in which the development of a medical school exclusively for physician training would be considered unreasonable and inadvisable. These include adequacy of existing training facilities for the physicians required for service; evidence of prospects for the establishment of an integrated center for health sciences in preference to a traditional medical school; inability of the national economy to support the recurrent expenditure; inability to absorb effectively the additional number of physicians produced; and possibility of adequate extension of health care coverage to a predetermined level through the services of other categories of personnel (2).

Despite these considerations, a new phenomenon has recently been and is being experienced in the Commonwealth Caribbean: diverse groups of entrepreneurs are approaching the Governments with plans to establish medical schools primarily for the benefit of students from the United States of America who have been unsuccessful in securing entrance to a medical institution in that country (3, 4). Some of these proposals for off-shore medical schools are presented with varying degrees of allure for the prospective host country. Notwithstanding, the Conference of Ministers Responsible for Health in the Caribbean, having been informed at its Third Meeting (St. Kitts, June 1977) of the establishment of a new medical school in the area, proposed that individual Governments examine the implications of this new development and requested that all relevant information be presented at the subsequent meeting (5). It is considered to be of interest to the area to review the entire subject of off-shore medical schools in detail; to study the original background for their rationale; and to analyze the reasons for the recent increase in interest in such enterprises as well as the implications for a host country.
THE AMERICAN BACKGROUND

Historically, small numbers of Americans have chosen to study medicine in foreign countries, particularly in Western Europe. Gradually, however, competition for admission to medical schools in the United States has so intensified that 45,000 applicants for the 16,000 places available annually is not uncommon. Increasing numbers of these students have therefore sought training in countries such as Italy, Belgium, Spain, France, and Switzerland. But pressures of overcrowding in medical schools in Western Europe and the demands of national medical services there have resulted in the introduction of restrictions on the admission of American students, who have therefore sought openings further afield—including Eastern Europe. With improved relations between the United States and Rumania, the number of American students enrolled in 1977 at Bucharest and Cluj has grown to 86 (6). They have also recurred to medical schools outside of Europe, in the Philippines and Mexico; in the latter country, for example, the Autonomous University of Guadalajara has an enrollment of over 1,000 Americans.

For the estimated 6,000 American medical students in foreign schools, several methods have been open for entry into the general professional stream at home. For those completing their training abroad, the examination of the Educational Council for Foreign Medical Graduates (ECFMG) was designed, success at which is required to enter a graduate program. For others attending schools such as Guadalajara, where a one-year period of social service—usually in rural areas—is a compulsory prerequisite for award of the medical diploma, the device was instituted in 1971 whereby a student completing the full academic training abroad and successfully undergoing a one-year supervised clinical training at a mainland medical institution graduated with an M.D. from that school and was eligible for entry into the first year of an approved graduate training program.2

More recently, however, an increasing number of foreign medical students from the United States (US FMS's) have been failing to complete their training abroad for a variety of reasons, including

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2 Approved by the Liaison Committee on Graduate Medical Education (LCGME).
language difficulties and problems of readjustment, that have contributed to attrition rates as high as 80 per cent in the first year. As a result, in 1970 the medical education establishment devised the Coordinated Transfer Application System (COTRANS) to facilitate educational repatriation to medical schools. Administered by the Association of American Medical Colleges (AAMC), in cooperation with the American Board of Medical Examiners, COTRANS determines the eligibility of students to take the first part of the national examination, sponsors it, and makes the test scores available to interested medical schools. On completion of the first two years of basic medical sciences abroad, a successful candidate may be accepted into a medical school in the United States to pursue the two clinical years and graduate. In 1975, 644 students took the examination, 377 were successful, and 243 were admitted; the corresponding figures for 1976 were 872, 459, and 373. Thus, over the two-year period, 55.8 per cent of COTRANS students passed the qualifying examination, and 40.6 per cent secured admission to continue their medical education in the United States (7).

