PERSPECTIVE

BECOMING A PHYSICIAN

Coming to America — International Medical Graduates in the United States

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They can't believe that I round at 6:30 a.m., that I am available to my patients 24 hours a day, or that I don't get paid overtime for long hours. My medical school classmates who continue to work in Ireland live a different life from mine — one that I have left behind.

But I am not alone. International medical graduates account for a quarter of the 853,187 physicians in the United States,[1] an increase of 160 percent since 1975. Immigrant physicians also account for 27 percent of the country's 96,937 residents and fellows,[1] having migrated in search of training and career opportunities that are unavailable in their home countries.

An examination of the U.S. physician workforce suggests that there is an ever-increasing dependence on international medical graduates. Although the number of physicians in the United States has increased at twice the rate of population growth in the past 10 years, many urban and rural communities continue to have shortages of physicians. Recently, the federal Council on Graduate Medical Education, in response to the findings of a study that it commissioned, acknowledged that the country appeared to be on the verge of a serious shortage of physicians and endorsed a recommendation that medical schools and training programs increase their enrollments over the next decade to help offset a future shortfall of doctors.[2] Primary care practices are likely to be the hardest hit; perceived challenges to a high quality of life and decreasing reimbursement rates for office visits have eroded the attractiveness of primary care specialties to graduates of U.S. medical schools. International medical graduates have consistently provided a safety net for such programs, hospitals, and areas of shortage. Some 40 percent of primary care programs in the United States are already dependent on immigrant physicians,[3] and a full two thirds of international graduates serve in hospitals that provide a disproportionate share of care for the poor in this country.[3]

The transition to life in the United States can be fraught with unexpected challenges for doctors who have trained abroad. Professional and doctor–patient relationships can be distinctly different from what they are used to. Physicians who have practiced abroad report that U.S. patients have higher expectations of their doctors' availability and the services to be provided. Patients here almost universally receive their hospital care in the privacy of a one-bed or two-bed room, whereas hospitals in Europe and Asia feature communal wards with their resultant microcommunities of nurses, aides, and doctors. Immigrant physicians can be disoriented by their different role within the health care team. Schooling in the United States strongly emphasizes evidence-based practice and the use of technology over personal style and traditional approaches, and nonphysician health care professionals have more responsibility in the U.S. system than elsewhere. Add in the need to learn hundreds of new brand names and laboratory values and to adjust to differently formatted medical notes, and it is hardly surprising that these adaptive challenges can be overwhelming for the newly immigrated physician.

Both physicians and their patients can find language barriers frustrating. Despite the requirement of the Educational Commission for Foreign Medical Graduates (ECFMG) for the demonstration of competence in English, only physicians with previous immersion among English speakers can reach the level of fluency that is typically required for discussions about medical decisions. When patients report what may be genuine problems with doctor–patient communication, their complaints can be in-

terpreted, rightly or wrongly, as evidence of intolerance or racism and can strike a further blow to the self-esteem of immigrants who are already struggling against suspicion.

International physicians contribute much more than medical manpower and have consistently infused every part of the United States with new ideas and skills that have been critical to the nation's economic, scientific, and cultural growth (see Figure). In addition to being overrepresented in the groups that care for the country's most isolated and vulnerable citizens, international medical graduates contribute enormously to the country's research endeavors.[4] Many of the world's most talented graduates seek U.S. medical positions out of a desire to engage in constructive medical research, for which few opportunities exist in their home nations. Despite this ambition, it is more difficult for them than for U.S.-born graduates to eke out a research career, since noncitizens are ineligible for training grants from the National Institutes of Health (NIH) — a particular challenge, since a large proportion of research fellowships are funded by such grants.

For many international medical graduates, gaining access to training in the United States is an enormous challenge. No applicant is spared the stress of the examinations, interviews, and licensing procedures or the tumult of adaptation to a new culture, often undertaken without family and friends. There is no reciprocal recognition of training between the United States and the rest of the world, which means that practitioners who wish to immigrate must complete an internship and a residency in the United States in order to be eligible for board certification for independent practice here. International graduates must demonstrate their readiness to enter U.S. training by passing the steps of the United States Medical Licensing Examination (USMLE) and the clinical-skills examination to fulfill the requirements of the ECFMG. This series of examinations now costs nearly $3,000, plus the cost of travel to the United States — a net amount approximately equal to one year's salary for a physician from a low-income nation. It is clear that these costs restrict access to the system for candidates from impoverished nations; the introduction

