

# The Foreign Medical Graduate in the US

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*These excerpts, from an article in the prestigious U.S. journal "Scientific American" portrays the position of the migrant professional in the land of his adoption. It appears that the flight of talent was mainly because these personnel were victims of educational systems not very appropriate to their own countries. Also, many of them migrated in order to better their own prospects; but once in the U.S. they were invariably looked on as "Second Class" professionals.*

As recently as 1950 most of the physicians beginning their career in the U.S. as measured by the number of internships and residencies filled, were graduates of medical schools in the U.S. and Canada. The ratio was almost 10:1, that is, 10 graduates of North American medical schools for each graduate of a foreign medical school. Today the ratio is 2:1. In five of the seven years through 1973 the number of foreign medical graduates obtaining American visas was larger than the number of graduates of all American medical schools. By the end of 1973 more than a fifth of the physicians practising medicine in the U.S. and Canada (77,660 out of 366,379) had been to medical schools elsewhere.

Although the U.S. is by no means the only country receiving foreign physicians, it outdoes all other countries in the number of physicians and in the number of originating countries involved. Before 1965 most of the foreign medical graduates arriving in the U.S. came from other countries of the Western Hemisphere and from Europe. Since 1965 Asian

sources have predominated, chiefly as a result of changes in the immigration law under the Immigration Act of 1965.

.....An aspect of this migration is that in general the countries contributing the largest numbers of physicians to the U.S. have the fewest physicians available for their own population. (The major exceptions are Canada and the United Kingdom). In other words, the underdeveloped nations are educating thousands of physicians who ultimately end up practising in what is perhaps the most developed nation of all.

Because of concern in certain countries about the loss of medical graduates the U.S. Department of State instituted in 1972 a "skills list", which was designed to enable interested countries to specify what occupations they thought were short of people. Anyone in such an occupation who has come to the U.S. with financial aid from his government or on an exchange-visitor visa must return to his home country for two years after he finishes his American studies. For reasons that are not altogether clear, many nations have taken little or no advantage of this option to curb the outflow of physicians and other health-care workers.

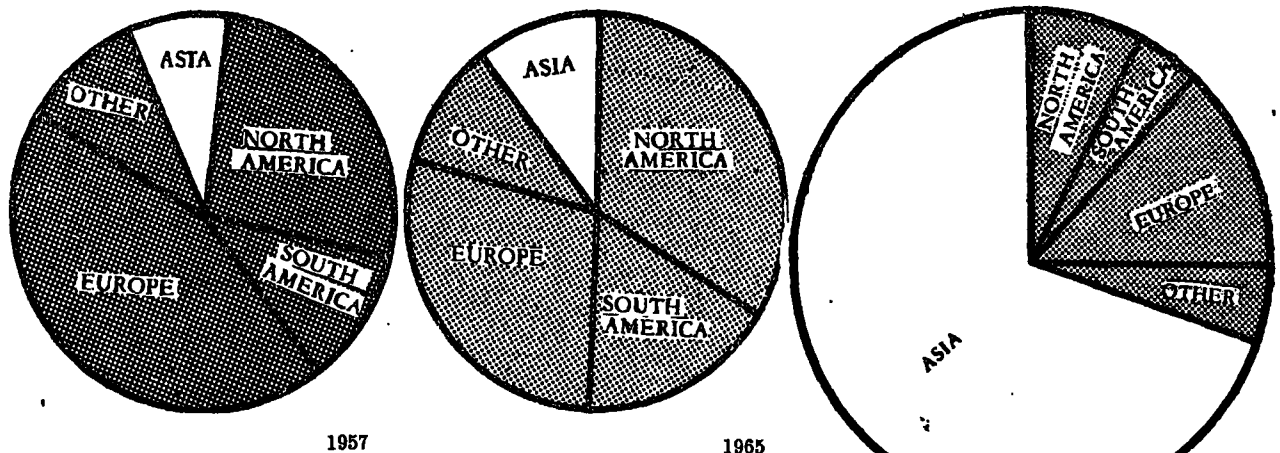
One can cite certain "push" factors, which originate in the home countries and tend to encourage physicians to leave. A general push factor is the tendency of medical schools in underdeveloped countries to pattern themselves after the medical schools in the developed countries of Europe and North America. It is a science-oriented and specialty-oriented training, and a graduate of such a school in an underdeveloped country is therefore predisposed

to seek advanced education in places where this kind of training is the norm.