In this context, the Health Professions Educational Assistance Act of 1976, commonly referred to as the Health Manpower Act, was enacted on 12 October of that year by the Congress of the United States as Public Law 94-484.

In respect to US FMS's, this Act required that each school of medicine, in order to continue to benefit from the health professions capitation grant program for the three academic years starting 1 October 1977, reserve a number of positions apportioned by the Secretary of the Department of Health, Education, and Welfare (HEW) to meet the needs of students who have been identified on 15 August of each of the three years. The criteria for student eligibility for identification were:

- Possession of U.S. citizenship prior to October 1976;
- Enrollment prior to 12 October 1976 in a full course of study leading to a degree of doctor of medicine or its equivalent in a school of medicine located outside of the United States of America;
- Acceptance of the diploma or degree by the host country as one of the prerequisites or necessary qualifications for licensure to practice medicine as a physician in that country;
- Successful completion of at least two years in the foreign medical school and eligibility for entrance into a full-time course of study as a
student in a class for which only third-year students are qualified in the same institution;

- Successful completion of the first part of the National Board of Medical Examiners' examination by the date of the application for identification by the Secretary.

The Act empowered the Secretary of HEW to determine the number of positions adequate to meet the needs of the students described and to apportion the positions (not the individual students) equitably among the medical schools (8).

This provision generated strong reactions in the academic sector of the United States, and, although some safeguards were inscribed for the schools in the enrollment of identified students, a number of them strongly expressed their preparedness to forego capitation grants, rather than forfeit their prerogatives in determining admission criteria. As a compromise, an amendment was passed in the House of Representatives that reduced the operational period of the provision from three to two years, mandated the medical schools to expand third year enrollment by 5 per cent in the first and by 6 per cent in the second year, but permitted the schools to retain their individual admissions criteria. Later in 1977, the Senate passed its own amendment, which eliminated entirely the original provision requiring medical schools to admit foreign-trained medical students born in the United States who had passed the first part of the National Board Examination (9). Subsequently, in December 1977, a joint House-Senate compromise amendment was signed into law that limited the provision to a 5 per cent increase in enrollment and for one year only (10). There are expectations that this will be accepted by the medical schools; however, for the 115 schools involved only a total of 1,000 (±200) additional third-year positions will be created (11).

There are indications that the legislative maneuverings will continue, thus leaving the future of the students described still uncertain.

Brief reference should be made in this review of the American situation as it affects US FMS's to the case of the full graduate returning home, classified by the American Medical Association and other medical institutions as a foreign medical graduate (FMG).

In the early 1960's a shortage of physicians, particularly in rural areas, the inner city, and in the primary care specialities, was widely publicized, while foreign nationals trained in medical schools abroad were filling an increasing percentage of hospital posts in the United
States. It was therefore argued that this unfavorable balance could be readily redressed by facilitating the return of both the citizen qualified abroad as well as the US FMS. In the 1970's, however, warnings were being voiced of a rapid change in the situation; indeed, the declaration of policy at the beginning of the Health Manpower Act of 1976 identified physicians as no longer constituting a profession in shortage (12). Limitations were therefore introduced in the granting of preferential status to alien physicians seeking entry to the country under the immigration laws. At the same time, the national education authorities are gradually raising the standards of both the first part of the National Board Examination and of the ECFMG (13). Success at the latter examination has hitherto qualified candidates only for entry into a graduate medical training program, not for licensure. In the near future, the Liaison Committee on Graduate Medical Education (LCGME) will replace the ECFMG with the more rigorous Visa Qualifying Examination (VQE) for all FMG’s—including citizens of the United States (11).

Eligibility to take either of these two examinations requires that the diploma or degree of the foreign medical school attended by a citizen of the United States be accepted for purposes of registration and licensure to practice medicine in the country from which it is issued. Receipt by WHO of official advice from any country that such a medical school is operating within its territory will automatically result in its inscription in the WHO World Directory of Medical Schools, and this is frequently misrepresented as signifying recognition by WHO.