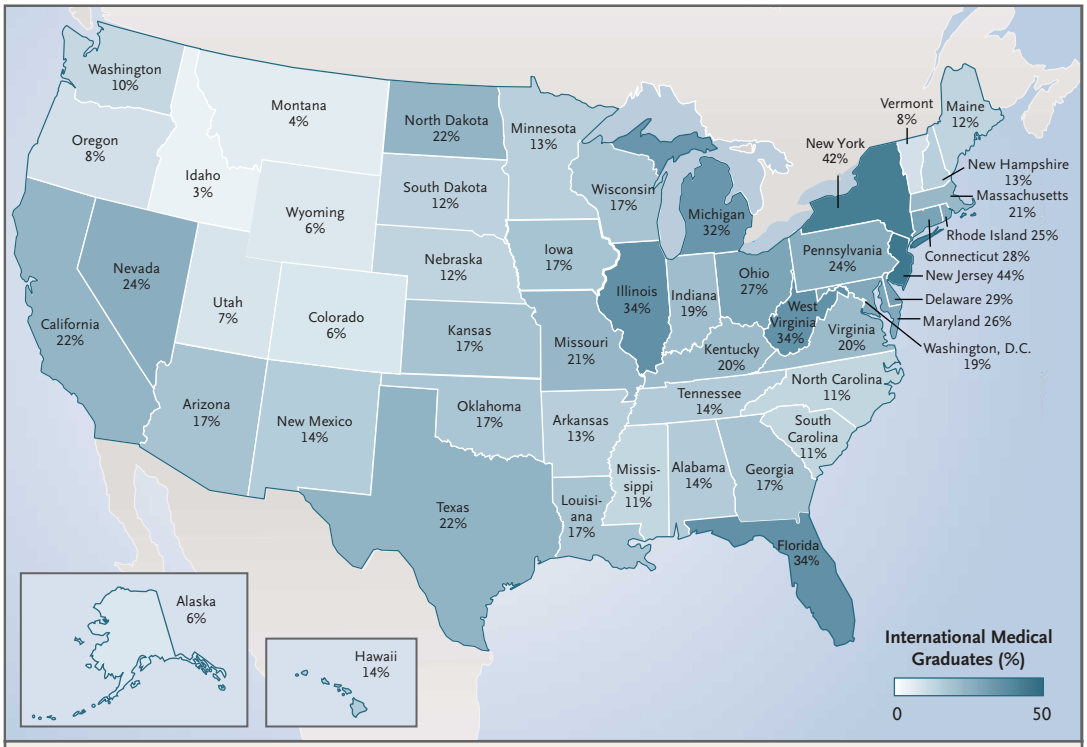

Figure. Prevalence of International Medical Graduates throughout the United States.
Data are from the American Medical Association, Physician Masterfile, 2004.

Table. The 10 Most Prevalent Non-U.S. Nationalities among International Medical Graduates (IMGs) Working in the United States.*

Country of Birth	Fraction of IMG Physicians	Fraction of IMG Residents and Fellows
	percent	
India	21.0	25.1
Philippines	9.0	3.9
Cuba	4.2	<2.0
Pakistan	4.2	6.8
Iran	3.1	3.3
Korea	2.7	<2.0
Egypt	2.5	2.7
China	2.4	3.9
Germany	2.0	<2.0
Syria	2.0	2.8

* Data are from the American Medical Association, Physician Masterfile, 2004.

of the expensive clinical-skills examination in 1998 halved the number of ECFMG certificates issued in 1999.[4] However, the examinations have made it easier for program directors to compare the knowledge attainment of U.S. and international graduates and have alleviated their qualms about judging the skills of applicants who come from disparate regions (see Table).

Multiple attempts to manage the medical workforce through the regulation of the immigration of physicians and concern about siphoning off medical talent from developing nations have resulted in a convoluted visa system involving restrictions that are peculiar to the medical profession. Visas for training purposes (J visas) may be sponsored by the ECFMG but require a return to one's home nation for a minimum of two years after training is completed; H1b "professional worker" visas provide broader opportunities but require the applicant to have passed step 3 of the USMLE, to have secured an offer of a training position, and to have been granted a temporary state medical license.

Since the United States depends on international medical graduates, much can be done to facilitate the integration of the immigrant workforce into the U.S. medical system. Peers and superiors of trainees can ease the process by communicating their understanding of the unique challenges that newly immigrated physicians face and allowing time for adaptation. Program directors can support professional-worker visas for physicians in order to facilitate their pursuit of diverse career paths, and expedited visa-processing procedures can be implemented. English-immersion courses can be extremely useful for some immigrants. And a reevaluation of the eligibility rules for noncitizens that would enable them to receive research training awards from the NIH and other sources may maximize the contribution of international graduates — and perhaps invigorate the national research enterprise in the process.

International medical graduates make an important contribution to the health and well-being of the American people. Initiatives that encourage greater participation of immigrant physicians in our clinical and research workforce may allow us to build a health care system that is equitable not only for these contributing physicians, but for the U.S. public itself.

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1. Physician characteristics and distribution in the US, 2004-2005. Chicago: AMA Press, 2003.
2. Council on Graduate Medical Education. Minutes of meeting, September 17, 2003. (Accessed May 20, 2004, at www.cogme.gov/minutes09_03.htm.)
3. Whitcomb ME, Miller RS. Participation of international medical graduates in graduate medical education and hospital care for the poor. JAMA 1995;274:696-9.
4. Whelan GP, Gary NE, Kostis J, Boulet JR, Hallock JA. The changing pool of international medical graduates seeking certification training in US graduate medical education programs. JAMA 2002;288:1079-84.