

Confronting the Elephant in the Room: Can We Transcend Medical Graduate Stereotypes?

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As a US medical graduate, I was not exposed to the travails of international medical graduates until 1993. That year, having just completed critical care training at the University of Chicago, I joined the faculty of a program where international medical graduates made up most of the trainees. I made this choice because I sensed an opportunity to have a positive impact on education and a community's health outcomes. At the time, some admonished me that I would be throwing away my career on "missionary work." While this elitist comment sealed the deal, my choice was also prescient. My impact in a place that had not had formal critical care education and team coordination was instant and substantial.¹ Eventually, I became program director of internal medicine and was charged with the task of building a top-tier residency. This journey has been simultaneously edifying, frustrating, and inspiring.

Demographics of 21st Century Graduate Medical Education

Data compiled by the National Resident Matching Program (NRMP)² show that the percentage of international medical graduate (IMG) residents has remained relatively stable during the past decade at 17% to 20% overall and 28% to 36% for internal medicine programs (FIGURE). While the NRMP publishes national specialty-specific match results, it excludes positions offered outside the match, which are often filled by IMGs. Thus, the number of IMGs in residency programs is unknown. Despite the sizeable proportion of IMGs who fill training programs, relatively little scholarly work has examined their demographics, distribution, and performance compared to US medical graduates (USMGs). A few studies and anecdotal data suggest that university programs train a greater percentage of USMGs, and community hospitals may have a higher percentage IMGs.^{3,4} A single large study of internal medicine residents examined aggregate examination scores over time finding that medical knowledge scores of IMGs compared favorably to those of USMGs.⁵ Between 1995 and 2000, IMGs "scored higher than graduates of US medical schools on every internal medicine in-training examination at every PGY level."⁵ Although overall rates of internal medicine board certification are less in

US-born international medical graduates (US-IMGs) than in non-US-IMGs and USMGs,⁶ no study has reported pass rates for first-time test takers in medicine or other disciplines.

Edification

As a new program director in 2001, the impediments to simultaneously implementing the Accreditation Council for Graduate Medical Education's (ACGME's) Outcome Project and strengthening the quality of the residency program seemed substantial. First, since the most talented USMGs were more likely to match into university residencies,^{3,4} our faculty grappled with whether to recruit less highly performing students from American medical schools or high-performing IMGs. In the 1990s our program's few USMGs sometimes performed suboptimally or created administrative headaches. We decided to shift our focus to identifying and recruiting from the best around the world.

A second impediment was evident: international medical schools necessarily provide a different experience, and most IMGs have both cultural and medical experience deficits. Training methods vary worldwide; foreign school review by the National Committee on Foreign Medical Education and Accreditation is cursory as compared to the accreditation process of US medical schools.⁷

Our goal was to draw the brightest learners *and* identify international medical schools with methods that complemented our system. We built a detailed website⁸ to advertise entry criteria that included top quintile test scores and added qualifications (eg, MPH or PhD issued from a US institution, number of publications, US rotations with strong recommendation letters, board certification from Western medical systems). We recognized that most of our brightest IMG applicants came to the United States focused on subspecialty training. Subspecialties are viewed as the "end-game" for many of the most ambitious and talented IMG students. The goals for many IMGs, especially from developing nations, include US citizenship as well. Accordingly, we crafted a deliberate strategy for landing prestigious subspecialty fellowships that could enhance trainees' candidacy for immigrant visas.⁹