THE CARIBBEAN SCENE

In the Caribbean area, a vast number of medical schools have been established during recent years, ostensibly to cater to this American market: 35 in Mexico, eight in Colombia, five in the Dominican Republic, two in Puerto Rico, and one in Grenada (14). Because it is known that other countries in the Commonwealth Caribbean have been and are being approached with schemes for establishing additional off-shore medical schools, it was considered of value to compile and disseminate information available on this subject.
A BAHAMIAN CASE STUDY

In the period from 1975-1977, eight proposals for the establishment of an off-shore medical school were made to the Government of the Bahamas. They ranged from a 40-word telegram to verbal and documented plans of varying degrees of elaboration, as summarized in Table 1.

With one exception, all the proposals emanated from the United States; none of the latter demonstrated previous knowledge of the type or quality of clinical facilities existing in the country. One proposal designated Freeport—where there are only 55 hospital beds—as a possible venue. Four specifically mentioned tuition fees as the sole source of financing; three indicated private sources only; and one made no reference to this subject. For physical accommodation, four of the proposals included some reference to plans for teaching facilities; one offered to pay for the use of clinical facilities; one projected the building of a limited number of residential units; another specifically excluded any intention of providing for the students; yet another merely inquired incidentally whether there was a building which could possibly accommodate the proposed school. Only three made mention of equipment; one envisaged a substantial sum for purchases; another foresaw minimal government outlay for the purchase of second-hand supplies at low cost. Five of the projects related to traditional schools of medicine, one intended a school for health sciences from the outset, another proposed subsequent development into such a facility, and one included a phase for promoting postgraduate training. Only one offered film prospects of affiliation to an established medical faculty, but inquiries to the institutions or individuals named failed to substantiate the claim.

While one group identified nationals at home and abroad as the source of faculty members, two others referred to American professors, and a third to a mixture of American and British teaching staff; three made reference to an undefined collaboration of local medical practitioners.

The student body of six of the proposals was to be comprised of surplus Americans, either wholly or largely; one of these also mentioned British, European, and South American students. The other two, of American origin, did not specify the source of students. Three offered scholarships, one suggested the possibility of such awards, and another
Table 1. Data supplied in eight proposals for the establishment of an off-shore medical school in the Bahamas, 1975-1977.

