It Is Time for the Internationalization of Medical Education to Be at Home and Accessible for All

To the Editor: The global COVID-19 pandemic has highlighted the importance of the internationalization of medical education (IoME). Here, we hope to initiate a discussion about changes to IoME formats—away from emphasis on students’ outbound travel to, instead, standardized curricula at home that are accessible to all—using an interdisciplinary approach with international higher education (IHE).1

To date, IoME primarily focuses on students’ international travel to less privileged, low- and middle-income countries.2,3 These programs are inherently inequitable, as they prevent participation of all students (e.g., students from low socioeconomic backgrounds, those with disabilities). Also, as the global pandemic continues, international student exchanges are clearly regarded as unsafe, unpredictable, and not timely. For both these reasons, it is imperative to consider how to develop students’ international skills without resorting to and expanding costly, resource-draining travel abroad programs that only benefit select students.

We propose the creation of an international curriculum at home that moves away from an emphasis on students’ international travel programs and brings IoME to all. Internationalization is now, more than ever, a priority, and its delivery must be equitable.

Internationalization of the curriculum at home is an area of educational research in IHE1 that investigates how to achieve objectives of internationalization by “… incorporating intercultural and international dimensions into the curriculum, teaching, research, and extracurricular activities, and hence [helping] students develop international and intercultural skills without ever leaving their country.”4

In medical education, the above statement means that international elements and concepts developed in IHE should be incorporated in an interdisciplinary manner to establish programs, protocols, and guidelines that foster IoME.

New technology offers many opportunities for international exposure. Formats can include virtual presentations from local cultural groups or international faculty, international exchange of online learning material, virtual courses at international partner schools, international case studies, international research projects, global journal clubs, and exposure to international peer collaborations. Expanding, strengthening, and standardizing existing local community-based projects involving refugee, immigrant, and underprivileged groups will also be important.

As international institutional partnerships, international faculty, and diverse local communities may not be available to all schools and programs, partnering with medical schools that have access to the above can provide IoME to more students.

We simply must find new ways to ensure that more, if not all, medical students acquire international competence and skills that can be used both in local and global practice.

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The MCAT Was a Barrier to Diversity Long Before COVID-19

To the Editor: The COVID-19 pandemic has forced us to renegotiate how we look at medical school admissions through the lens of equity and inclusion. Questions about test center availability and safety led some schools, despite little evidence of test center-related infections,1 to waive the Medical College Admission Test (MCAT) requirement for the 2021 cycle.2 Temporarily waiving the MCAT not only fails to acknowledge but also exacerbates the test’s harmful prepandemic effects on racial, ethnic, and socioeconomic diversity. Any decision regarding the MCAT should be substantive and create lasting change to promote the diversification of the medical profession well beyond COVID-19.

Many schools with the highest average MCAT scores often have modest levels of diversity in their student bodies, valuing the cost of maintaining stature in U.S. News and World Report rankings over diversity, equity, and inclusion.3 We must balance the MCAT’s role as a normative keel with our need to open medical school admission to more students from diverse backgrounds. Recent literature demonstrates medical schools accepting students with MCAT
scores in the middle third (495–504) increased diversity and that they progressed through their academic program at rates similar to those in the upper third.1 Because the difference in academic progress varies by 3%–5% between students with MCAT scores in the middle and the upper third (defined by 4- and 5-year graduation rates on the old MCAT and on-time progress year 1 to 2 on the new MCAT), “prestige” is forcing many of our top-ranked medical schools into the bottom quartile for diversity.

If COVID-19 redefines our social contract, it should also prompt us to reconsider our relationship with standardized testing. Although holistic admissions can help bridge this moment, a wholesale reconsideration of how we use the MCAT is also necessary. We should evaluate the feasibility of making the MCAT a pass/fail exam, like the United States Medical Licensing Examination Step 1. This is not an effort to eliminate the MCAT but rather to “right size” its importance. By dichotomizing the MCAT into pass/fail scoring groups, we would leave open the door to more multidimensional discussions of what our applicants offer the profession and future patients without sacrificing quality.

Until medical training becomes less reliant on multiple-choice assessments, the MCAT will remain a normative marker in medical school admissions. The question becomes: How do we use the MCAT to create the workforce we seek and not just the workforce with the “highest score?”

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Medical School Inaugural Class Faces Additional Challenges Due to COVID–19 Distancing Restrictions

To the Editor: In the fall of 2020, I started my first year in medical school as part of the inaugural class of 30 students at the University of Houston School of Medicine. A new medical school faces many challenges, including developing a culture, establishing student support systems, and building relationships between students and faculty. However, when the COVID-19 pandemic hit, social distancing requirements severely hampered efforts to build relationships with classmates and create a supportive culture.

In Houston, Texas, the COVID-19 threat level was high at the start of the school year, and the county recommended only leaving the house for essential activities. All classes, apart from the anatomy lab, were moved online. As a result, my interaction with classmates was rare and primarily focused on the anatomy lab. Gatherings and group study sessions were discouraged to help prevent the spread of the virus.

The few classmates I had contact with shared my feeling of forced isolation that resulted due to the distancing requirements. We could sense there was limited trust in one another, so we created a group chat that included all 30 students to help build personal connections. Through this chat, we organized a beginner’s Spanish class and a summer book club that we renewed for the winter break. Additionally, video conferencing enabled us to meet virtually and still read body language and facial expressions; we even became comfortable joking with each other. Through these interactions, we bonded as a class, which has helped to form a more supportive and cooperative school culture.

My relationships with professors have also been slow to develop due to online-only classes. I could not stay after class or drop into a professor’s office just to talk. Professors were available by appointment, but most students, myself included, were hesitant to schedule an appointment simply to chat. However, to help form these relationships, each student was paired with a faculty mentor to help guide them through common pitfalls of their first year. My mentor has not only offered academic guidance but has also provided support and direction, including encouragement to write this letter.

Regardless of the circumstances, the first semester for a new medical school is always challenging. The pandemic has made it even harder, but small-group video conferencing, along with active relationship-building efforts, and faculty mentorship, have proven to be effective tools in bridging connections between students, as well as between students and faculty. This support system, though atypical, has been crucial to develop the perseverance and creative solutions required for success. At the start of the semester, I was concerned how to make meaningful connections in this environment. But after completing the first semester, despite my initial apprehension, I had formed close relationships with classmates and faculty.

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