

UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF POSTSECONDARY EDUCATION
NATIONAL COMMITTEE ON FOREIGN MEDICAL
EDUCATION AND ACCREDITATION

OPEN SESSION

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Hungary

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61

Committee Readers:

Dr. Martin Crane

Dr. Kiran Shah

Department Staff:

Dr. Rachael Shultz

Country Representatives:

Dr. Gabor L. Kovacs

Prof. Klara Mater

Mr. Balazs Erdei

Dr. Dockery: Next, we will take Hungary, after we ask our guests to please return. We welcome Dr. Rachael Shultz to make the presentation on Hungary.

DR. SHULTZ: Thank you. Good morning. I am Rachael Shultz. I will be presenting the information regarding Hungary's medical standards. The materials are located

behind Tab F.

The Hungarian Accreditation Committee, or HAC, initially submitted Hungary's medical education accreditation standards for review by the NCFMEA in Spring 1997.

At its Spring 2003 meeting, the committee reaffirmed its prior determination that the standards and processes used by the HAC to evaluate its medical schools were comparable to those used to accredit schools in the United States.

To keep apprised of the accreditation activities of the HAC, the committee requested that Hungary submit a report on its accreditation activities for review at the Spring 2005 meeting. However, all NCFMEA meetings subsequent to the Fall 2004 meeting were suspended, and it was not until the Fall 2007 meeting, after the Secretary had appointed new committee members, that the NCFMEA had its first opportunity to review the HAC's accrediting activities.

An updated report presented at that time noted no concerns and was reviewed and accepted by the committee. The current redetermination is based upon information that the committed submitted in December 2008.

As has been the case when the country has appeared before the committee in the past, there continue to be four medical schools in Hungary. All are based in state institutions of higher education and are fully accredited.

During 2007-2008, the most recent year for which figures are available, 25 American students received approximately \$650,000 Title IV dollars to attend Hungarian schools.

Based upon the information provided, it appears that Hungary has an evaluation system that remains substantially comparable to that used to accredit medical schools in the United States. While the HAC has provided information regarding the country's quality assurance system for medical education in

Hungary, four areas need to be further addressed.

These areas of concern were identified in the draft staff analysis. While Hungary did provide additional documentation regarding the four areas in its response to the draft analysis, the documentation submitted was written in Hungarian and, therefore, staff was unable to evaluate it. As a result, additional information is still needed regarding the four issues.

The four areas of concern are related to: Part 2, Section 5.3, Medical Students. The country's higher education law does not appear to address the provision of health services, including mental health counseling, for its medical students.

The country responded that these services are covered in Section 22 of its Higher Education Act. Section 22 does require healthy and safe training conditions in educational settings. It also requires that the university provide services that contribute

to a healthy lifestyle free of addictions.

Section 22 does not address the provision of health services, including mental health services, to students.

The response also references a government decree that reportedly addresses these requirements. Again, this decree was not provided in English, so staff was unable to evaluate it.

Finally, the response also states that such services would be provided to students through the country's national health care system. However, it is unclear if such a system would cover non-Hungarian nationals studying in the country.

Part 2, Section 6.1, Resources for the Educational Program: The country's Higher Education law does not appear to address the necessity for facilities for the humane care of animals in teaching and research.

Part 3, Section 1, Site Visit: The country provided templates of the site visit evaluation and self-study requirements.

However, it did not provide examples of actual self-studies or on-site evaluation visits.

In its response to the draft staff analysis, the country stated that actual self-studies or on-site evaluation reports may not be released to third parties without the consent of the universities' presidents. Since no reports were provided, staff assumed that permission to view the reports was not granted.

However, in a second response the country stated that it had actually not requested the evaluations, but was sure that they would be provided if requested.

ED's Foreign Schools -- The Department of Education's Foreign Schools team has expressed a concern regarding the monitoring of clinical sites used by Semmelweis University. In light of these concerns, it would be particularly helpful to have a copy of that particular institution's site visit evaluation.

It should be noted that schools participating in Title IV are obligated by

regulation to supply this information as a condition of accepting Title IV funds, when requested by the Department. The schools may supply redacted copies in order to satisfy privacy concerns, but must provide the requested information, translated into English, in response to this requirement.

Finally, Part 3, Section 3, Reevaluation and Monitoring: The country has stated that there is no ongoing accreditation monitoring by the HAC during the medical school's eight-year recognition period.

The most recent reviews were conducted by the HAC in 2005. Presumably, the schools will not receive their next HAC review until 2013. In the interim, the schools are expected to have internal controls in place to ensure ongoing program quality, rather than having the HAC, itself, go in.

Based upon its review of the material submitted by the HAC, Department staff concludes that Hungary has provided most of the information requested by the committee.

However, as noted previously, there are still areas where additional information is needed.

There are country representatives present today, and I trust that they will provide clarification as to what was written in the un-translated documents that were provided in response to the draft analysis.

I will also be happy to answer the committee's questions. Thank you.

DR. DOCKERY: Thank you, Dr. Shultz.

Are there questions for Dr. Shultz before we ask the representatives from Hungary to approach the table?

Just one before they approach. Have you had any informal conversations with them about the lack of materials that have been supplied? Have there been any problems with understanding what we need in terms of making these determinations?

DR. SHULTZ: I haven't had any conversation with them, and I would add that their response was a little unusual, in that instead of supplying any rebuttal to what we

had written as an analysis, they actually went in and rewrote my analysis for me, which of course, we could not accept.

Other than the rewritten analysis and the additional documentation that was in Hungarian that, I'm sorry, I couldn't read, we have not had any more information.

DR. DOCKERY: Are there other questions before -- Dr. Hallock?

DR. HALLOCK: It just raises the question. Do we have the ability to get the Hungarian documents translated?

DR. SHULTZ: No. They need to be supplied in English.

DR. HALLOCK: Okay, thank you.

DR. DOCKERY: Thank you, Dr. Shultz.

We will ask the representatives from Hungary that are present to please approach the table.

Could I ask, please, for the record that you each introduce yourselves and use the microphone so that we can record the discussions.

PROF. MATER: My name is Klara Mater

from the University of Debrecen. I am Professor of Anatomy and a member of the advisory board for the international education.

DR. KOVACS: My name is Gabor Kovacs, Professor of Laboratory Medicine from the University of Pecs, and I represent here the Hungarian Education Committee, because I am the Chairman of the medical section of this committee.

MR. ERDEI: My name is Balazs Erdei. I am with the Hungarian Embassy, and I am responsible for science and technology.

DR. DOCKERY: Are there any comments that you would like to make before we go into Executive Session? Go ahead, sir.

DR. KOVACS: First of all, I would like to thank for the evaluation of our medical education system, and apologize for the -- what? -- for the quality of answer that our ministry gave to you, because I think they should have given the materials in English.

So coming to the comments of the committee, first is the insurance of the

students. Every Hungarian medical student is insured by law. That means it is fully covered, including psychic disorders or any kind -- whatever disorders. The same holds true for our foreign students coming from countries of the European Union. There are mutual agreements with the countries of the European Union.

It is different for the overseas students. They are not covered by law, and every -- all four medical schools have the regulation that, before they enroll these students, they should give them the chance to make their own insurance, and they do not enroll the students without any insurance, but they have to pay for that insurance themselves.

In addition, part of the problem, we have special organizations within the universities, partly run by the university administration, partly by the students of government, that care for the disabled students. We have special measures for physical disabled students, including transfer

of them by special buses, or students with dyslexia and so forth.

So I believe that this issue is -- although not regulated in our higher education law, it is, in fact, functioning without any practical problems, at least in my eyes.

The second problem was the use of experimental animals in teaching. It is true, it is not regulated in our Higher Education Law, but it is regulated in another Act, an Act on animal protection in the use of experimental animals in teaching and experimentation.

All universities have a special committee on approving experimental animals in teaching or research. This includes the use of experimental animals, the ethical issues, and once they approve, then the researcher can submit this application to the local office of the Surgeon General, and this local office is entitled to give you a permit to use experimental animals.

This is controlled, and this permit usually lasts one or two years or, if you have

a grant, it lasts usually to the end of your grant.

The third issue was the self-study requirements. Yes, during the accreditation process, our four medical schools prepare the self-studies. It is not -- There is no secret in the self-studies. It is quite a thick material, and I am a bit astonished that we -- that our ministry did not provide you with the English translation of this, because it is not publicized in any universities. It is not on the Web page of the university, but on request it is available, and it is also available, of course, at the Hungarian Accreditation Committee, because we did the analysis.

The eight-year accreditation period:

Yes, it is regulated by law that Hungarian universities are accredited once in every eight years, but Hungary itself has realized that it is not sufficient.

Now we are in a transition. We are moving to an accreditation period of four or five years. It has not been decided yet, but

it is submitted to the Parliament now, these two options, four or five years. But even if you take this eight years' period, there are a lot of activities in between.

One of these activities is the so called parallel accreditation. That means that in mid-term period we decided to control all four medical schools by the same accreditation staff at the same time and make a comparison. We have finished that.

There are other controlled ways which are not -- well, you cannot call it accreditation, but contain a number of control elements regarding quality. One of these is the three years financing plan. The university signs a three years financing plan with the Minister of Education, and this three years period, they must report what they achieved or so, including quality.