<table>
<thead>
<tr>
<th>Data</th>
<th>Proposal No.</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tr>
<td>Proposer's knowledge of local clinical facilities</td>
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<td>Nil</td>
<td>Nil</td>
<td>Yes</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
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<tr>
<td>Type of institution</td>
<td>SHS</td>
<td>MS</td>
<td>MS</td>
<td>MS</td>
<td>MS</td>
<td>MS:SHS</td>
<td>MS</td>
<td>University</td>
<td></td>
</tr>
<tr>
<td>Affiliation with other university</td>
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<td>ND</td>
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<td>ND</td>
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<td>Yes</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
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<td>Yes</td>
<td>Private</td>
<td>ND</td>
<td>Private</td>
<td>ND</td>
<td>Tuition fees</td>
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<td>Payment for local facilities</td>
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<td>ND</td>
<td>Yes</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>Yes</td>
<td>ND</td>
<td>ND</td>
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<td>Physical plant – academic residential</td>
<td>ND</td>
<td>ND</td>
<td>Lease</td>
<td>Buy</td>
<td>ND</td>
<td>ND</td>
<td>Open Mkt.</td>
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<td>Build</td>
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<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
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<td>ND</td>
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<tr>
<td>Faculty—main corps</td>
<td>US</td>
<td>ND</td>
<td>ND</td>
<td>Yes</td>
<td>ND</td>
<td>Bahamian</td>
<td>ND</td>
<td>UK:US</td>
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<tr>
<td>Local participation</td>
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<td>ND</td>
<td>ND</td>
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<td>ND</td>
<td>Bahamian</td>
<td>ND</td>
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<td>Yes</td>
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<tr>
<td>Course duration (years)</td>
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<td>4</td>
<td>ND</td>
<td>ND</td>
<td>5</td>
<td>ND</td>
<td>2.6</td>
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<td>Semesters (per annum)</td>
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<td>ND</td>
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<td>ND</td>
<td>ND</td>
<td>2</td>
<td>ND</td>
<td>3</td>
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<td>Clinical: years</td>
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<td>2</td>
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<td>ND</td>
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<td>ND</td>
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<td>ND</td>
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<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
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<td>ND</td>
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<td>Students—Origin</td>
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<td>ND</td>
<td>US 70%</td>
<td>US</td>
<td>ND</td>
<td>US 60-200</td>
<td>ND</td>
<td>600</td>
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<tr>
<td>Annual intake</td>
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<td>300</td>
<td>400</td>
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<td>ND</td>
<td>800</td>
<td>ND</td>
<td>1,800</td>
<td>ND</td>
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<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>800</td>
<td>ND</td>
<td>1,800</td>
<td>ND</td>
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<td>Yes</td>
<td>ND</td>
<td>NA</td>
<td>Modified</td>
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<td></td>
</tr>
<tr>
<td>Tuition (Per annum)</td>
<td>US scale</td>
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<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>$4,500</td>
<td>ND</td>
<td>$7,500</td>
<td>ND</td>
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<tr>
<td>Degree</td>
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<td>ND</td>
<td>WHO recog.</td>
<td>WHO recog.</td>
<td>ND</td>
<td>Govt. recog.</td>
<td>WHO recog.</td>
<td>WHO recog.</td>
<td></td>
</tr>
<tr>
<td>Government participation</td>
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<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>Owner</td>
<td>ND</td>
<td>Nil</td>
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</tr>
</tbody>
</table>

ND — No details supplied.
SHS—School of health sciences.
MS—Medical school (traditional).
NA—Not applicable.
mentioned reduced tuition fees for Bahamian nationals. In the five proposals that gave details on annual student intake, these varied from an initial 60 for the first year or two to 600, with student build-up varying from 600 to 1,800. Only three proposals mentioned the level of fees: one quoted $7,500 for a three-semester year; the second $4,500; and the third "US scale" for two-semester years.

Two projects based course duration on four two-semester years, one on a little over two and one-half three-semester years, and another on five two-semester years. Except for this last, which was to be patterned after the British-type curriculum, the other three were fashioned on four semesters devoted to the basic medical sciences and four to clinical studies. As venue for the latter, four projects envisaged the United States either for all or the majority of students, with passing reference to the Bahamas by three of them; one made mention of rural areas for part of the clinical experience. The eighth project, with 600 entrants annually, guaranteed placement of all students in the United States for the period of clinical studies.

Six of the eight projects made reference to the degree to be awarded. The sixth, which planned a Government-owned institution, envisaged a Government degree; one mentioned a Government-recognized degree; four others a WHO-recognized degree.

Full Government participation was foreseen only in the sixth proposal. Another conceded Government representation on the governing body of the institution to help ensure that the educational and clinical policies were in step with national interest. A third frankly excluded any such participation, while five others made no reference to the subject.

TRAINING OF MEDICAL MANPOWER NEEDS FOR THE COMMONWEALTH CARIBBEAN

One of the most important developments in the English-speaking Caribbean has been the establishment of the medical faculty of the University of the West Indies (UWI), which has largely assumed responsibility for the education and training of the medical manpower needs of the area. At the Mona campus in Jamaica, the annual student intake started at 31 and gradually increased to 110. In 1971, a study on the feasibility of extension and/or duplication of the faculty
recommended that the medical faculty of UWI should consist of two medical centers, one based in Jamaica and the other in Trinidad and Tobago (15). This proposal was generally accepted. Plans are underway to establish the latter campus at Mount Hope.

