JOURNAL OF PALLIATIVE MEDICINE
Volume 11, Number 4, 2008

DOI: 10.1089/jpm.2008.9925

The Role of International Medical Graduates in the Future of Palliative Care

VYJEYANTHI S. PERIYAKOIL, M.D.

THE PALLIATOR'S DIARIES

IT WAS CLOSE TO MIDNIGHT on the very first day of my internal medicine internship and things were not going swimmingly well. The emergency department was bursting at the seams and the emergency medicine doc had told us to "not bother going back to the call room" as he had quite a line up for us. I had picked up a super-active inpatient medicine service just that morning and we were on call the very first night. To make it worse, I could not understand a word of American drawl of my brand new colleagues. So, of course I did what any self-respecting international medical graduate would do under the circumstances: I superglued a big smile on my face and I nodded. *A lot*.

"*Can you go check on the lights in the X-lab*"? My tired, sleep-deprived brain barely registered the suppressed irritation in my resident's voice but I gave her a vague smile and nodded. Why did she want me to check the lighting in the laboratory? Where was the hospital electrician? I had heard a lot about the "do-it-yourself" American culture but this was ridiculous!

I walked back and forth in the hospital for several minutes looking for the X-lab and drew a blank but was too intimidated to go back and quiz my irate resident. I did not really feel like admitting my ignorance to anyone else either (after all they were all complete strangers). Thirty frustrating minutes later, I decided to stop the futile quest. Feeling both incompetent and defeated, I went to check on the seizure patient in bed five when my resident tracked me down again.

"Have you checked the lights, yet" she asked pointedly, now making no effort to hide her annoyance.

"Yes, yes," I smiled again and nodded. "I am looking into the situation," and slipped away quickly for one last desperate attempt at identifying the cursed lab.

Twenty minutes later, I was just about to give up and totally ready to break rule number one in the International Medical Graduate secret code book. *Enough* with the smiling and nodding! They were getting me nowhere. I was going to find my resident and admit the truth. . . . that I could not understand *a word* of her accented English. Also it was pretty obvious to me by now that the cultural and language barrier were insurmountable and I had no hope in hell of making it through residency. So I decided to sign out all my patients to my resident and quit then and there.

As I strode past the nursing station determined to track down my resident, the ER charge nurse thrust a piece of paper under my nose. "Here are the lytes on your ex-lap patient. Your resident was looking for these."

"Oh. *Oh! The electrolytes on my exploratory laprotomy patient,*" I exclaimed in sudden profound relief. As I vigorously shook the hands of the bemused nurse parroting "Thank you. Thank you very much" over and over again; I could almost hear her thinking "*These crazy foreign doctors. . . .* "

DISCUSSION

One in four[1] new physicians in the United States is an international medical graduate (IMG). Internal medicine (37%), psychiatry (31%), anesthesiology (28%) and family medicine (24%) are the medical specialties[2] that have the most percentage of IMGs and these numbers are slowly increasing. At the same time, the numbers of American applicants to U.S. medical schools is plummeting. In addition, it is to be noted that American medical graduates are drawn to high-

Stanford University School of Medicine, Stanford, California.
VA Palo Alto Health Care System, Palo Alto, California.

tech subspecialties, leaving a critical work force shortage in primary care. Consequently, there is a higher concentration of IMGs in subspecialties such as geriatrics (66% of the geriatric medicine fellows in 2005 were IMGs) compared to specialties such as cardiology and gastroenterology.

The subspecialty of hospice and palliative medicine (HPM) is similar to geriatrics in the following ways:

1. Both specialize in caring for vulnerable and marginalized patients which is both stressful and rewarding work.
2. Both specialties are not procedure driven and thus not highly reimbursed. In fact, according to a recent survey[3] conducted by the American Geriatrics Society, the median income of Medical School Faculty at the assistant professor level is higher for an Internist ($137,000) compared to a geriatrician ($127,000)!

Extrapolating from the trend seen in geriatrics, it is likely that the field of hospice and palliative medicine will have a significant dependence on IMGs. It has been noted that IMGs contribute enormously both to clinical care and to biomedical research, as exemplified by pioneers like Dr. Bruera.[4] However, it is also true that IMGs have to overcome daunting immigration barriers as well as financial, sociocultural, and language barriers in order to successfully integrate with American biomedicine. Historically, the biomedical system has taken a very one-dimensional approach to this problem. The system delineates a series of steps that IMGs have to overcome. However, there is very little coaching or mentoring that help and empower IMGs to overcome these barriers. While this approach may have worked in the past, the imminent shortage of doctors in specialties like geriatrics and (potentially) palliative care calls for a very different approach.

We have to identify creative strategies to empower high quality IMGs to overcome the formidable barriers they face by taking a proactive approach in facilitating their smooth integration into the biomedical system. The new subspecialty of HPM needs and is critically dependant on the influx of large numbers of physicians dedicated to the practice of palliative care. IMGs may serve as creative solution to alleviate the growing shortage of HPM experts.

REFERENCES

1. ⟨www.americangeriatrics.org/policy/public_policy_news.shtml#students_021408⟩ (Last accessed February 2, 2008).
2. American Medical Association: ⟨www.ama-assn.org/ama/pub/category/211.html⟩ (Last accessed February 2, 2008).
3. AMA and AAMC data from the National Survey of GME Programs compiled by ADGAP Status of Geriatrics Workforce Study. ⟨www.adgapstudy.uc.edu/Files/ADGAP%20Geriatric%20Medicine%20in%20the%20United%20States.ppt⟩ (Last accessed February 2, 2008).
4. Bruera E: On third base, but not home yet. J Palliat Med 2008;11:565–569.

Address reprint requests to:
Vyjeyanthi S. Periyakoil, M.D.
3801 Miranda Avenue
100-4A
Palo Alto, CA 94304

E-mail: periyakoil@stanford.edu