There is an accreditation of the university capacity. So the Minister of Education must approve how many students you can enroll, and it is limited. You should not

have more students than what quality requires.

In these eight years period, all doctoral schools in Hungarian medical universities -- there are around 40 doctoral schools which are responsible for the PhD training -- are accredited by the Hungarian Accreditation Committee. It is not a complete accreditation, but the Ph.D. doctoral schools are accredited.

All universities must report any changes in the curriculum and get to the accreditation committee if there are changes. Another special aspect of the Hungarian accreditation is that universities are not entitled to appoint a new professor without the approval of the accreditation committee. So we have an opinion on every single new professor appointed in this period.

Finally, all four medical schools are ISO certified. They are certified according to the norms of ISO 901, and this describes how they should behave in the period between two accreditations.

Last, but not least, our department chairmen are appointed for four years. After four years, they have to reapply for their jobs, and the Senate has to approve, and this is also a very strong quality control over the quality of teaching.

Concerning the site visits: If we talk about teaching hospitals, more than 95 percent of teaching goes on in hospitals which are part of the universities. We only have state-owned universities, and all our clinics are the same organization. They report to the university. Of course, the accreditation controls all these clinical sites.

We then have teaching hospitals outside of the university area. These are also site visited by the Hungarian Accreditation Committee. They usually are involved in -- some are practicals or clerk-ships of medical students.

The Semmelweis University in Budapest, which is the largest medical school in Hungary, has come up with a plan -- a new

type of program. They decided to set up a second faculty in Germany, Hamburg, and this staff, of course, is also under accreditation Phase 1 element, I must admit, which is not site visited, and these are the period of medical students. They spend a couple of weeks in western European universities during summer period or in the States, and for that we had no capacity for site visiting or -- well, western European universities. But these are short time visits that we accept.

Usually -- not usually -- it is mandatory that the Dean of the faculty make sure that the clinic the students are visiting is of a good quality, and they perform the program of the university. But it is not site visited by the Hungarian Committee of Accreditation.

Thank you. Maybe Professor Mater?

PROF. MATER: Yes. I would like to add. Okay. So I am from the University of Debrecen, and our medical education is accredited by the New York State and California

State, and the New York State Educational Department asked our university to have a teaching hospital, accredited teaching hospital, in New York State.

They made an agreement with the Wyckoff Medical Center in New York, Brooklyn, and the New York State Educational Department site visited this teaching hospital.

So our students, not only the international students but the Hungarian medical students, can spend 12 weeks as an internship in this Wyckoff Medical Center.

DR, DOCKERY: Thank you. Did your colleague want to make any comments?

MR. ERDEI: No.

DR. DOCKERY: Okay. Are there questions from the committee before we go into Executive Session? Then we will ask our guests to please depart.

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

We can ask our guests to please return.

Dr. Hallock?

DR. HALLOCK: A parenthetical for the committee. We are probably going to see more Eastern European countries coming forward as the market for Americans increases. I wonder if at one of our next meetings we might have a review of what the Bologna Process brings and what the accreditation status is of Europe? I would be happy to help facilitate that, because there is no standard of accreditation. The standard has to do with the transferability of student credits. So maybe that would be helpful if we began to look at something like that.

DR. DOCKERY: Let the record note that we have placed that on the agenda for future consideration and, of course, it will be up to the committee and staff to decide on an appropriate time to consider that. Dr. Crane?

DR. CRANE: Mr. Chairman, may I ask a question perhaps of legal counsel with respect to Dr. Hallock's last question?

Is there any process that we have to

specifically follow when we do make an approval? Can it be done, as Dr. Hallock suggested, if they meet the requirements and staff feels that way, then we will accept it? In other words, it is a conditional acceptance based on staff's review, or does it have to be done in an open public meeting of this sort?

MS. WANNER: That is an interesting question that has just come up recently, and this committee can operate by con-call. You could do it by e-mail. It does not have to be a public meeting.

DR. DOCKERY: I would offer, though, I think that it is beneficial to the committee members to receive the information that they have requested, because it is quite detailed, and I think it is also a disservice to the accreditation process if we would have an informal process that would violate our more formal process that makes us more legitimate.

END OF EXECUTIVE SESSION

DR. DOCKERY: Let me have the will of the committee express itself. We will reconvene at

12:15 for lunch. Serve yourselves, and we will have lunch in place and hear from Dr. Nasca.

(Whereupon, the foregoing matter went off the record at 11:53 a.m.) - - -

A F T E R N O O N S E S S I O N

12:22 p.m.

DR. DOCKERY: In the interest of being on time and courtesy to our guests, we would like to go ahead and get started, and to thank Dr. Thomas Nasca for agreeing to come and speak with us.

Dr. Nasca is the Chief Executive Officer of the Accreditation Council for Graduate Medical Education. As you all know, the ACGME is a very important organization to the NCFMEA in regard to the provision of accredited residency training programs.

In advance of Dr. Nasca's presentation, I would like to tell you that I have already told him that we work for the government, and we apologize for our spartan environment. Dr. Nasca brought his own computer and his own technological cook-ups.

So he is supplying everything for this presentation, including his transportation here and back. So, hopefully, he will get back safely.

Dr. Nasca, thank you so much for coming and being with us.

DR. NASCA: Thank you very much. Well, it is certainly a pleasure to be here with you. I was not exactly clear how well you understood the specific nature of the ACGME. So if I give you information that you already know, please just give me a signal -- Dr. Hallock is very good at giving me signals -- and we will move on to the next topic.

What I would like to do is tell you a little bit about the ACGME, and then maybe we could have a discussion on the impact of accreditation on graduate medical education.

I am going to give you an overview of the kinds of impacts we are attempting to have and talk to you a little bit about the use of accreditation structures as a lever to move the educational system in the United States,

and then talk a little bit about the structure, because it is my understanding -- and if this wrong, we can skip that part -- that the alphabet soup of American organizations can sometimes be confusing to those uninitiated.

I have only one disclosure, and that is the ACGME actually does pay me, but other than that, I have no other disclosures. I don't own stock in anything to speak of, certainly anything that is worth anything, certainly nothing associated with medicine.

I think it is important to recognize that there is a legacy of graduate medical education in the United States, and we sometimes have the mistaken perspective that it was always there. It really wasn't always there, and if you go around the world, you can actually see countries in various stages of development that we have gone through over the last 60 or 70 years.

Graduate medical education in the United States has evolved into a required component of the continuum rather than an

optional component of the continuum in medical education. We have evolved into production of highly trained specialists and subspecialists, and we provide the clinical workforce for the United States.

Now the ACGME is an interesting entity. It has evolved over the last 60 years.

It is really the embodiment of de Tocqueville's and Franklin's vision of private entities serving the public good, and it is a 501(c)(3) not-for-profit corporation. I will tell you a little bit more about that in a second.

It is really the meeting place of the thought leaders in American graduate medical education. The members of the Board of the ACGME are nominated by at least five organizations which, you can see, are the umbrella organizations of the United States involved in either medical education, the certification of specialists, or the receiving organizations, the American Hospital Association, the American Medical Association,

and the Council of Medical Specialty Societies.

Then at the Residency Review Committee level, the specific specialty level, we have three organizations that nominate individuals who volunteer to serve on those committees, the AMA, the respective Board and the respective college or academy from the specialty specific entity.

So you can see, the ACGME really is the framework for the profession coming together to do its work to create and accredit the educational programs that sustain the profession over time.

Now the ACGME has evolved from independent individual specialty review committees through a council within the AMA, in the year 2000 spun off as an independent 501(c)(3) corporation, and its mission is the advancement of the health of the citizens of the United States through enhancement in graduate medical education.

I will add parenthetically that "the citizens of the United States" was added by me

just for the purposes of this presentation. It is not actually part of the mission statement.

It is just "the advancement of health through enhancement of graduate medical education."

The authority of the review committees is delegated by the Board to each committee. In other words, each residency review committee has no authority to accredit on its own. It is delegated from the Board of the ACGME to each specialty committee, and the ACGME is responsible then -- that is, the ACGME Board is responsible to the public for the oversight of the work of each of these committees, and we have an extensive process that allows that to happen.

Now the Board of Directors of the ACGME are selected. There are four individuals selected from slates that are nominated by five member organizations, those five that I showed you. There are two resident members, three public members, and the Chair of the Council of Review Committee Chairs. In other words, all of the chairs of the review committees, the 28

review committees, sit together and they elect a Chair, and that Chair sits on the Board.

The Chair of the ACGME can be supernumeratedly elected by merit from the members of the Board, and I sit on the Board as Secretary of the Board without vote by virtue of being the CEO.

Now the ACGME believes very strongly that the output of our work produces a social good, and that is that we produce individuals who provide patient care, basic and clinical research, education of the future physicians and other health care professionals, and provide community service beyond the clinical care that we provide.

We do believe very strongly that patient care is improved through education of the next generation of physicians, and that is not only patient care in the future. It is patient care in the present.

Now I am just going to try and give you some idea of the complexity of the relationships within the ACGME. Each of us,

depending on our specialty, views the ACGME in this fashion. There is a specialty review committee -- in my case, for instance, internal medicine -- and there is a Board of Directors of the Accreditation Council, and there is an interchange between these two entities.

There is an Executive Committee of the Board. About 10 years ago, an Institutional Review Committee was added to the mix. So that, in addition to adjudicating the effectiveness of implementation of the standards of each specialty within an institution, the institution itself is reviewed.