These plans have necessitated a review of the estimated number of medical practitioners required for Trinidad and Tobago and the eastern Caribbean in order to determine the center's annual student intake. Consideration has been given to the target of a doctor: population ratio of 1:2,000 recommended for the area in 1971 (15). This has been affected, in turn, by the drastic reduction in prospects for emigration of West Indian physicians to the United States and Canada, imposed by increasingly exclusive legislation in those countries as well as by the changing pattern in methods of health care delivery in the area—particularly the trend in utilizing nurse practitioners, health auxiliaries, and other nonmedical personnel in primary care. As a result, it is already envisaged that the originally planned annual intake of 110 medical students at Mount Hope should be reduced substantially to avoid overproduction of trained physicians. The actual number to be admitted annually has yet to be decided. The potential does exist, however, for the English-speaking Caribbean to develop at the Mona and Mount Hope medical facilities the full capacity necessary for the education and training of its medical manpower requirements—all within the framework of its own centers of learning. Any additional facility established in the area would be superfluous to those needs.

DISCUSSION

The eight promoters who approached the Government of the Bahamas emphasized the advantages of its proximity to mainland United States, its English language culture, its climate, and the importance of tourism to its economy—i.e., the contribution to the development of tourism by the expenditures of students and their periodic visitors. None of them, however, had had previous experience in the establishment or operation of a medical school. None had any notion of the medical problems, facilities, or practices of the country. None presented a comprehensive scheme for study. At least one was found to have presented inaccurate information in respect to prospects of affiliation with first-line universities in the United King-
dom and its sponsorship by the American Medical Association. Four did mention placement of students for clinical studies in the United States, but obviously exaggerated their effectiveness in that regard. None of them demonstrated an understanding of the medical student transfer situation as it exists today. It is doubtful that any promoter as ill-equipped in any other industry would have received a hearing at any important governmental level.

Since the offer of scholarships or other assistance to national students featured in a number of the proposals, the form and content of the corresponding training program should be a matter of serious concern to the host country. The Faculty of Medicine of UWI has been criticized for alleged failure to produce a medical graduate capable of delivering the type of health care best suited to the local environment and its community (16). Partly as a result of this, but partly because UWI also recognizes its role in a system designed to improve the quality of life of the Caribbean people, the faculty has made laudable efforts to modify its medical education program to reflect the importance of primary care and to make its training program generally reflect the health needs of the people (17). In the light of this situation, the curriculum of an off-shore medical school must be considered far removed from West Indian reality, based as it is on four semesters (60-64 weeks) of basic medical sciences and four of clinical studies—the latter to be undertaken in the very limited hospital facilities of one of the less developed countries or in the ultra-modern setting of a hospital in the United States.

It is in that context that the Bahamas Medical Council decided in November 1977 not to accept for registration the graduates of off-shore medical schools of the type described unless the school were established as an affiliate in the first instance of the medical faculty of a reputable university (18). It is evident, however, that any university in the United States wishing to expand its medical teaching facilities would opt to do so within its national territory and not on foreign soil. The practical implications of the decision of the Bahamas Medical Council is that the Government would be unable to advise WHO that graduates of a medical school of dubious standards in the Bahamas would be acceptable for registration to practice in the country. Such a school would therefore fail to be inscribed in the WHO World Directory of Medical Schools and this would automatically eliminate the interest of the entrepreneurs in establishing a school in the country.
Two important factors contribute to the eagerness of promoters in establishing off-shore medical schools: first, the high capital costs of building, equipping, and operating an acceptable training institution in the United States; second, the difficulties in securing accreditation by the American Medical Association. It must be realized, however, that the United States has the capability for dealing with its medical manpower and educational problems. A number of plans are underway and under study for increasing the number of undergraduate training environments that would not involve the high costs of building new medical schools. The Indiana-type teaching plan, for example, mobilizes existing nonmedical school facilities for preclinical subjects and suburban and county hospitals for clinical work under the auspices of the Indiana Medical School (7).

