PRACTICE IN THE PROMISED LAND—INTERNATIONAL MEDICAL GRADUATES

Health care reform in the United States concerns every American, and no one is sure what is going to happen. But change is going to come and is going to cause discomfort.

Big changes are in store for the international medical graduates, a sizable provider force, which accounts for 20% of all practising physicians.1 Of all the foreign-trained physicians most are also foreign-born from such Third World nations as India, Pakistan and the Philippines. The influx goes back more than thirty years, when they were called foreign medical graduates. Recently, both sides, the medical officials and leaders of organized medical politics as well as the alien physicians themselves, changed the term of description to 'International medical graduates (IMGs)', leaving the American medical graduate, peculiarly, outside the genre.

From the very beginning it has never been a perfect deal for either side. Medical officials have always been wary of graduates of medical schools about which they know very little. And IMGs have often felt uncomfortable in a system that has always been extremely distrustful of them. Now, as the health care reform debate focuses new attention on physician supply and the IMGs role, tougher scrutiny and even tougher standards will come into play. Tens of thousands of IMGs have filled jobs when US graduates were not available (or those that they would not go to as in rural areas with few facilities). A specialist in health care policy has said, 'By filling in the gaps, IMGs have, in effect, postponed the crisis in physician supply that would have come.'

President Clinton's current health reform package and several other bills now in Congress would reduce the number of incoming IMGs as part of an unprecedented set of curbs on physician supply. Through controlled allocation of residency slots US graduates would be routed to primary care, and total training slots would be reduced allowing fewer IMGs than ever to enter into the system. The current consideration is to limit the number of first year residency positions, across the board, to 10% over the total number of graduating physicians from the nation's medical schools.

Federal policy makers argue that cutbacks in the IMG entry into the system are essential. Does it make sense, they ask, to continue inviting IMGs to work in underserved areas, only to see them leave? 'Are we really doing the underserved areas a favour?' asks a member of the American Medical Association (AMA) IMG council. Policy makers also note that most other countries have tough restrictions on the entry of foreign-trained physicians. Even Canada, one of the few nations that welcomed IMGs, is becoming stringent. Canada has been more dependent on IMGs than the US. Twenty-seven per cent of its doctors are foreign-trained and almost half the doctors in the province of Saskatchewan are IMGs who initially started serving in the Arctic villages. Recently, Canada's two most populous provinces, Ontario and Quebec, have imposed quotas on residency slots going to IMGs and other provinces are expected to follow.

Before the mid 1970s, the IMGs influx grew because it was driven by demand, and by an immigration policy that kept the door open. The trend then reversed when US medical schools increased class sizes and authorities began speaking of a doctor glut. Now, over the past four years, there has been a doubling of first year residency slots, from 2500 to 6000 and although the entire picture is unclear, there is again a steep rise in IMG immigration, attributed to the break up of the Soviet Union, changes in licensing examinations and new immigration procedures.

At present, IMGs make up 21% of practising physicians and 20% of residents in training programmes. The heaviest concentrations are in the states of New Jersey (43% of all doctors), New York (39%) and Illinois (33%). Forty-one per cent of IMGs are generalists v. 38% of US graduates. The majority of IMGs (56%) are training in primary care specialties v. 42% of US graduates. The largest national group is of Indian origin—18% of the total. The American Association of Physicians from India (AAPI) represents a strong professional, economic and cultural force. Eighty-two alumni organizations representing Indian medical schools, numerous state and specialty groups constitute its membership which also includes patron members and individual members, directly or through member associations.2 The AAPI offers the following statistics. Twenty-two per cent of the 570 000 physicians in the US are IMGs (about 130 000) of which 26 000 or 20% are of Indian origin—not only from India, but also from Britain, Canada, East Africa, Fiji, Guam, Malaysia and several other countries. Contributions from patron membership have funded a treasure chest of over $1 million which is administered by the Board of Trustees, charged with ensuring the fiscal welfare and stability of the organization. The AAPI has interacted with the AMA and in collaboration with other interested organizations, its Political Action Committee has worked at state and national levels to sponsor several pro-IMG bills in the US House and Senate. The AAPI Charitable Foundation and Continuing Medical Education Committees continue to provide valuable services to the people of India as well as its medical community. Annual conventions of the AAPI, now in the twelfth year, draw large numbers of participants; discussions cover medical, societal and political issues amid a vibrant atmosphere of cultural and social interaction between old friends.