We have a series of committees that interface with the review committees. The Monitoring Committee is the committee that is charged with overseeing the work of the review committees.

In other words, every five years at a minimum, and sometimes more frequently, each residency review committee must submit a report to the Monitoring Committee, and the Monitoring

Committee judges their effectiveness of accreditation and their consistency, and then they render citations or deficiencies, and they render an accreditation cycle or delegated authority to accredit cycle that can be anywhere between one and five years, very much the way we accredit residency programs.

There is a Program Requirements Committee that reviews the proposed specialty specific requirements, and then for appeals when an institution is not happy with the decision that they receive, if it is an adverse decision, they can appeal it.

Obviously, there are a whole series of other committees of the Board that support the work of any not for profit 501(c)(3) corporation.

The complexity comes, because there are 28 committees. There are not just a couple, and the relationships then are governed very strictly by policies and procedures.

The reason for that is twofold. The first is there would be chaos without policies

and procedures that were rigorously applied. The second is that it is very important for every program and every program director to know the rules, and the rules are not only the standards. The rules are also how we interrelate and how we enforce those standards, the policies and procedures.

As I mentioned, there is a Council of Review Committee Chairs that is the interface between the Board and the committees, and that work of that interface is very, very important in making sure, first of all, that the Board is understanding of the challenges that these committees are facing, and these committees understand the intentions and needs of the Board.

Just one other parenthetical remark:

We are adding a peer review journal. That journal will publish its first issue in September of this year, and have added a Journal Oversight Committee.

Now the Board has approved a set of values, and these values look very much like

many of our institutional values, with a couple of additions.

Obviously, the values are: Professionalism, as articulated in honesty and integrity and excellence in innovation; accountability and transparency, what you would expect for an accrediting body; fairness and equity, absolutely essential, because if we cannot instill and maintain the trust of our colleagues in each one of our teaching programs that we won't have the opportunity to accredit; and then we have a stewardship responsibility.

The only source of revenue for the ACGME are accreditation fees, and so we must be good stewards of that largess. Then, obviously, engagement of the stakeholders. If you are going to lead an educational enterprise, there needs to be engagement of those who are actually accomplishing the education in order to do this well.

Now there are a whole series of accreditation goals. First and foremost is to

assure the safety and excellence of patient care in the teaching setting; to create excellence in the graduate program, and we take that very seriously, and hence the move toward outcomes and outcomes based accreditation.

Our goal is to standardize to some degree -- we would never standardize completely the clinical and educational experience and outcomes of trainees in disciplines across a jurisdiction, but we do hope, to some degree, to create some homogeneity in the output.

In order to accomplish the above, the really have to assure effective evaluation of the trainees. We have to assure that the trainees learn in humanistic and reasonable settings, obviously anything from duty hours to service versus education issues related to that bullet. Then we have to coordinate the requirements for programs with the required experiences of the trainees for certification.

So we need to make sure that we work in concert with the boards or at least understand when there are difference between

our standards and boards' standards, because obviously, the goal is to produce individuals who become board certified in their specialty.

Now I probably don't need to point this out to you as an overseer of accreditors. But obviously, there is a significant difference accreditation and certification in the context of graduate medical education.

The accrediting body for programs sets accreditation standards and assesses compliance with those standards; whereas, the certifying bodies -- those are the ABMS boards in our situation -- set benchmarks for recognition of individuals, and then assess the individual's level of achievement in comparison to that benchmark.

Now -- and please, if this is information that you already know, please let me know. But there are a number of organizations that oversee the continuum of formal medical education in the United States, and you heard about five of them when it comes to the ACGME.

The AMA, the AAMC, the American Hospital Association, American Board of Medical Specialties, and Council of Medical Specialty Societies are involved in the continuum, obviously. The AMA and AAMC specifically oversee medical student education in the United States, and that is overseen by the U.S. Department of Education.

The ACGME gets its membership from these five organizations and oversees the graduate phase of medical education. Then the Federation of State Medical Licensing Boards, the National Board of Medical Examiners and the ECFMG oversee key steps in the licensing process in the form of both the USMLE medical knowledge exams and the clinical skills examination. Then finally, recognition of the specialists is by the ABMS at the specialty board level.

So you can see that we have organizations -- those are the shaded ones -- that are involved in both individual recognition, as well as on the part of the

ABMS, program specific accreditation.

Now the philosophy that I was talking about as we attempt to introduce trends into graduate medical education that bring out excellence in outcomes of our trainees is summarized in this sort of a tension that is brought about by what I am going to tell you next.

If we look at an accrediting body, it is very unusual for an accrediting body to have as a mission to drive innovation. In general, accrediting bodies function as trailing edge phenomena.

In other words, the majority of institutions or programs provide education in a certain fashion and, when they provide education in that certain fashion for long enough, if it is shown to be of benefit, that fashion of education then is incorporated into the accreditation standards, that so called trailing edge.

It is in the community. Eighty percent of programs already do it, and you get

the 20 percent of programs that are not doing it to do it well by introducing a standard.

That is different than a conceptual framework of a leading edge kind of a standard.

A leading edge standard is a standard that is introduced to drive the profession or the educational programs in a particular direction.

Over the course of the last 15 years, the ACGME has gradually moved from trailing edge standards to leading edge standards. What would be examples of those leading edge standards? The competencies would be a classic example, as would resident duty hours standards would be examples of leading edge standards.

Now the other important dimension here that is the same in both of these boxes is the method of assessing compliance is a substantial compliance model where the program is judged to be in substantial compliance if the vast majority of the rules are satisfied, and where deficiencies are identified, they are rectifiable or are not lethal kinds of

deficiencies in the educational program.

Of late, the -- Well, let me take a step back. One of our leading edge standards that has caused considerable discussion in the United States has been the discussion around resident duty hour standards.

The duty hour standards were introduced in 2003, and the enforcement model was a substantial compliance model with a set point very similar to the accreditation of the rest of the standards around substantial compliance model.

Now those of you who had the chance to read the Institute of Medicine report and hear the criticisms in the public of the ACGME, this is the basis of that disagreement.

The expectation of some in the society is that we be dealing with leading edge duty hour standards that have regulatory adherence as opposed to substantial compliance as the judge of compliance. Let me say that again.

There is this expectation that the

duty hour standards not be treated as educational accreditation standards and judged by substantial compliance with those standards.

There is the expectation that they be considered regulation and that the ACGME assess compliance by regulatory adherence -- in other words, a zero tolerance for violation model.

If you read the medical literature, you will notice that the ACGME, using a substantial compliance model, assesses that there are about eight percent of programs that have duty hours violations that cross the threshold of substantial compliance violation.

In other words, they do not reach the threshold of substantial compliance.

Whereas, if you read someone like Landrigan, who has done studies with interns in pediatrics and other specialties, he assesses that deficiency at somewhere around 60-70 percent of programs, because his standard of violation in one intern saying that one time they work rated at 80 hours or stayed more than 30 hours.

So there is a dichotomy, and the IOM is driving toward this set of expectations, and hence the conflict between the ACGME and the public sector.

Now where is the ACGME trying to drive the profession? Well, I am going to give you some information that you all know, but try and give it to you graphically, quickly, so that we can frame the discussion.

That is that all of us remember that the structure of our educational programs are based on this particular model. That is graded or progressive responsibility. In other words, we start out in physical diagnosis with a very high degree of supervision and absolutely no authority in decision making.

Then we move through the continuum of medical education with greater degrees of authority and decision making and lower degrees of supervision, ultimately ending up as an attending with no direct supervision, more distant supervision from a quality perspective, and absolute authority in decision making.

Now David Leach, my predecessor, introduced into our lexicon in medical education the Dreyfus conceptual model of the development of mastery, and with the student beginning as a novice, not knowing what they don't know, and some of us were fortunate enough progressing to mastery.

So graphically we can look at it in this fashion. We have this conceptual framework on the Y axis of starting from a novice and then moving all the way to master, and then starting in undergraduate medical education as a novice and then moving into graduate medical education, the phase that we are talking about today, somewhere as an advanced beginner to competent, and then moving to proficiency, and then in clinical practice maintaining at least proficiency, some going on to expert status, and even fewer going on to mastery. That is the conceptual framework.

What we talk about now is this graduate phase. What I would like to do is maybe peel the onion for you. You know, we

have these six domains of clinical competency, probably soon to be seven with technical proficiency being a separate seventh category or competency. That will probably be approved by ABMS and ACGME over the next year.

If we think conceptually, say, about a three-year residency program, we would start out as an advanced beginner, but is it really that simple? It probably isn't.

It may well be that, say, in internal medicine or pediatrics that we would believe that they would start out as an advanced beginner. They sort of know how to do a complete history or physical, but they don't really know how to develop a good differential diagnosis yet and the like. So they are really not competent yet.

Over the course of the PGY1 year, we would expect that they would move to competency and then proficiency by the end of the PGY2 year, and then refine that and enhance that.

Now would we have the same expectation for systems based practice?

Probably not, because if they didn't train in your institution, they don't know your systems.

So they would start off as a novice in your institution, and then assume to move very quickly in the PGY1 year to a competent level, because otherwise they wouldn't get their work done, and we have all seen interns who have been in that category, who can't really figure out how to get the work done.