Under these circumstances it may well be asked what legitimate role can be identified for the countries of the Commonwealth Caribbean to participate in an industry of doubtful sponsorship ostensibly aimed at meeting an American need which legislators and educational authorities in the United States do not recognize. In considering this matter, participants at a PAHO-sponsored meeting on basic principles for the development of medical education in Latin America and the Caribbean area expressed "concern over the emergence in Latin America of training institutions of a profit-making type, where physicians are trained for developed countries" (19). It is suggested that for the Commonwealth Caribbean that concern should be translated into a decision by the Conference of Ministers Responsible for Health to discourage and arrest that trend.

In this, the Commonwealth Caribbean Medical Council has already taken a stand at its November 1977 biennial meeting by expressing in its press release "concern over the setting up of medical schools in the region without the support of relevant regional groups in relation to standards, and the use of scarce local resources for the training of doctors intending to practice in the United States, which can better afford to train them" (20). Obviously, it would be beneficial if the Medical Councils of Barbados, Jamaica, St. Lucia, and Trinidad and Tobago translated that opinion into action by adopting the decision already taken by that of the Bahamas in respect to registration of graduates of such schools.

There are potent arguments to support such a regional approach to this problem. From the national standpoint, there is little doubt that an educational institution should be meant to service the needs and
expectations of the country and region in which it is located. It should address the problems of the society and the social aspirations of its people. Specifically, a medical school should produce the type of physician required to deliver appropriate medical care to the community and should avoid the image of cultural imperialism by dubious representatives of a friendly nation imposing foreign students on persons in need of medical care. If regional medical facilities that are yet to be incorporated into the UWI training program are capable of making a contribution to medical education, attention should be directed to upgrading them to a standard necessary to augment the limited resources of the region. Unfavorable publicity regarding these schools already appeared in the press in the United States, including such observations as: "medical educators in the U.S. are becoming increasingly concerned about a proliferation of medical schools in the Caribbean and Mexico, which, they maintain, are being hastily created to tap the thousands of Americans who are rejected each year by medical schools in this country" (3).

It may be safely assumed that each proposal for the establishment of an off-shore medical school will include a number of full or partial scholarships for national students as part of the "package deal" normally proffered. There can be no justification, however, for the official exposure of these students to a curriculum demonstrably unsuited to equip the West Indian practitioner to render the type of health care acceptable to the Government and the community. These students would encounter difficulties in enrolling for compulsory rotating internships and could therefore expect to be cut off from practice within their national frontiers.

Legislators surely have an important obligation to future medical practitioners to ensure that the basic degree earned by their sponsored students will qualify them to pursue postgraduate studies. In the case of the overseas doctor aspiring to pursue postgraduate studies in the United Kingdom, full registration will be required by the General Medical Council, which will need to satisfy itself that the basic qualification furnishes "a sufficient guarantee of the possession of the requisite knowledge of medicine, surgery, and midwifery." One of the criteria applied by the Council in this determination is "whether the population of the effective teaching hospital catchment area provided a sufficient range of case material for clinical teaching of the standard required" and that "the standard of these qualifications is not less than the minimum standard required for primary qualifications".
granted in the United Kingdom" (21). Those planning postgraduate studies in North America should realize that, because of the Visa Qualifying Examination and the prevailing labor laws, entry into Canada and the United States is becoming ever more difficult.

Although UWI is increasingly expanding its facilities for postgraduate medical education in the area, its responsibilities, as delegated by the General Medical Council in respect to reciprocal arrangements in medical qualifications, dictate that requirements for entrance to these training programs be no lower than those of the General Medical Council. Moreover, since 10:1 is a generally accepted standard of bed:student ratio in a well-balanced teaching hospital (22), few of the less developed countries could provide the facilities necessary for the large numbers of undergraduate students sought by promoters primarily interested in high profits.

