

IMPORTED CARE

International medical graduates add value to hospitalist teams

| By Gretchen Henkel

In this first of a two-part series, we examine the implications of international medical graduates (IMGs) in hospital medicine groups, and explore how hospitalist group leaders can improve communications and integrate them into their medicine teams. Part 2 will feature stories from hospitalist IMGs as they establish themselves as professionals in their communities.

International medical graduates (IMGs) comprise 25% of the total U.S. physician workforce.¹ Despite post-9/11 barriers to immigration, the number of IMGs entering internal medical residencies has risen in recent years.

In 2006, more than 6,500 physicians who graduated

medical school in foreign countries entered accredited residency programs, according to the Association of American Medical Colleges. U.S.-born residents who have attended medical school in another country account for approximately 25% of the total IMGs in training.

Further, the proportion of foreign-educated residents who will go into primary care is higher than for U.S. medical graduates. In 2006, 50% of the physicians training in internal medicine residency programs were IMGs.

What do these trends mean for hospital medicine? In light of projected physician shortages IMGs will continue to be a vital part of the physician workforce.² Because internal medicine is a primary feeder of hospital medicine, it's likely many hospital medicine programs will also continue to see an increase in hospitalists who are IMGs.

What the Trends Show

"International medical school graduates have been and continue to be a major source of physicians in the U.S.," says Edward Salsberg, director, Center for Workforce Studies at the Association of American Medical Colleges.

According to a survey this year in *Health Affairs* of IMG trends since 1981, most IMGs working in the United States come from India, the Philippines, Mexico, Pakistan, China, and the Republic of Korea. When starting full-time employment, most IMGs tend to gravitate to the East Coast, the Midwest (particularly Illinois, Ohio, and Michigan), and California.

Although the overall percentage of IMGs in the United States has remained about the same, more U.S. citizens graduate from medical schools outside this country, according to Salsberg. Noncitizen IMGs are gravitating toward the H-1-B visa for foreign-born professionals for a duration of not more than six years instead of J-1, or exchange visitor visas.

A slightly higher percent of IMGs go into primary care. "International medical graduates have tended to go into

the specialties that U.S. graduates were less interested in entering," Salsberg notes. "They fill gaps because many are willing to go into some specialties in order to get into the U.S."

Location, Location, Location

Entering residency, obtaining fellowships, and embarking on the practice of medicine all pose challenges for the foreign-born IMG. Throughout their residencies and into practice, IMGs can face biased perceptions from peers, attending physicians, and patients—especially if English has not been their primary language.

Rachel George, MD, regional medical director for Cogent Healthcare, is an international medical graduate, who received her medical degree from JIM Medical College in Kamataka, India. She observes that the challenges for IMGs and hospital medicine groups often depend on the predominant cultural mix of the surrounding community, as well as the hospital community culture.

For example, one program Dr. George oversees is situated within a culturally diverse community near Los Angeles. "Almost any international medical grad can go there, do very well, and be very comfortable, just because the rest of the community is very comfortable with international grads," she says. However, the first employment for many IMGs here on J-1 visa waivers may be in medically underserved areas, which tend to be rural areas.

"When you go to those places, I think communication becomes much more of a challenge because people in the local area may not be used to interacting with people of different cultures with different accents," Dr. George says. In some of those cases, Cogent has sent physicians to English classes to help improve communication skills.

Perception versus Reality

Dr. George notes that international medical graduates often face the perception that they are not as good as American



—Rachel George, MD, regional medical director for Cogent Healthcare

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graduates.

Much of this perception may be related to an IMG's lack of English fluency, she says. But those familiar with the certification process for IMGs know they face multiple difficulties to attain the status of a practicing physician in this country.

"It might actually be harder for an international medical grad to be able to practice in this country," notes Dr. George. "Your scores almost have to be twice as good as the scores of the American grad standing next to you to get into residency. Fellowships are also extremely difficult to obtain. Foreign medical grads have to jump through a lot more hoops to get into the system. And because of that, we actually probably have the cream of the crop here."