Now I would ask you the question: How many of you want an advanced beginner when it comes to professionalism as an intern? You probably want a more developed set of professional behaviors than an advanced beginner for your first year house officer. So you have an expectation that they would start at a different level.

What I would posit to you is that in each one of our specialties, these are milestones. These are expectations that we have of house officers of levels of performance, and those levels of performance in

key areas should be common across all programs, and this is really the outcomes project, is figuring out how do we go from this conceptual framework where we track a house officer.

They deteriorate in their performance in this case with regard to patient care capabilities, and then we rectify them with information based on where we think they should be, not based on the individual program director's gut feeling about where they should be or the program's culture about where they should be, but really on national standards or national expectations.

Then ultimately, these final milestones or expectations, as they are articulated, become the entry into the initial phase of a certification process. So we need to be sure that, as each specialty articulates these, that the Board agrees with them.

Now it is the same for surgical discipline as well. If you look at surgical skills, they may well project from advanced beginner all the way through in this envelope,

but surgical training is different than nonoperative surgical training, is loaded to a great degree to the front.

Systems based practice -- again, if you haven't worked in that particular OR, you don't understand how it works, but you may have greater expectations with regard to nonoperative patient care based on the structure of, for instance in this case, general surgery.

So we need to really understand the expectations. We have three specialties now that are in the process of determining these milestones. Internal medicine, pediatrics, and general surgery are in the process of defining these milestones across the six domains of clinical competency.

We hope eventually to be able to do this in all specialties so that we can rectify those deficiencies and be sure that each trainee then does enter practice or completes graduate medical education at the level of at least proficiency and be able to certify that

to the public.

Now let me switch gears a little bit here. When we look internationally at prototypes of systems of accreditation and oversight of graduate medical education programs, which is different than what you look at, we see that there are three models.

The first model is the government oversight model, which is a ministry of health model, in some cases a ministry of education, but that is more frequently at the undergraduate level than it is at the post graduate level, and in most countries it is called post graduate training.

There is the self-regulation model.

In other words, the profession is self-regulating, and the two models would be -- The one that predominates internationally right now is the Royal College model or the representational organizational model, where the college also accredits and also certifies in many circumstances.

Licensure in those countries may or

may not be present. There are many countries where there is no such thing as formal licensure, and it is really the college activities that determine whether you are entered into the practice of medicine.

Then we have the U.S. system of professional self-regulation, and in this system there is corporate separation of accreditation and certification functions, and licensure is a third dimension. That is local, as you are well aware, and is a state governmental function, not a Federal function.

Then interestingly, in most of the world there is a nonregulatory model. In other words, in most of the world, if you counted countries, most countries would have no formal structure or oversight of post graduate training.

Now to give you some frame of reference for the U.S. system of the ACGME -- and I would add that these numbers do not include osteopathic training. That is governed by a separate body, the American Osteopathic

Association.

So to look at the full portfolio of postgraduate training that is accredited, you would need to look at AOA, which is much smaller than this, but it has some number of programs and trainees.

We have 8,696 programs accredited as we speak in 692 sponsoring institutions. We have almost 3,000 teaching hospitals or institutions that participate in residency training in the United States, and we have over 111,000 residents and fellows currently enrolled in ACGME accredited residencies and fellowships.

The ACGME itself does its work with about 365 volunteers, physician volunteers, and about, right now, 162 full time administrative staff.

Now if you look at the economic impact, the Medicare reimbursement for GME in the United States is about \$10 billion, which on average is \$93,000 per resident. The ACGME expense budget is \$32 million, which is less

than .3 percent of total Medicare GME expenditures or about \$280 per resident per year.

Now what is the impact of accreditation in the United States? Well, we believe we have been continuously raising standards, and actually we can demonstrate that, if you look at -- track specialty standards over the years. Every specialty has raised standards and promoted excellence in many institutions that otherwise would not have been very good.

Parenthetically, I will give you an example. In the state of New Jersey in the 1980s, there was not one internal medicine program that had an American Board of Internal Medicine pass rate greater than 50 percent. Today there is not a single program in the state of New Jersey who has a Board pass rate less than 90 percent, which is five points above the national average.

The reason for that is that in 1987 the Internal Medicine Residency Review

Committee put in a standard with regard to board passage rate, and lo and behold, everyone's performance improved.

So we can give you many, many examples. That is just one example of where the changes in standards resulted in improvement in outcomes, measurable outcomes.

We have introduced physician competencies into American medicine. I mean, that really came from the ACGME. We are developing the milestones of training, and we have enhanced the learning environment, including resident duty hours and resident wellbeing.

Then finally, I can tell you with confidence that the care in the United States in teaching hospitals, the outcomes of care as well as the processes of care are better than in non-teaching hospitals.

There are any number of reviews, and I will tell you, the reason these reviews were done had nothing to do with education. The reason these reviews were done was because it

costs more in teaching hospitals than non-teaching hospitals.

So there were many people interested in demonstrating that care was not better in teaching hospitals than non-teaching hospitals, but it turns out that in every situation where meta-analyses have been done and reviews have been done of studies, with one exception teaching hospitals provide better care than non-teaching hospitals, as measured by outcomes as well as process.

The one exception is in some studies looking at neonatal intensive care units in community hospitals, non-teaching community hospitals versus academic medical centers.

There are many confounding variables in those studies, and they continue to look at that, but that is the only setting where it has not been demonstrated that teaching hospitals are categorically superior.

Now I could go on and talk about the pipeline, if you want, but I will stop here and answer questions, if that is what your pleasure

would be.

DR. DOCKERY: Thank you, Dr. Nasca.

It might be helpful to have a few words about pipeline, because we are dealing with that through many issues. So I think we would benefit from that, if you have the time.

DR. NASCA: I always have slides. I'm a nephrologist. I have graphs, too. So now I'm in heaven.

This is a graphic that Ed Salsberg gave to me a year ago. So it is a little bit out of date, but the numbers really haven't changed very significantly.

What this shows is that back in 2002-2003 Jody Cohen called for expansion of U.S. allopathic medical school output by 30 percent, and you see the response of the community. This is first year enrollment, very similar to output numbers just with a time lag of four years.

What you see is that existing schools are projected to expand over the next decade, and with the addition of new schools,

by around 2015 we are projecting around 21,000 graduates and plateauing, I think -- Jim, is it about 2022 at around 22,500 graduates. Okay? So remember that number.

This is the striking one, though, to me. If you look at allopathic expansion, by 2013 we will be at about 20,000, but remember, the curve is upward.

This is the most striking one. If you look at this number back in 1992, 10 years before this, this number was 1800, and in about 20 years it will have almost tripled. So you can see that the osteopathic output has dramatically increased.

So in 2013 it is expected we would have about 25,000 onshore graduates as opposed to 19,500 in 2002. So now remember this number, 25,100.

Now everyone, when they start to look into this, gets a sense of comfort in the fact that the total number of accredited entities accredited by the ACGME continues to increase. So you've seen a fairly significant

increase in the number of residency training programs accredited by the ACGME.

This is the data from 2003 to 2008, and we went from less than 8,000 in 2003 to, in 2007-2008, about 8400; and as I just told you, we are almost at 8700. So you can see that that slope continues. Right?

Here is the problem. There has been almost no increase in residency positions. It has all been in fellowship positions. This is accredited positions -- accredited programs, pardon me.

This increase is somewhat artifactual. This, in some sense, is artifactual, because it represents the accreditation of medicine/pediatrics combined training programs who were previously not accredited, but the trainees were there.

They were just part of -- counted as part of either pediatrics or medicine in existing, accredited medicine and pediatrics programs. So this 1.5 percent increase is even artificially inflated.

Now if you take the pipeline positions -- and by pipeline -- you know, we always have to be worried about definitions. You can see the specialties that we listed here. These specialties are the specialties that we accredit that lead to initial board certification.

So for instance, you would say, well, colon and rectal surgery is a separate RRC. Yes, it is a separate RRC, but it is really a fellowship program, because you must complete five years of general surgery before you can enter a colon-rectal surgery -- what is called a residency, but it is really a fellowship.

So you need to recognize those nuances. So if you look at this as the pipeline, there is an additional phenomenon that you need to recognize in counting the numbers.

If we look at the GY-1 positions -- in other words, the first year of specialty training in each of these disciplines. So in

anesthesiology, that would be a PGY-2, right? You can see that the total number of positions in 2007-2008 was about 25,800. But the number of positions that were available to first year residents who had no previous GME experience was only 24,000.

So that defines the real pipeline for people who are coming in de novo into the GME system. It is 24,000. So what we -- if you remember that number that I showed you, in 2013 matriculating onshore students will be 25,100. Even if we have an attrition, they are not going to lose that percentage. They are not going to lose more than four or five percent.

So we are looking at around 2015 to 2017 when these lines are going to cross. In other words, if we project out, even if we projected out a 1.5 percent growth in the pipeline which, I will tell you, hospital CEO say will not happen, because they don't see any reason to expand their residency positions -- What we see is, if we project Ed Salsberg's

line on there, you can see that those lines start to come together around 2013, and they cross around 2015 to 2017, not shown on the graph.

So we are heading for trouble, and I am not going to say anything more about this than that, and then entertain questions, because there are certain constraints that I have coming from the accrediting body around manpower.

DR. DOCKERY: Thank you very much, Dr. Nasca. That was a delightful and informative presentation, and we will even applaud now.

