

Caribbean offshore medical schools - Accreditation and financial challenges

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I. INTRODUCTION

A. Why This is an Issue of Global Importance

Offshore Caribbean medical schools (OCMS) were first established in the late 1970s. In 2013 more than three-quarters of the United States (US) International Medical Graduates (IMGs) graduated from OCMS (Eckhart & van Zanten, 2015). Many also admit students from Asia (predominantly from South Asia) with many graduates returning home to practice medicine (Morgan, 2017). Students from the Middle East and West Africa, especially Nigeria and Ghana are also admitted. There has been no published study on these proportions but at the medical school where the author works over 70% of students are from South Asia and over 15% from Nigeria. The proportion at other medical schools varies and a comprehensive study may be required.

The quality of these medical schools varies greatly. Certain older and well-resourced medical schools compare well with international standards while many others often lack qualified faculty, research exposure, student advising and integrated curricula (Eckhart & van Zanten, 2015). From 2023, to be eligible for Educational Commission for Foreign Medical Graduates (ECFMG) certification, physicians should graduate from an appropriately accredited medical school using criteria comparable to those accepted globally like those developed by World Federation for Medical Education (WFME).

II. PERSONAL VIEW

A. Accreditation of OCMS

The two major agencies are the Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP), Jamaica and/or the Accreditation Commission for Colleges of Medicine, Ireland. With the 2023 deadline fast approaching, most OCMS are strongly pursuing accreditation. Recently, CAAM-HP strongly recommends that new schools seek accreditation before admitting their 'charter class' of students.

B. Newer OCMS

Students from North America typically attend older, more established schools which may offer an educational program of North American standards and a better chance of matching into a residency program. Students from the developing 'South' mainly attend new and developing schools (Morgan, 2017). The newer OCMS are smaller and have typically between 10 to 20 basic sciences faculty members. A recent article examined challenges with regard to undergraduate education in OCMS (Shankar, Balasubramaniam, & Dakubo, 2017). The major focus of this article will be on issues of economic sustainability and growth of OCMS and the influence of the business model on academic decisions.

C. Competition Among OCMS

Competition among OCMS for students is fierce (Morgan, 2017). Many new entrants undercut the competition offering a relatively low tuition fee. The reported tuition fees vary widely from under USD50000 to USD250000 (Morgan, 2017) with some of the new

entrants offering the entire program at around USD40000. The most cost-effective teaching-learning model predominantly uses traditional lectures in large classrooms which transmit information to a large body of students. Many OCMS use 'agents' for recruiting students. While published data is lacking, the author's experience and data obtained from talking to other educators indicate that most agents earn a commission of around USD3000 per admitted student and some avail schemes like an incentive payment as students move to higher semesters. For recruiting Asian and African students, OCMS have to compete with medical schools from China, and Eastern Europe who are able to offer lower tuition and larger teaching hospitals and advertise and market aggressively. The number of students at most new OCMS is low; usually less than 40 students in an intake, creating pressure on resources. There is usually a shortage of capital for innovative small-group learning methods and modern educational technology.

D. Early Clinical Exposure and Clinical Rotations

Most OCMS do not have their own teaching hospitals. Students do their basic sciences in the Caribbean and complete their clinical rotations in the US or Canada. Not having their own teaching hospitals creates challenges for providing early clinical exposure (ECE) during the basic sciences. OCMS do not have a close linkage with the health systems of the countries where they are located. Due to financial competition, they also may struggle to pay local practitioners for providing ECE to students.

The other challenge is the increasing cost of clinical rotations. Most hospitals in metropolitan cities in the US charge around USD400 per week of clinical rotation (McLean & Charles, 2018). These hospitals accept students from a number of medical schools. The oversight of the school over the teaching programs is difficult. Teaching hospitals in the Caribbean primarily under the University of West Indies (UWI) system may charge a comparable amount and offer limited seats. Schools may have their students do their rotations in local hospitals or with local specialists. This may compromise educational quality in many ways ranging from lack of a sufficient pool of qualified faculty, small catchment populations leading to a small number of patients and in some cases reduced inpatient exposure.

E. The 'Business' of Education

A major challenge in a private educational institution is the 'mixing' of business and education. In the Caribbean, it is very easy for students to transfer from one school to the other. The OCMS vary widely in their standards and academic integrity and students not happy with their grades at one university/school easily transfer into

another (van Zanten & Boulet, 2008). Each medical school is usually its own university which means external academic oversight is often minimal. Many schools try to address this issue by offering external standardised exams to their students. Many also require students to pass the United States Medical Licensing Exam (USMLE) Step 1 before starting their clinical rotations (Morgan, 2017). The teaching hospitals and the practitioners are also under pressure to admit and train a large number of students. In many hospitals, the standards of assessment may require strengthening.

F. Number and Quality of the Faculty

On examining the websites of different OCMS, the author noted that Asia and Africa account for a large percentage of the OCMS faculty. Most schools have one or two faculties per course/subject. OCMS develop their curriculum and courses of study. I personally believe that to ensure quality, OCMS should recruit only middle-level faculty members with at least five years' teaching experience. However, lower tuition fees may entice schools to hire less experienced faculty members or those without a postgraduate degree in the subject. Online video lectures and preparatory programs are available which may partly offset some of these shortcomings. The author's personal experience and insights obtained from talking to educators at other OCMS indicate most faculty members are also involved in teaching premedical students and sometimes other health programs as well.

G. Students Not Intending to Practice in North America

A large percentage of students intend to return to their home country outside North America to practice after graduation. This may create challenges for OCMS. CAAM-HP standards are derived mainly from those used by the General Medical Council of the United Kingdom and the US Liaison Committee on Medical Education. First-time pass rates, especially in USMLE Step 1, are used to measure the quality of the basic sciences program and widely advertised by medical schools in their promotional materials (Morgan, 2017). However, appearing in the USMLE is expensive and requires rigorous preparation. Students not intending to practice in North America may not be interested in appearing in the USMLE.

H. Physical Facilities

Though I have not come across studies in the scientific literature, my personal observations, inputs obtained from faculty and students and careful analysis of school websites indicate that OCMS vary widely in the quality of their campus and physical facilities. For full accreditation or accreditation with conditions, it is important that the school develops its own campus and

physical facilities. New OCMS struggle to find funding for this major upgrade requiring millions of dollars. Facilities for sports and other extracurricular activities are often compromised due to the limited physical facilities.

The number of published studies on OCMS is low. Some of the descriptions are based on the personal experience of the author, discussions with faculty and students at different OCMS and a review of the school websites. This factor should be considered while drawing conclusions.

I. In Conclusion

Newer OCMS suffer from a variety of financial challenges. Accreditation places an increasingly heavy financial burden. Lower student intake and cut-throat competition may result in low tuition fees insufficient to ensure quality medical education. Promotion and advertising costs and commissions may also impact the bottom line. The 2023 deadline from ECFMG may also impact admissions. Other regulatory authorities may also consider making regional accreditation for OCMS mandatory. The future looks challenging for new, developing OCMS. Hopefully, many of them will be able to weather the challenges during the next five years.

Obtaining objective published data on various aspects of OCMS has been difficult as the number of studies is low. Studies should be conducted to address this gap in knowledge.

Note on Contributor

Dr Pathiyil Ravi Shankar is Professor of Medical Education and Pharmacology at the American International Medical University, Saint Lucia, Caribbean.

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Declaration of Interest

The author works as a faculty member at an offshore Caribbean medical school.

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