For Salsberg, credentials count. "A graduate of an LCME [Liaison Committee for Medical Education]-accredited medical school provides a high degree of assurance to a residency program director that the physician has received a comprehensive, solid medical education," Salsberg says. "This is not to suggest that foreign IMGs are not well prepared: Many of the IMGs that we're getting now are really among the best and the brightest in the world."

Issues that Surface

Program directors of ACGME-accredited residency programs rely on certification by the Educational Commission for Foreign Medical Graduates (ECFMG) to ensure that their prospective residents have met standards of eligibility.

HOOPS, HURDLES, AND VISAS

Entry of foreign-born IMGs to the United States is governed by the Immigration and Nationality Act, administered by the U.S. Immigration and Naturalization Service.

The J-1 visa was set up as an educational exchange program and carries with it a requirement that the graduate return to his or her native country upon completion of residency. However, a waiver of the requirement to return to their country of origin can be obtained if the physicians agree to begin practice in a Health Professional Shortage Area.

These service areas are determined using a scoring system based on four variables: the ratio of primary medical care physicians per 1,000 population, infant mortality rates, percentage of the population with incomes below the federal poverty level, and percentage of the population over 65. The vast majority of J-1 waivers are administered through "Conrad 30" programs administered by individual states

and the District of Columbia.

In recent years, AAMC's Center for Workforce Studies has observed a shift to the H-1-B, or temporary worker visa, allowing hospitals and group practices to hire IMGs in areas where there are physician shortages. This visa is employer-specific, and some hospitalist programs have become involved in helping their applicants secure this visa.

Visa issues present a range of financial, legal and personal hurdles for the IMG. In addition to obtaining legal entry into the country, IMGs applying to U.S. residency programs must obtain ECFMG certification, a multistep process that includes:

- Graduating from a medical school listed in the World Directory of Medical Schools;
- Obtaining a license to practice medicine within their own country;
- Passing the medical science examination (Step 1 and 2 of the



United States Medical Licensing Examination);

- Passing the ECFMG English test or Test of English as a Foreign Language; and
- Passing the Clinical Skills Assessment component of the USMLE.

An IMG can apply for lawful permanent resident status based on a job offer, provided that he or she has passed parts 1 and 2 of the National Board of Medical Examiners examination, and has fulfilled the other ECFMG certification requirements.

For more information, visit the Web sites of the Accreditation Council for Graduate Medical Education (www.acgme.org) and the Educational Commission for Foreign Medical Graduates (www.ecfm.org).—GH

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ECFMG certification is also a prerequisite required by most states for licensure to practice medicine. Vijay Rajput, MD, associate professor of medicine and program director of Internal Medicine Residency at UMDNJ-Robert Wood Johnson Medical School in Camden, N.J., and senior hospitalist with Cooper Health System, acknowledges that depending upon their country of origin, IMGs may have difficulties becoming acculturated when it comes time to start practicing medicine. During his time as a residency program director, Dr. Rajput has encountered residents who have problems with hierarchical issues. "A resident may come from a part of the world where they do not like to take orders from women," he says. "It will be difficult for them to work with peers who are women."

Hospitalist directors need to exercise good judgment when hiring new members of their team, and ascertain the prospective candidate's bedside skills with language, communication, and cultural competency, says Dr. Rajput. He believes that evaluation of residents' interpersonal communications skills varies from program to program.

The "hard skills" pertaining to the resident's breadth of medical knowledge and technological expertise are easily evaluated by in-service and board examinations, as well as procedures tests. However, the "soft skills" of communication, professionalism, and interpersonal skills are not as easily evaluated.

He suggests hospital program medical directors speak with program directors to glean important information about the candidates' interpersonal skills, including areas where they might need improvement.

"I think the hospitalist director will have to recognize their own community and the cultural, language, and communication issues in their own hospital's patient population and then acclimatize their younger hospitalists, providing specific training as part of CME," Dr. Rajput advises. "The hospitalist director has to keep his or her eyes open and see whether their IMG might need extra training—whether it's in cultural competencies or ethical principles—because even in our country there are different cultural issues in each community."