(Applause)

Are there questions from the committee? It is very timely, particularly, that you come today, because we have been charged with the responsibility of writing a report to Congress on the requirements for certain schools that have been exempt from certain criteria in advance, and trying to predict their access to accredited residency

training programs.

What we have discovered is validated in your slides, and I am glad that you went ahead with the pipeline.

Dr. Hallock?

DR. HALLOCK: Maybe just for context, the 11,000 total trainees you put there, roughly 25 percent are IMGs.

DR. NASCA: Yes.

DR. HALLOCK: So that would be 25,000. Of that group, 20 percent are U.S. IMGs, which is really vital for this group. So in training, there are probably 5,000 to 6,000 U.S. citizens, IMGs, coming out of the system that we talk about, just to give everybody that perspective.

So as Dr. Nasca showed you these numbers changing, the availability of spots for IMGs and for the U.S. IMGs begins to be a part of that pinch that he demonstrated.

DR. REGAN: Excuse me. I have a question on the slide right before that where you had the two lines. Can you go back to

that?

I see you have a line, and at the very end you added in the total estimated increase in allopathic and osteopathic graduates, but the line that you first started with -- wasn't it only allopathic? So did you actually increase -- So you added -- So it is cumulative?

DR. NASCA: Yes. You can see, the number is approaching 25,000 in 2013 there. Let me go back, and I will show you where that comes from. Right there.

DR. REGAN: Okay. I knew you had separated them out, and then I didn't know if you were cumulative at the end. Okay. Thank you.

DR. DOCKERY: Other questions?

DR. MALDONADO: Are there any specialties, primary specialties, that are losing positions and accreditations overall?

DR. NASCA: Yes. Well, accredited versus occupied, because there are clearly specialties over that five-year period of time

that had a downward trajectory in occupied positions, not accredited positions.

Thoracic surgery would be one of them, dramatically down. Medical genetics would be a second. A third would be down but only slightly down, is general surgery. So there a number of specialties that have a downward trajectory in occupied positions.

I didn't talk about occupancy rates of accredited positions, which is another dimension to this whole issue, because the number of vacant GME positions that are accredited in the United States has dropped dramatically over the last five year, and that is before this big influx of onshore graduates really hits the pavement.

DR. DOCKERY: What has been the success of the encouragement to the effort to grow more primary care accredited residency and training positions and to encourage people to enter primary care?

One of the reasons that I ask that question, too, is the impact of the student

debt that influences specialty choices.

DR. NASCA: Well, there are no deficiency in primary care positions in the United States. So the issue is not accredited positions. The issue in family medicine is it is applicants in internal medicine and, to a lesser extent, pediatrics. It is the specialty choice at the end. It is the subspecialization after core residency in those disciplines.

OB/GYN is pretty stable. Hasn't gone up dramatically, hasn't gone down at all, really. It is up slightly, if you consider that a primary care discipline.

So the barrier to U.S. graduates choosing primary care is not availability of accredited residency programs.

DR. DOCKERY: And is OB/GYN the only specialty that does their own accreditation? Their special requirements are approved by the ACGME, but they have their own accreditation process.

DR. NASCA: Only for two subspecialties. I guess it's -- It is not

their core residency. Their core residency --

DR. DOCKERY: Reproductive endocrinology and --

DR. NASCA: -- MFM, maternal fetal medicine, and there is discussion about that stopping.

DR. DOCKERY: Other questions? Dr. Shah.

DR. SHAH: How do the international medical graduates fit into the pipeline, because I don't think you included that one in there. Correct?

DR. NASCA: Well, by implication -- If one makes the assumption that the majority of the positions will first go to U.S. graduates, the implication is that international graduates will be crowded out.

Now that is not a given, and it is not 100 percent. So what I actually believe will happen is that somewhere around 2011-2012 we will start to see some U.S. graduates from the bottom of the class not get residency positions, because there will be very highly

competitive international graduates who will be seen as more desirable than some of those graduates.

We have seen that in a microcosm on occasion in the past, but I think we will start to see that long before the lines cross.

DR. DOCKERY: Dr. Regan?

DR. REGAN: And what is the medical community doing to address this issue? They are looking forward to increasing anymore slots?

DR. NASCA: The issue -- This is really a governmental issue. This is all driven by government funding. There has been a cap on the number of residency positions since 1997, and until that cap is lifted, you will not see -- I don't believe you will see -- and I am not controlling this. This is individual hospital decisions about whether they either start or expand residency positions.

The reason that fellowship positions continue to expand in the absence of specific funding for them is because, at an

institutional level, there are benefits to having fellowships.

Most of the fellowship numbers we are seeing are in new subspecialties, clinical cardiac electrophysiology, interventional cardiology, sleep medicine, palliative care. All of these are new subspecialties that have been introduced that are on the end of the pipeline. They don't increase the diameter of the pipeline.

They provide a programmatic advantage to the institution. So they are willing to front the dollars to support these trainees; whereas, for core residency positions there is less of an economic benefit.

The other factor is that many of our primary care residencies or pipeline residencies are at or near their maximum size in each of the institutions that are currently active. They don't have the capacity to expand. So we would really be talking about putting on new institutions.

MS. LEWIS: Dr. Nasca, do you know

the status of the regulation proposed by the Center for Medicare/Medicaid Services in 2007 that would eliminate the Medicare funding for GME positions in the U.S.?

DR. NASCA: Well, there have been numerous different kinds of approaches. You know, MedPAC continues to recommend continuing reductions in the indirect graduate medical education component. I think that -- and there have been at times in the past single payer models proposed -- I mean all payer models, not single payer -- all payer models proposed for graduate medical education.

As far as I can see, there has neither been a mounting charge to increase the number of positions, and there hasn't been a lot of support for doing away with graduate medical education funding. I think there would be -- It would be very difficult to do that. So they whittle at it, I think.

DR. DOCKERY: Are there other questions? Mr. La Porte?

MR. LA PORTE: So I am a little

confused about the location of the bottleneck, because I heard two things. One is that there is a cap on the number of seats and funding, and then two is that the hospitals have their own restraints.

So is the bottleneck with the hospitals or with the government funding?

DR. NASCA: I don't understand your question.

MR. LA PORTE: I heard you explain that the hospitals aren't inclined to increase the number of residency positions. I also heard that there is a limit on the number of seats -- I mean there is a limit on funding.

DR. NASCA: Yes.

MR. LA PORTE: And so I am getting confused. Let's say, for example, a hospital in Chicago wants to add more residency positions. Are they blocked from doing so because of their own constraints? Is that your point, or is it because, even if they applied, there wouldn't be funding?

DR. NASCA: Depends on the hospital.

Both of those can be true in one institution. One can be true in one institution and not in another.

What is clear, for instance, is -- For instance, in the Commonwealth Medical School in -- the new medical school in Northeastern Pennsylvania, they are attempting to start residency programs in support of that medical school in the multiple specialties that you need.

Unfortunately, small numbers of residents from other institutions have rotated through the participating sites. So they have an existing cap with Medicare. They have an existing number that is very low. They cannot afford to start those residency positions, because they will receive no medical education funding, incremental funding, from Medicare because of the cap.

So that institution -- it's purely money. In other institutions -- for instance, University of Chicago -- may not be able to increase its internal medicine residency

because they have all of their beds covered. They have the appropriate numbers. Then in that situation, it wouldn't necessarily be cap money. It would be capacity.

DR. DOCKERY: Dr. Hallock.

DR. HALLOCK: The problem with the cap is exclusively one of limitation of funding.

DR. NASCA: Yes.

DR. HALLOCK: If a hospital chose to go over its cap, it could, if it could afford it.

DR. NASCA: Right. And that is exactly what is happening with these fellowships, because there is an economic equation that makes sense to them.

DR. DOCKERY: Dr. Crane?

DR. CRANE: Yes. I have a question for you. When we consider public and private hospitals, is there a differentiation in terms of foreign medical graduates and U.S. medical graduates that are accepted into some of those programs? Is it proportioned or do your

standards prohibit that?

DR. NASCA: Our standards are neutral on the medical school of attendance. The entry criteria for any ACGME accredited program include ECFMG certification. So it is one of the -- There is no prioritization, either in our standards or in the eyes of the institutions. I think it is on an individual basis.

As regards particular types of institutions having a predominance of one origin or another of the trainee, I think that is largely institutional. It is not in any way accreditation related.

DR. CRANE: There is no regulatory requirement to --

DR. NASCA: There is no regulatory directive. We do not direct trainees in any direction, nor am I aware that anybody does.

DR. DOCKERY: Other comments or questions? Have you worked out the coordination between the institutional accreditation visit for the institutional

requirements and then the program review of the residency training programs?

It is terrible when you have lived long enough that you lived through the installation of the institutional requirements and the grumbling and carrying on about they get the institutional visit and then they get the program visit, and how are those things going now?

DR. NASCA: Well, they are going grumblingly well, depending on where you are, I guess.

DR. DOCKERY: So nothing changes.

DR. NASCA: Nothing changes, and we are about to make it worse, because we are probably going to have a separate institutional review for duty hours compliance around that philosophic issue that we talked about.

DR. DOCKERY: Would you briefly just tell us what the six competencies are, so that we all can know what those are, and you're thinking about a seventh, which you mentioned?