For the American undergraduate student lured to the shores of a Caribbean island in search of a medical education, the host Government should assume some degree of moral obligation to ensure at least against undue disappointments. It has been shown that for those who plan to transfer from a foreign medical school to a clinical program in the United States, COTRANS offers only limited opportunities; that the more liberal provisions of the 1976 Medical Manpower Act, originally applicable for a three-year period and only to students who had enrolled at such a foreign school prior to October 1976, have been reduced to one year only; that the number of third-year positions thus created total no more than 1,200; and that these legislative concessions are under constant and severe attack in the Senate of the United States. No guarantee exists, therefore, that the undergraduate students completing their basic medical science training abroad will find the necessary places for continuing their medical education in their home country. The claim of any promoter assuring such transfers must be viewed with grave scepticism.

For the graduate born in the United States and returning with a foreign medical qualification, two significant hurdles stand in the way of a satisfactory medical career. First, he is classified by the Liaison Committee of Graduates of Medical Education, the American Medical Association, and other medical institutions as a foreign medical graduate (FMG) who must complete the ECFMG examination before being permitted to begin graduate medical education. With the object of reducing to a minimum the number of foreign-born FMG's entering the country, the standards of that examination are being
upgraded, so that in 1975 there were an estimated 10,000 FMG’s who failed it (7)—many of whom subsequently had to serve in state mental and chronic disease hospitals under temporary arrangements.

Secondly, the 1976 Medical Manpower Act, aiming to provide for the needs of medically underserved areas in the United States, imposed another condition for receipt of capitation support for medical students: medical schools must ensure that a specified percentage of first-year residency positions be allotted to the program in primary care, ranging from 35 per cent in the 1977 academic year to 50 per cent in 1979 (11). This will have the effect of increasing the pressures in competition for placements in the disciplines of internal medicine, pediatrics, surgery, and obstetrics/gynecology that have traditionally been more popular. Incidentally, this provision will affect adversely the opportunities for West Indian medical graduates (like other FMG’s) to gain admission for postgraduate training in the United States.

CONCLUSIONS

1. From the foregoing, it is readily concluded that off-shore medical schools have no rational role to play in the immediate or future health needs of the Caribbean Commonwealth. The development of any such institution in the area is therefore not in the best interests of the English-speaking Caribbean.

2. The training program that proposed schools offer is not calculated to produce a physician capable of delivering the types of primary health care recognized as essential for the general welfare of the area’s population. There are already indications that graduates of such schools will not be acceptable for registration and licensure in all of the countries of the area, and it is possible that such graduates may find difficulties in entering postgraduate training programs of their choice.

3. Training facilities for medical practitioners in the area, within the framework of UWI and jointly sponsored by countries in the area, are today adequate for the planned requirements and can be extended in the future to meet new additional needs.

4. Clinical and field facilities that have not yet been utilized in this training program should, wherever possible, be reviewed with the
object of upgrading them to the standard necessary for incorporation into the training complex of the area, as and when required for area needs.

5. The principal justification of off-shore medical schools in the Caribbean, which attract American students who were unsuccessful in securing entrance to a mainland school, is the generation of profit for the entrepreneurs promoting them.

6. Long-term prospects for American students wishing to return home are uncertain and becoming increasingly difficult. For those completing the basic medical sciences—half of the course offered—present legislation provides transfer possibilities only for students who started their course before October 1976 and only for one year. For those who choose to complete the full training program abroad, ever greater barriers, contrived to limit the numbers of a profession no longer in short supply, will need to be faced.

7. If problems exist in the medical education of physicians in the United States, there is no country better equipped to formulate solutions and implement plans to meet the identified requirements.

8. Highly unfavorable publicity has already been generated by the establishment of off-shore medical schools in the Caribbean; such publicity in no way contributes to enhancing the positive image of the countries of the area, particularly in the United States. This, taken along with the uncertainties in the continuing education and future careers of both Caribbean and American students lured to these off-shore schools, appears a high price to pay for the promises of earnings in hard currency, earnings which are themselves precarious in view of the most recent legislation on health manpower education and regulations by medical educational authorities in the United States.