Another type of push factor is specific to the country from which the physician comes. In a survey of foreign medical graduates in the U.S. that my colleagues and I at the Yale University School of Medicine have been conducting for several years the two reasons most often given for emigrating are "Better Training in the U.S." (69 percent) and "Political Factors" (8 percent). A closely related reason appears to explain why the physician who has left his native country usually does not return, namely his judgment that the possibility of developing a satisfactory practice there is severely limited compared with his prospects in the US.

Here one encounters a general problem that has been cited by a number of observers. Although the need for physicians in underdeveloped nations may be substantial, those nations have little capacity for employing physicians. Such a capacity includes several things that the underdeveloped countries have in short supply: an adequate system for delivering health care, sufficient opportunity to advance within the system and attractive economic prospects. Moreover, most physicians would rather work in large cities than in rural areas, and the underdeveloped countries offer too few opportunities for urban practice.

.....As matters now stand, a foreign medical graduate cannot engage in anything more than a limited type of practice in the U.S. without passing the examination administered by the Educational Council for Foreign Medical Graduates. The convention of obtaining the council's certificate is now established, and it represents the major attempt by the medical profession to establish standards for foreign medical graduates. Nonetheless,



Regional distribution of countries contributing foreign medical graduates to the U.S. is shown for the three years, 1957, 1965 and 1973. The charts reflect the region of last permanent residence of the physicians admitted to the U.S. as immigrants in each year. The section in each chart indicated by North America comprises personnel who came into USA and Canada and received medical degrees in these countries. The charts also reflect by their relative size the total immigration each year, from 1,990 in 1957 to 7,119 in 1973.

the council's examination has its critics, who argue that it provides too easy a path for foreign medical graduates and promotes a system of dual standards circumventing the entire process of quality control that is assumed to exist in American programs. As a result, it is argued, the U.S. has a "two-class" medical profession, with American medical graduates constituting the upper class and foreign medical graduates the lower class.

It is certainly true that foreign medical graduates tend to differ from American medical graduates in the roles they fill. They are heavily represented in house-staff positions and among full-time hospital-based physicians. They are under represented in private practice and in administrative jobs. Geographically they are heavily concentrated in the North-east and the Great Lakes states. They fill definite shortages in urban environments and in non-affiliated hospitals, that is, hospitals, without ties to medical teaching programs. With certain exceptions the patterns seem to support the two-class hypothesis.

.....The foreign graduates have been welcomed to the U.S. through lenient regulations on visas. In some cases they were actually recruited by representatives of American hospitals. Yet once here they are attacked as being less competent than American physicians.

In this situation the foreign medical graduate has become a pawn among warring factions in a medical profession that is caught up in ambivalence over what to do about changing the system of health-care delivery in the U.S. Lacking a coherent policy regarding the numerous issues in medicine, the medical profession in the U.S. has allowed the foreign medical graduate to fill in the most obvious cracks in the system. Once here, however, the foreign graduates have their own interests to protect.

Meanwhile the problems of the countries from which the foreign medical graduates came remain unsolved. Indeed it can be argued that these problems are being intensified as a result of a decline in the amount of foreign aid provided by the U.S. Foreign medical graduates understandably express reluctance to return to their home countries unless those countries develop better systems of health care.

Because of the large number of licensed foreign-educated physicians who have become naturalized citizens of the U.S., it is easy to predict that foreign medical graduates will continue to play an important role in the nation's health-care system. It is more difficult to predict whether this dependence on foreign medical graduates will continue to increase or whether it will decrease under the pressure of the complaints raised about it. It may not be possible for other nations to solve their problems regarding medical manpower until the U.S. has solved its own.