DR. NASCA: Medical knowledge,

patient care, professionalism, communication skills and interpersonal relationships, practice-based learning and improvement, and systems-based practice.

DR. DOCKERY: Dr. Munoz, you had a question?

DR. MUNOZ: If the logjam breaks and the funding is lifted or the cap lifted, what do you think the -- or what is the estimation of the catch-up rate will be? Given that the projection of increasing both U.S. medical graduates and an increased number of foreign medical graduates, would you, even if you started now, be able to create enough slots that you wouldn't still run into the pinch?

DR. NASCA: I think that will be specialty specific. One of the things we are trying to understand is, you know, we know pretty much how fast you can create a medical school.

It takes between three or four years to go through the pre-accreditation process, depending on what time of the year you start,

before you actually matriculate your first class. Then it is, obviously, three years -- or four years later then you graduate the class.

It probably takes almost as long to start a neurosurgical residency or a general surgical residency, the reason being that the infrastructure for the GME programs, especially around research and the breadth of clinical opportunities and faculty depth in all of those areas that is required is very similar to starting a medical school.

A lot of these people are small in number -- for instance, neurosurgery or some of the subspecialties in surgery -- and there is significant difficulty in doing that and significant expense.

So I would anticipate that, were we to start tomorrow to expand, we would barely be coming online about this time. So I think the clock is running.

DR. DOCKERY: Again, thank you very much, Dr. Nasca.

(Applause.)

DR. DOCKERY: The committee will adjourn briefly to say goodbye to Dr. Nasca, while he also collects his technological accompaniments.

(Whereupon, the foregoing matter went off the record at 1:16 p.m. and went back on the record at 1:24 p.m.)

DR. DOCKERY: If Mr. James has returned with his entourage we will now hear the Dominican Republic. Are the guests from the Dominican Republic here, Mr. James?

MR. JAMES: I believe they are.

DR. DOCKERY: Okay, thank you.

MR. JAMES: Have you ever had déjà vu? I mean, I just dreamt I just was here not too long ago.

DR. DOCKERY: Well tell me, how did it go?

(Laughter)

MR. JAMES: I thought it went pretty well. But that was just my dream, of course.

DR. DOCKERY: Well this is the post-

test.

MR. JAMES: This is the post-test? But I hate post-tests. All right.

Members of the Committee, I again will be presenting the report submitted by the Dominican Republic and you can find that again at Tab D.

The Secretary of State for Higher Education, Science and Technology is the entity responsible for evaluating medical schools within the Dominican Republic. In 2007 approximately \$37 million in federal student financial aid was awarded to students that enrolled in post-secondary institutions located within the Dominican Republic.

At the spring 2004 meeting, you determined that the Dominican Republic accreditation and approval process continued to be comparable to that used by the United States to accredit its medical schools. At that meeting you also requested that the country submit a report of its activities regarding its accreditation of medical schools within the

country.

That report was reviewed at the spring 2007 meeting, and as a result you asked the country to provide an additional report covering three issues reviewed at your fall 2007 meeting. Your review of that report determined that only one of three issues was satisfactorily addressed, and you requested an additional report that covered the two remaining issues, as well as an additional issue that you raised.

That report again was reviewed at the fall 2008 meeting with the determination that the country provide information on two issues, which would be reviewed at this meeting.

First, you asked the country to provide evidence that demonstrates that it collects and analyzes student outcomes measures.

The country responded by stating that it requires medical schools to achieve a 65 percent passage rate for all students taking

the USMLE examination. It reiterated that as of January 1, 2008, all medical schools must require students from the United States to sign a form authorizing the release of USMLE test scores to the medical school in which they were enrolled. However, because this requirement had just been implemented, the data collected is incomplete.

The country also stated that beginning in 2009 it will conduct unannounced visits to verify that test results are in fact being collected. Further, it notes that medical schools must submit an annual report that provides student data, including USMLE test information, and in fact the country provided a spreadsheet to demonstrate that it is collecting the data.

However, Department review of those spreadsheets observed that only dates were entered under the examination column, but no test results were entered. The staff also noted that no data had been entered for the majority of the students from the United

States, that is, the dates for taking the test.

The country noted that it was going to meet with the accreditation committee to determine what standards would be developed regarding outcomes. The staff notes that it was not aware or has no knowledge about an accreditation committee and what role this entity plays in the evaluation of the country's medical schools.

Second, you requested that the Dominican Republic provide information regarding student retention each year for each medical university.

The country responded by providing a spreadsheet that identified withdrawal rates for its 10 medical schools. However, the country again stated that it needs to meet with the accreditation committee to determine the standards that it will use to evaluate that data.

In conclusion, the country has responded to the issues raised by the

committee. However, you may want to explore with the country two issues: one, the involvement of the accreditation committee in establishing standards for medical schools and what role the accreditation committee plays in the evaluation of medical schools; and two, how the country intends to gather licensing examination test data for the USMLE and Puerto Rican licensing examinations.

Currently the country has not demonstrated that it collects and evaluates test data. It simply gathers - it has only provided evidence that it puts dates down for when I guess the test would be administered.

And further, you may want to explore how it intends to evaluate licensing examiner's patient examination pass rates and retention rates.

Representatives from the country are here to answer your questions that you may have and that concludes my remarks, and I am now available to answer any questions.

DR. DOCKERY: Thanks, Mr. James.

Are there members of the Committee before we ask the representatives from the Dominican Republic to approach the table? Are the representatives from the Dominican Republic here? Please join the table. Please state your names and use the microphone and I invite you to make any comments you would like to make.

DR. HUYKE: Good afternoon. My name is Emilio Huyke. I am the consultant for the Dominican Republic and I will be speaking on their behalf.

MS. CESPEDES: Greetings Mr. President and other members of this honorable board. For us, the Dominican delegation, it is a pleasure to be again before you. According to the request of this committee we are delegation of Mr. Emilio Huyke. The mission of the coming, the spoken - asked the advisor of the ministry and of higher education. We would like to remind you once more of our compromise and best intention to cooperate with you. Thank you. My name is Rosa Cespedes. I am

Director of Medical Education in the Dominican Republic.

DR. DOCKERY: Are there questions from members of the Committee before we go into executive session? **If we could ask our guests to please depart and they'll be called on when we open up again.**

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

DR. DOCKERY: **We can ask our guests to please return. And next we will start with India.**

And I understand that the Pakistani representative is here and would be able to be heard today, so for those that would need to know, we will plan to hear Pakistan immediately after we complete India. Dr. Hong-Silwany, welcome again.

DR. HONG-SILWANY: Thank you. Good afternoon, Mr. Chairman and committee members.

I will now summarize the analysis for the Medical Council of India submitted on behalf of the Government of India. The materials are behind Tab G. I will refer to the accrediting

council as the MCI or the council.

In March 1997 this committee first determined that the standards and processes used by India were comparable to standards of accreditation applied to M.D. programs in the United States. In March 2003 you affirmed a prior determination of comparability. At the September 2004 meeting you requested that India submit a report on its accreditation activities involving its medical schools. This report was reviewed and accepted at the September `07 meeting.

The council is before this committee again for redetermination of comparability. Based on information provided by India, Department staff concludes that India's standards and processes for evaluating medical schools remain comparable to those used in the United States.

As you are aware, the Indian medical education system is a highly structured process that is based on educational inputs. Standards are prescribed in detail and regulation, and

are verified by inspection teams during their site visits. Given the emphasis on educational inputs in the Indian system and the detailed standards that are specified for student examination format, content, and procedures, less attention has been directed toward the assessment of graduate performance outcomes in evaluating the effectiveness of the medical education curriculum and the quality of the clinical experience. However, goals, objectives, knowledge and skills are clearly outlined for every curriculum requirement.

The Indian system also requires a very comprehensive onsite inspection in order to assess the quality of a medical education program. As a result, it appears that India's system remains comparable to the process used to accredit medical schools in the United States.

Representatives from India are here today and this concludes my presentation. I'm available to answer any questions you might have.

DR. DOCKERY: Thank you. Are there any questions from the committee before we welcome the representatives from India? Thank you.

Will the representatives from India please come forward? Good afternoon. Please use the microphone and introduce yourselves, and we would welcome any remarks that you would like to make.

DR. KUMAR: I am Dr. Ashwani Kumar, Professor of Microbiology at University College of Medical Sciences. I am the representative of Delhi University and Medical Council of India.

DR. MISHRA: I am Dr. Vedprakash Mishra. I am member of the Executive Committee of Medical Council of India and also former chairman of the Postgraduate Committee of Medical Council of India. I am Vice Chancellor with the Health Sciences University in Nagpur.

At the outset, sir, we would like to record our sense of gratitude for this

opportunity whereby we are before this learned committee for the purposes of re-validation of the parity which was accorded in the previous recommendation.

As far as the self-study for the evaluation report, which is there before us, there were concerns which were ventilated, which have been dealt by being part of the information. And I would just like to briefly put those three concerns which are put across.

The first concern was about the preventive and promotive healthcare aspects of the students admitted to medical school and medical colleges. Wherein we had brought it out very categorically that every student admitted to a medical school, which ultimately is affiliated to an examining university, the university by law stipulates that enrollment is subject to satisfaction of the physical status of the child, and simultaneously he is subjected to periodic health appraisals which are a condition precedent for the purposes of grant of affiliation by that university. So the

bylaws are very speaking and that particular position is well in place in all the medical schools affiliated to various universities in the country.