Frustrations

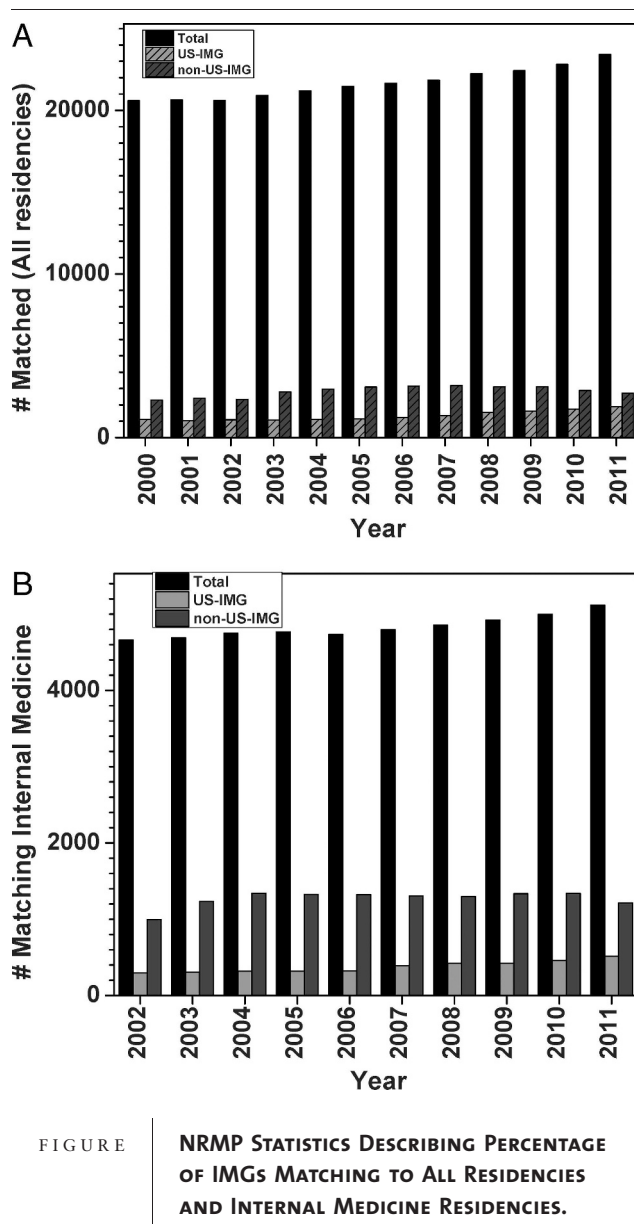
Cultural Incompetence

Cultural competence describes clinicians' knowledge, understanding, and application of the racial, ethnic, national,

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Abbreviation: NRMP, National Resident Matching Program; IMG, International Medical Graduate.

Compiled from 12 years of NRMP data.² Panel A: Total positions filled compared with those filled by US-born IMGs (US-IMGs) and non-US-IMGs. Panel B: Total internal medicine residency positions filled compared with those filled by US-IMGs and non-US-IMGs.

religious, and psychosocial aspects of each patient.¹⁰ International medical graduates may have little exposure to US minorities,^{11,12} which can undermine their effectiveness in clinical care. This lack of exposure extends to the medical culture: they may arrive with little or no training in the unique manner in which we present cases and document care. Another difference is that our medical culture expects trainees to take ownership of patient care, and offer their ideas, rather than simply doing what they are told. Thinking aloud is encouraged in the US system, but can be intimidating

to IMGs, especially in environments without perceived psychological safety, particularly environments that welcome team members from various disciplines and at all levels of proficiency to participate and contribute to care.¹³

Bias

Despite the accomplishments of our residents,⁸ some clinician-educators and administrators equate the absence of USMGs as program weakness. Some internal medicine fellowships are out of reach for IMGs. Given a USMG and IMG with equal qualifications, it is reasonable for the USMG to get the job. However some university fellowships did not interview our graduates regardless of their achievements. Perhaps most astonishing, we have encountered IMGs who have risen to positions of authority, who now express the same views that they themselves transcended. Despite a country founded on waves of multicultural immigration, a meritocratic culture, and a profession that prizes respect of persons, IMGs are still set apart from USMGs.

Another form of bias resides at the level of US medical students. After 10 years, no matter how strongly our internal medicine program performs, we struggle to match positions with USMGs. As internal medicine has become an ever less popular career selection, the best and brightest USMGs match with top-tier university programs.^{3,4}

Inspiration

What we have learned during the past decade has been inspiring.⁸ Our carefully selected IMGs pass the board examinations on the first attempt at a rate greater than 98% (since 2001) and score in the top decile or quintile of the country on standardized tests. They win local and national research prizes and publish in the peer-reviewed literature. They go on to prestigious university fellowships and excellent primary care practices, where their supervisors rate them as superior across competencies (unpublished data). Many take university faculty posts at some of the best programs in the world.⁸ Our graduates do everything that the best university-trained physicians do. This is inspiring because our residents arrive with little US medical experience and must learn medicine as quickly as their USMG counterparts, while transcending biases and acquiring cultural competence.

Conclusion

Our health care system needs IMGs. Without them, more than 30% of US internal medicine program positions may go unfilled² and our national primary care shortage might be substantially greater.¹⁴ We are a country whose central ethos is predicated on liberty and merit, yet IMGs may remain marginalized. National accrediting bodies espouse cultural competence, while as a system we entertain labels

that support stereotypes that are inconsistent with inclusiveness and tolerance. We should embrace IMGs as essential and meritorious contributors to the health of our populace. In an ideal world, “IMG” would not carry stigma and the distinction of national origin would evaporate. After successful completion of an ACGME-accredited residency and board certification, IMGs would be celebrated as consistent with the American experience. We must aspire to cultural competence by embracing and respecting diversity in how we treat both patients *and* our international colleagues.

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