Dr. Rajput, in collaboration with Gerry Whalen, MD, a former vice president at ECFMG, has conducted a pilot acculturation project for the past two years. It entails a one-day program for 40 to 50 IMG participants to acquaint them with challenges they will likely face. This "snapshot" provides an overview of Western medicine's ethics, bedside skills,

insurance issues, and peer-relationship issues.

Pave the Way

Experts suggest various ways leaders of hospital medicine groups can address perception and communication challenges when they surface.

IMGs can be encouraged, for instance, to open their dialogue when meeting patients for the first time by telling them they are welcome to ask questions if there are words or terms they do not understand. In addition, says Dr. George, IMGs can slow the pace of their conversation to be better understood.

Perhaps more important is how the hospital and the practice group introduce new members of the team to their communities. Dr. George advocates a hospital-wide announcement when a new physician joins the hospital medicine team. It's important that the hospital clearly communicates to the hospital staff and the community at large that the IMG is a "well-trained physician, is highly regarded and respected, has good credentials, was chosen very carefully, and will be a great addition to the team."

Communications consultant Douglas Leonard, PhD, advised Richard H. Bailey, MD, medical director of Inpatient Care and Hospitalist Services at Saint Clare's Hospital in

Wausau, Wis., to create a brochure to introduce new members of the hospitalist team. Dr. Bailey leads a team made up entirely of hospitalists who are foreign-born IMGs. He had received complaints about his hospitalists' English skills from other specialists at the hospital and hired Dr. Leonard to perform a needs assessment of his team and other staff members with whom they interface.

Dr. Leonard found that nursing staff, because they liked the hospitalists and wanted to help them, had begun to act as interpreters between physicians and patients.

"Because these hospitalists had such good attitudes, the staff had learned to understand their accents and had really made an effort to work with these doctors effectively," Dr. Leonard reports. Part of that effort was that nurses would often step in to interpret for the hospitalists when patients could not understand their accents.

Dr. Leonard recommended that the hospitalists become better communicators with patients—even if that means softening their accents—and that they avoid reliance on nurses interpreting with their patients. The latter, says Dr. Leonard, "makes the hospitalists seem like second-class citizens in the world of doctoring." Although the nurses were happy to provide the service, he says "the hospi-

talists have got to establish their own ability to communicate with their patients."

In a case like this, the medical director can work with hospital administration to provide language training. Dr. Bailey has been exploring the possibility of working with local outside resources, including a local technical college, for this service.

The technical college is willing to schedule classes at night or when the hospitalists overlap on changing shifts. In addition, "Classes might alternate with on-site, one-to-one coaching sessions in speaking skills," says Dr. Leonard.

Two-Way Street

IMGs will continue to be a valuable resource and an increasing presence in hospitalist programs. The challenge for hospital medicine group leaders is to ensure that their talents are nurtured and respected.

Dr. Bailey sees his job as that of champion and advocate for his team. For one member of his team, he solicited involvement from his congressman to help resolve complications with visa and immigration issues.

He has also seen tensions erupt when his hospitalists interact with other physicians or patients who have misperceptions about their medical skills. "I'd put my physicians up against

anybody—they just don't speak as well," he says.

There are times when Dr. Bailey becomes concerned about the welfare of his team. "My job as medical director is to create an environment in which they can be successful—and that's a two-way street," he says. "That means I have to help them to be able to communicate, but it also means that I have to back them up when their professional competency is being questioned by preconceived notions about their language and their accents."

Dr. Rajput underscores this message. "Acculturation is a two-way street," he agrees. "As international doctors get acculturated, we as a society also need to adjust and help these well-trained physicians to understand us as well. In the interests of providing the best possible patient care, education and training will be needed for both sets of stakeholders [the IMG physicians and their employers]." ■

Gretchen Henkel is a frequent contributor to The Hospitalist.

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