The second proposition was pertaining to the grievance redressal of the students in the medical school to which we clarified that there is a grievance redressal cell, which is constituted in every medical school, and this is also a condition precedent for the purposes of grant of affiliation and of the regulation of the respective universities to which the medical schools are affiliated.

The third chairman's recommendation was pertaining to the concerns of the faculty vis-a-vis the contradictions or conflicts, if any, between the professional and personal propositions. They're also the two mechanisms, standing mechanisms which are available in India. One is a standing grievance committee which a university has, which is open to teach the faculty and medical schools and simultaneously there is a university and

college tribunal which is constituted for each of the universities which is responsible for the process of adjudication pertaining to any one of these grievances of various magnitudes which are structured and defined.

And the fourth concern which was put across was about the orientation and training of the inspectors who are conducting the onsite inspection of medical schools in the country. To wit, the situation was that Medical Council has got full-time medical inspectors who are appointed on a full-time basis subject to fulfillment of the eligibility conditions and they are oriented in regard to what exactly the process of inspection is. The team, which comprises of the full-time inspector along with two inspectors who are drawn from a panel, which is prepared by the Medical Council of India. Out of the senior faculty members in public sector medical colleges who could be holding the rank of professor, maybe with minimum of seven years of experience, and they are oriented by the full-time inspector.

Other than this, Medical Council of India also conducts periodic update of how exactly the inspections are required to be conducted. Although the format of the inspection is heavily structured, it is almost like a checklist and therefore there is not much of a scope whereby a real rigorous training is required, but still, as an abundant caution and in order to ensure that objectivity, transparency and accountability is worked in the entire process of onsite inspection, structuring of the mechanism along with periodic orientation which is structured and carried out by Medical Council of India, for the group of inspectors who are out of - the panel of whom is made along with the full-time inspectors.

So these were the four concerns which were put across which have been replied to and in the context of that we are here to answer any questions, if any.

DR. DOCKERY: Thank you very much.
Are there questions from the Committee before

we go into executive session?

MR. La PORTE: So just a quick follow-up on what you said. So if I understand, points one, two, and three that you address I think with regards to student health and grievances - I can't recall the third one - they would fall under the surveillance, I guess, of the University Grants Commission?

DR. KUMAR: Not - the University Grants Commission basically is the vital body. Like Medical Council of India is for medical education, University Grants Commission is for higher education. But you're right, medical universities also fall under University Grants Commission and therefore the affiliating conditions and the various bylaws which the universities are expected to make will be in the context of a central, you know, a model act, or a model bylaw, which is stipulated by University Grants Commission.

MR. La PORTE: Right.

DR. KUMAR: So that basically ensures uniformity of bylaws all over the

country and as you're right, it is the accreditation of these universities is subject to by the National Accreditation and Assessment Council which is a body created by University Grants Commission, autonomous in nature. Therefore it is a dual control. The educational component of medical education by Medical Council of India and the other associated conditions which are governed by University Grants Commission in regard to universities, they will be falling under those bylaws.

DR. DOCKERY: One question which I think is good to be answered in the public forum is when you were here before and as we've looked at the applications there's concern about the proliferation of private medical schools in India and how you were addressing that. Do you have any updated information in terms of how you're addressing those concerns?

DR. KUMAR: Absolutely. Yes. Chairman, because you have brought a very right concern because this is also the concern which

the Medical Council of India is going to be sharing with this committee. Because if you take into consideration the report, it contemplates 284 medical colleges when we applied, but when I am before you, I have five more medical schools added and I have 289 medical schools under Medical Council of India of which 137 are in public sector and remaining are in private sector. But as far as the standards, regulation and other propositions are concerned, regulations are common, mechanisms are similar, and therefore the standards which are required to be involved by the Medical Council of India irrespective of the nature of the college whether it is private sector or public sector, regulatory control is uniform, standards prescribed are uniform, monitoring measures are uniform, and therefore the parity of standards amongst the two are absolutely maintained as it is required to be.

DR. DOCKERY: Dr. Shah?

DR. SHAH: All medical schools are affiliated with the university, or are there

any freestanding medical schools?

DR. KUMAR: There aren't. You see, ultimately we have an affiliated character, the three-tiered mechanism. Medical Council of India is a unitary body for controlling the entire standards of medical education, all medical colleges. But invariably it's a condition precedent that if a medical school is required to be open, first there has to be an affiliation with the university which ultimately will be examining the students and resulting in conferment of a degree. Because the recognition schedule which we have is university-based and not institution-based.

DR. DOCKERY: Thank you very much.

If we could ask our guests to please depart.

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

DR. DOCKERY: Okay. We will take just a 10-minute break and then we will consider **Pakistan**, to be followed by the United Kingdom.

(Whereupon, the foregoing matter went off the record at 2:13 p.m. and went back

on the record at 2:22 p.m.)

DR. DOCKERY: Mr. Sneed.

MR. SNEED: Good afternoon, Dr. Dockery, Committee members, and guests. I will summarize the analysis of the application for redetermination submitted by the Pakistan Medical-Dental Council. Hereafter I will refer to as the agency or the PM&DC. You will find materials relating to the analysis under Tab H.

In March of 1997 this committee initially determined that the standards used by the PM&DC were comparable to those used to accredit medical schools in the United States.

In March of 2003 this committee again reviewed the PM&DC accrediting standards and reaffirmed its prior determination that the standards were comparable to the accrediting standards supplied to medical programs in the United States and requested a report of its activities. In March of 2004 this committee reviewed and accepted the PM&DC report of its accrediting activities. This committee also

requested that the council submit another report on its accrediting activities for review at its March 2005 NCFMEA meeting. However, in 2005 this Committee's review activities were suspended. In September 2007 this committee accepted the report and requested that Pakistan reapply for comparability determination at the March 2009 NCFMEA meeting, which is the subject of today's presentation.

Department staff have reviewed Pakistan's guidelines and supporting documentation and found the following. The standards of accreditation used by the PM&DC to accredit medical schools offering programs leading to a medical doctorate degree are closely comparable to standards of accreditation applied to MD programs in the United States. However, it should be noted that there are some issues the Committee may want to explore with the country's representatives. These include a concern that the agency's policies are not clear regarding the requirement for maintaining the

confidentiality of student records. If the - and if the country intends to use a percentage of post-graduation achieved by students from each medical school it needs to clarify what is meant by post-graduation. If the country intends to use pass rates achieved by students on international examinations, the country needs to clarify whether a significant number of students take these examinations.

Based on a review of the report submitted by Pakistan, the Department staff concludes that Pakistan has provided a response to all but two concerns requested by the Department.

There have not been any known Title IV funds dispersed to this country to date. There are representatives present today to receive questions. This concludes my report.

DR. DOCKERY: Thank you, Mr. Sneed.

Are there questions from members of the committee for Mr. Sneed? Then we welcome the representatives from Pakistan to come forward please. We welcome you and thank you for

coming such a long distance to be with us. And if you would please use the microphones and introduce yourselves and let us know your names and your respective positions.

DR. AKBAR: I'm Dr. Ahmad Nadeem Akbar. I'm the Registrar of the Pakistan Medical & Dental Council and the CEO.

DR. DOCKERY: And your other colleagues?

PROF. A.J. KHAN: I'm Professor A.J. Khan. I've been the principal of and established a few medical colleges for the government. I've been Director of Health of Government of Pakistan. I've also been a federal minister and I'm very closely connected with Pakistan Medical Council and medical education in Pakistan.

PROF. UMAR KHAN: I am Dr. Umar Khan. I am professor of physiology and also associate dean at my university. And I'm a member of the Pakistan Medical & Dental Council.

DR. DOCKERY: Thank you. Are there

any remarks to the committee?

DR. CRANE: Thank you very much. There are a few things which I want to say. This gives me immense pleasure to reiterate the fact that the Pakistan standards of education were declared comparable to U.S. standards by the NCFMEA in 1997. And the NCFMEA has reaffirmed the comparability since then, so we are very grateful for that.

I would like to share with the committee that the graduates of our system are doing exceedingly well in the U.S. system as IMGs. And there are a lot of U.S. nationals who come and study in Pakistan and then they join back your system in the U.S. Although study and review of emerging trends are continuously carried out by the Pakistan Medical & Dental Council, to stay abreast with the emerging trends only the prudently adopted measures are included, and there is no substantial change in the education protocols and standards. We can all take your questions.

DR. DOCKERY: Are there questions by

members of the Committee before we go into executive session? If we could ask our guests please to depart and we'll go into executive session.

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

DR. DOCKERY: Have a safe trip home. Thank you very much. We'll next hear the United Kingdom, please. Mr. James, welcome back again.

MR. JAMES: Thank you, Mr. Chair.

DR. DOCKERY: And I notice in the - and I mentioned this to some of the staff earlier, that they offered to have video conferencing for their appearance today. And how seriously did you take that?

MR. JAMES: Well, I think that the answer is that we would have liked to have done that, but unfortunately it just was not feasible to do that through the hotel here I think. I think it was even teleconferencing, I believe is what they were talking about. So it just, I think price-wise, just was not feasible

for us to look at that. But we would have liked to have done that. I mean, that would have been ideal, I think.

DR. DOCKERY: I remember though that the price tag for that single event would have been \$7,000?