However, questions regarding IMGs as victims of bias or cast offs from quality control remain ever present.3 On the one hand IMGs complain of poor treatment in residency selection, licensing and obtaining hospital privileges and on the other not just European-trained doctors, but many Third World IMGs say they have never faced discrimination. And IMGs are particularly worried that under an increasingly competitive health care system, they may be the first to be squeezed out of managed care. While AMA officials and Congressional investigators stop short of stating that discrimination against IMGs exists, most agree that IMGs have been subject to unnecessary ‘separate treatment’. Further,
almost everyone thinks that such measures are necessary to ensure the quality of foreign graduates. What they find difficult to agree on is what is the appropriate degree. While US and Canadian medical schools are monitored by one accreditation system, the Liaison Committee on Medical Education, there is no such standard for some 1000 medical schools abroad and IMGs as a group seem to perform more poorly on licensing examinations. In some typical 1992 sittings for parts I and II of the US Medical Licensing Examinations, about 90% of US graduates passed compared with only about 40% of foreign-born IMGs. Their rate was slightly better than that of US-born IMGs. Despite greater general acceptance of IMG applicants for residency programmes, specialties popular with US graduates take in very few. Licensure is another area of great concern. Medical boards tend to demand piles of paperwork, document verification, reports on full-time faculty or even the number of books in the school library. Particularly upsetting to established IMGs are licensing reciprocity requirements which have increased the difficulties in moving to practice in another state. Thus, IMGs must take several steps not required of US graduates. A certificate from the Education Commission for Foreign Medical Graduates, which reviews medical competency, English comprehension and credentials; usually at least three years of training are required to become eligible for licensure; US graduates need only one. Half of the states must approve the medical school, others ask for details about the school or request personal interviews. Once seeking separateness, IMGs have now begun to join the medical mainstream. Since the late 1980s, Third World IMGs have been elected to top medical society posts, relations between the AMA and IMG groups have improved with the creation of an IMG Advisory Council, and IMG lobbying has paid off with federal anti-discrimination laws.

There are also about 40,000 Americans, currently practising in the US, who have studied medicine abroad. They comprise 6% of the US total and 27% of all IMGs. Over 2000 are in residency training—2.6% of the total. Traditionally enrolled are older students, often from other health professions and a large number are the children of physicians. Ten schools, in the West Indies, Mexico, Israel and the Dominican Republic, accounted for almost 90% of US medical school loans abroad in 1991 and 1992. The Department of Education in a recent report approved as much as $117.6 million in assistance, with about $20 million tied to medical education loans given mainly to students at these offshore schools. As a group US IMGs have raised even more questions about quality than foreign-born IMGs. Certifying examination pass rates have been lower and in licensing examinations their performance has been well below US graduates. The past three years witnessed a new flood of interest in medical careers, with the highest number of applications to US medical schools and a concomitant increase in the interest in offshore schools. But with rising hurdles to residencies and licensure there is a feeling that although the stigma of an offshore medical degree will eventually go away most people would advise against going to a foreign school unless there is no other choice.

As health care reform evolves, the IMG influx and opportunity has reached a nadir. US production and quality control, coupled with a drive towards increasing opportunities in primary care have now reduced the demand for IMGs and there is diminished opportunity for them to practice in the promised land.

REFERENCES
2 Kapasi C. Facts about IMGs and AAPI. AAPI Journal 1993;6:1

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Book Reviews


It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of light, it was the season of darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, . . .

A Tale of Two Cities, Charles Dickens

Dickens could not have been more apt had he been writing about this book, rather than about the French Revolution. On the one hand, more progress has been made in reducing poverty, disease and death among the world's children in the past fifty years than in the previous two thousand. On the other hand, the glory of this achievement is considerably clouded by the fact that it is far short of what could actually have been done.

UNICEF estimates that with an expenditure of $25 billion a year within a decade it should be possible to end child malnutrition, preventable disease and widespread malnutrition. But while the world spends $1 trillion per year on armaments (p. 23) there is no evidence that this $25 billion is likely to be committed to social welfare.

Present situation

Within the last ten years great progress has been made in the developing countries. About 75 million children