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SUMMARY

Facilities existing and planned in the University of the West Indies for training the medical manpower requirements of the Caribbean Commonwealth are adequate and can be extended to meet additional future needs. No valid justification exists, therefore, for the development in the area of off-shore medical schools promoted by profit-oriented entrepreneurs who have little or no experience in medical education and aimed principally at students from the United States who have failed to secure admission to an American medical school. Such students are liable to experience serious disappointments either in transferring to the United States for the clinical half of their course or in qualifying for entrance to postgraduate training programs sponsored by American educational authorities. Participation in the establishment of such medical schools has already generated unfavorable publicity, which can be ill-afforded by the countries of the English-speaking Caribbean.

REFERENCES


REPERCUSIONES DE LAS ESCUELAS DE MEDICINA FORANÉAS EN LA COMUNIDAD DEL CARIBE (Resumen)

Los recursos con que cuenta la Universidad de las Indias Occidentales y los que proyecta disponer para capacitar al personal médico necesario en la Comunidad del Caribe son adecuados y pueden ser ampliados para satisfacer las necesidades futuras. Por lo tanto, no existe una justificación válida para establecer en esa región escuelas de medicina foráneas—auspiciadas por empresas que pretenden obtener ganancias con ello y que poseen poca o ninguna experiencia en la enseñanza de la medicina—y que estarían destinadas principalmente a estudiantes de los Estados Unidos de América que no han logrado ser admitidos en una escuela de medicina de ese país. Dichos estudiantes correrían el riesgo de experimentar grandes contratiempos al trasladarse a los Estados Unidos para seguir la parte clínica de los estudios o para satisfacer los requisitos de admisión a programas de capacitación de posgrado patrocinados por las autoridades docentes de los Estados Unidos. La participación en el establecimiento de tales escuelas de medicina ya ha dado lugar a publicidad desfavorable, la cual no pueden permitirse los países de habla inglesa del Caribe.
As instalações já existentes e planejadas da Universidade das Indias Ocidentais para formar o pessoal médico de que a Comunidade do Caribe necessita são adequadas e podem ser ampliadas para fazer face a necessidades adicionais futuras. Não há, por isso, justificativa aceitável para a criação na área de escolas médicas extra-territoriais promovidas por empresários que buscam obter lucros, que têm pouca ou nenhuma experiência em educação médica e que têm as vistas voltadas principalmente para estudantes dos Estados Unidos que não conseguiram ingressar numa escola médica americana. Tais estudantes se arriscam a passar por graves decepções, quer ao procurarem transferir-se para os Estados Unidos a fim de fazer a parte clínica de seu curso, quer ao pleitearem admissão em programas de treinamento de pós-graduação patrocinados por autoridades educacionais americanas. A participação no estabelecimento de escolas desse tipo já deu origem a publicidade desfavorável, que os países de língua inglesa do Caribe não podem dar-se ao luxo de sofrer.

LES IMPLICATIONS DES ÉCOLES DE MÉDECINE OFF-SHORE DANS LA COMMUNAUTÉ DES CARAÎBES (Résumé)

Les installations que possède et envisage de construire l'Université des Indes occidentales pour assurer la formation des personnels de santé dont a besoin la Communauté des Caraïbes sont adéquates et peuvent être agrandies pour satisfaire de futurs besoins additionnels. C'est pourquoi rien ne justifie la création dans la région d'écoles de médecine par des entrepreneurs qu'attirent les profits mais qui n'ont guère ou pas d'expérience en matière d'enseignement de la médecine et visent essentiellement des étudiants n'ayant pas pu se faire admettre par une école de médecine américaine. Ces étudiants risquent en effet d'être considérablement déçus lorsqu'ils décident de se rendre aux États-Unis pour y faire la moitié clinique de leur éducation ou lorsqu'ils veulent s'inscrire aux programmes de formation que patronnent les autorités éducatives américaines. La participation à la création de ces écoles de médecine a déjà engendré une publicité défavorable que ne peuvent pas se permettre les pays anglophones des Caraïbes.