MR. JAMES: That's what I heard, yes.

DR. DOCKERY: So.

MR. JAMES: That's a great dive trip to Australia.

DR. DOCKERY: Yes. Roundtrip.

MR. JAMES: Exactly.

DR. DOCKERY: Mr. James.

MR. JAMES: Thank you. Good morning, members of the Committee. I will be presenting the application for reconsideration of comparability submitted by the United Kingdom which I shall refer to as the UK. The documents can be found at Tab N.

The UK was first reviewed at the fall 1995 meeting of the National Committee on Foreign Medical Education and Accreditation.

Continued comparability was granted at your fall 2001 meeting. In 2007 approximately \$19 million in student financial aid was awarded to students attending post-secondary institutions in the UK.

In its current application the UK outlined a process that is in most ways comparable to the evaluation process used to evaluate medical schools in the United States.

However, the standards used by the UK to evaluate the medical education in some areas are broad and do not provide any specific guidance regarding to the guidelines outlined in the Department's questionnaire. For example, the standards neither provide any specific guidance on what subject areas should be included in the basic science component of the medical education curriculum, nor do the standards outline core clerkships that all students must have.

Department staff reviews of site visit reports verify that the teams do review the curriculum and some reports identified some

basic science courses that are offered. However, the staff could not determine that the country requires all the elements of the basic science as outlined in the guidelines to be taught in medical schools.

Similarly, site visits verify that teams evaluate the clinical portion of its medical education program, but there's no indication of what clinical rotations are required.

In other instances there were no standards, written standards, for some of the guideline requirements. For example, there are no written standards regarding the qualifications required by the chief academic officer of the medical school, or the involvement of the faculty in hiring, retention and discipline of faculty members.

In these instances the GMC, the General Medical Council, who is the entity responsible for accrediting the medical schools within the United Kingdom stated that these issues are under the purview of the

universities.

The analysis of the country's application led staff to identify seven issues the committee may want to explore further with the country. These same issues were raised in the country's application in 2001 in a meeting between a Committee member, Department staff, and the Chair of the General Medical Council's Education Committee was arranged to explore these very issues. As a result of that meeting, the country was able to satisfactorily answer all of the Committee's concerns. However, the Department's staff analysis of the country's current application and their response to the analysis of their application did not fully resolve the seven issues.

Therefore, you may want to gather more information from the UK on the following issues: whether the country has standards or how the country determines if the qualifications of the chief academic officer of the medical school are appropriate; the involvement of the faculty in the hiring,

retention and discipline of faculty members; whether the country ensures that all basic sciences are included in the curriculum; whether the country ensures that all students must take all of the clinical clerkships described in the guidelines; whether the country requires disciplines that support the fundamental clinical subjects such as diagnostic imaging and pathology; how the country ensures that a student is given the opportunity to challenge the accuracy of their student record; and finally, whether the country has written policies that require medical schools to obtain approval regarding offering new courses, major changes to the curriculum, or the assessment of the program.

In summary, the Department staff believes that the medical education program is comparable in most ways to that used in the United States. Further, based upon the documentation submitted by the UK, based upon the review of those documents provided by the UK, Department staff believes that the

graduates of medical schools are fully qualified to enter the field of medicine. The main difference between the process used to evaluate medical schools in the United States and the UK are in the lack of specificity of the standards in some areas.

There are, as you are aware of, no representatives from the UK present today. And that ends my prepared comments and I am now available to answer any questions.

DR. DOCKERY: Thank you, Mr. James.

Are there questions from the members of the committee before we go into executive session?

If we could ask our guests to please depart then.

BEGIN EXECUTIVE SESSION

END EXECUTIVE SESSION

DR. DOCKERY: We can ask our guests to return. And let me ask the Committee how you would like to function for the rest of the day.

I have about six issues that I need to talk with the committee about to get some direction.

It's now 5 after 3:00. There is not a

representative here from Canada. It would be my suggestion that we hear Canada and then we close the deliberations on the countries today and then go to deal with our business and try to anticipate that we could adjourn a few minutes before 5:00. What is the favor of the Committee? Okay, in that case then we'll go ahead and hear Canada. Let me interrupt our progress of the meeting to recognize a representative from Pakistan who would like to make a presentation.

PROF. A.J. KHAN: Thank you very much, sir. This is just - we are really, we have come from far off and we are impressed, and particularly impressed and I'm sure not only that we have given some information. We have learned a lot. And from Pakistan Medical & Dental Council it is just a memento as you can see. It's not a very gainful thing, but it'll just perhaps remind you that we came here and you were kind to us and you listened to us and we learned from you. And according to the United States rules it does not cost even, I

think, ten dollars. It's less than that. So, I understand you have got a rule that it should be less than twenty dollars. This is much less than that. But this will - perhaps you will like it, the reminder that we came here. And you have been kind to us. And of course, because of we're coming here and all these things, we are learning so much. And we continue. And we also admire what you are doing here. The questions that you asked are so good, so nice, and so informative and useful for us. If I may give this to each member.

DR. DOCKERY: Thank you very much. Rather than taking your time, let us thank you with our applause and if you'll just leave them on the table, then I promise you that each of us will pick them up and we also admire the box in which they're contained. So thank you very much.

(Applause)

PROF. A.J. KHAN: Thank you.

DR. DOCKERY: Staff will tell you to where to leave them.

PROF. A.J. KHAN: Thank you very much.

(Canada)

DR. DOCKERY: Thank you. Dr. Jones, we welcome you back again.

MS. JONES: I shan't go until Dr. Dockery returns. I think that your chairperson should be in the room.

DR. DOCKERY: Just for you all to know, I refused a photograph. Dr. Jones?

MS. JONES: Good afternoon, Dr. Dockery, and Committee members. I am pleased to present you with the summary of the e-petition for comparability of redetermination submitted by the Committee of Canadian Medical Schools, or CACMS. It's found behind Tab A.

Just a little background on CACMS shows that in February 1995 this committee originally determined that the CACMS used accreditation standards and processes in Canada that were comparable to the standards of accreditation applied to the M.D. programs in the United States. Similarly, the CACMS

reports that it is the Canadian counterpart to the Liaison Committee on Medical Education, or LCME, and uses the LCME standards and processes to accredit the Canadian medical schools.

Since the initial comparability determination in 1995, the CACMS has received continued redeterminations from this Committee.

CACMS has also submitted reports requested by the Secretary that included, one, an overview of its accreditation activities, two, changes to the laws and regulations, three, changes to the standards, processes, and procedures, and four, a schedule of upcoming accreditation activities. After returning from a break in this committee's activities in 2007, the Department postponed the NCFMEA's review of Canada until this meeting to allow the CACMS to compile information requested by your executive director and Department staff.

The executive director specifically requested, among other things, that the CACMS provide, one, written evidence of the accreditation relationship that exists between

the LCME and CACMS, and two, explain what acknowledgment, recognition, or delegation of authority the CACMS had received from any governmental entities, either national and/or provincial, to serve as the insurer of quality medical education programs leading to the medical degree or its equivalent in Canada.

The CACMS Secretary, Dr. Nick Busing, spelled B-U-S-I-N-G, submitted a few documents and participated in a telephone conference with Department staff. The conference focused on identifying the entity responsible for approving opening and closing of medical schools in Canada. Dr. Busing explained that ministries of education in each province have the responsibility to open and close a medical school because no federal Department of Health or Department of Education exists in Canada. Additionally, two separate decision meetings on the Canadian medical schools occurred. The LCME makes an accrediting decision on a Canadian medical program. Then the CACMS also makes an

accrediting decision which may have different findings. Each group merges their respective findings and sends the combined findings to the school in one decision letter. The decision letter is signed by both the LCME and CACMS representatives.

The Department of Education's Office of Federal Student Aid provided the latest data on the federal student loan program disbursements under the Federal Family Education Loan program at 13 of the 17 accredited schools in Canada. For Fiscal Year 2007-2008, 1,391 students attended Canadian public universities that had medical schools and received nearly \$19 million in loans. The 2006 cohort rate, default rate shows that there were 703 individuals in repayment status with six individuals in default for a current default rate or the last known default rate at 0.9 percent.

The information provided by the CACMS in its application for redetermination of comparability for accreditation of medical

colleges is, of course, the subject of this analysis. First, the standards of accreditation used by Canada to accredit medical schools offering programs leading to the M.D. degree are the same standards of accreditation that are applied to review medical programs in the United States. Second, the CACMS has submitted written documentation demonstrating the implementation of its accreditation process.

Through Dr. Busing the CACMS, it has reported that medical schools have a relationship with the provincial governments related to the approval, the opening, and closing of a medical school, and the licensure of medical graduates who complete training at a CACMS accredited medical school. Yet, the CACMS has not reported on the relationship it has with Canada. Therefore, this committee may want to ask CACMS to provide evidence demonstrating that a relationship exists with Canada and that the country accepts the agency as the organization it relies upon for ensuring

that the accredited programs provide quality medical education.

No representatives from the country or CACMS are present today. However, I will respond to any questions that you have regarding the staff analysis. Thank you.

DR. DOCKERY: Thank you, Dr. Jones. Are there any questions from members of the committee before we go into executive session? Thank you. If we could ask our guests to please leave again.

(Whereupon, at 3:40 p.m., the proceedings went into Closed Session and the Open Sessions ended for the day.)