Commentary: **Coming to America: The Integration of International Medical Graduates into the American Medical Culture**

Gerald P. Whelan, MD

**Abstract**

This Commentary is a companion piece to two Research Reports appearing in this issue: “Behavioral Science Education and the International Medical Graduate,” by Searight and Gafford, and “International Medical Graduates and the Diagnosis and Treatment of Late-Life Depression,” by Kales et al. International medical graduates (IMGs) come to America from diverse cultures around the world to complete their graduate medical education (GME). These residents are and will continue to be a fundamental part of the American health care delivery system. IMGs’ acculturation into the norms and standards of medicine as practiced in the U.S. is crucial to their education as well as to quality patient care. The time has come for GME to begin to systematically and effectively address the cultural challenges that IMGs face not only within the context of American medicine and GME, but in the larger context of American culture. Specific programs and strategies need to be developed and put in place early in the GME experience—or even before entry into GME—to assist IMGs in understanding the context for, and issues associated with, providing optimum health care in the United States. The author reflects on the findings of the two Research Reports, and calls for increased attention in the medical education community to acculturating and educating IMGs for optimal patient care.


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**Editor’s Note:** This Commentary is a companion piece to the Research Reports by Gafford and Searight on page 164 and by Kales et al. on page 171. It provides an important context for the results of these two studies. Searight and Gafford and by Kales et al. The decision to publish those two reports was based almost entirely on the fact that they bring to the attention of the medical education community an extremely important issue: What steps should residency programs that enroll non-U.S. citizen international medical school graduates (IMGs), and the institutions that sponsor the programs, take to ensure that those residents are “culturally competent” when they graduate from these programs and enter practice? It is ironic that while a great deal of attention is being devoted to preparing future graduates of U.S. medical schools to provide culturally sensitive care to patients of different cultural backgrounds, we need to prepare IMGs to provide culturally sensitive care to citizens of this country who have largely gone unnoticed.

International medical graduates (IMGs) constitute roughly one quarter of all practicing physicians in the United States¹ and one quarter of all residents in training.² This has been the case for many years and, given the current projections for a physician shortage in the United States over the next decade, the number of IMGs in American health care—and their importance—is unlikely to decrease and may very well increase. Although IMGs are required to pass examinations identical to those administered to U.S. medical graduates (USMGs), and their credentials are verified as part of the certification process of the Educational Commission for Foreign Medical Graduates (ECFMG), there is still a great deal of variability in the education, training, and experience that IMGs bring to the American graduate medical education (GME) programs that they enter. In addition, notwithstanding overrepresentation from a few South Asian countries (particularly India and Pakistan), IMGs historically have had remarkably diverse backgrounds, having studied in over 160 different countries around the world.³ If these physicians from cultures that often radically differ from American culture are to be successfully integrated into American medicine, conscious effort needs to be directed toward the facilitation of their acculturation into American society at large and the American medical environment in particular.

Two Research Reports in the current issue of *Academic Medicine* have direct relevance to this issue. “Behavioral Science Education and the International Medical Graduate” by Searight and Gafford⁴ reports the findings of a series of interviews of IMGs conducted in a family medicine residency program. The investigators sought to obtain information about the previous training of IMGs in behavioral science, which is “a widely used term in family medicine that encompasses traditional psychiatric diagnosis and treatment, interviewing skills, and physician–patient interaction.” Although at first reading this may seem a somewhat limited area of investigation, in the process of categorizing interview responses the authors identified seven recurrent themes, including mental health and psychosocial content as part of clinical medicine, the physician–patient relationship, IMGs’ perceptions of U.S. family life, and specific challenges for the IMG. These clearly begin to address the broader range of cultural issues with which IMGs must learn to deal.

The responses of IMGs confirm that there are major differences in the ways that individuals coming from some other cultures perceive the concepts, beliefs,
values, and attitudes that we take for granted and that are part of American culture. In many cultures, depression is seen as a normal part of life and not a condition for which medical attention or intervention would be expected or sought. The perception by patients in other cultures of physicians as “God-like” and the attitude that “whatever the doctor says, that’s enough” contrasts starkly with current American concepts of patient-centered care and shared decision making. Permissive parenting and a perceived low threshold for seeking medication to control children’s behavior in America are a far cry from the absolute parental control of children (including corporal punishment by parents and teachers) prevalent in many other cultures; likewise, American “family life” that is limited to the typical single-family unit, often damaged by divorce or having only a single parent, is foreign to the expectations of the role of supporting staff in patient care. And these challenges reference only the circumscribed medical environment; IMGs, like USMGs, go home every night, but unlike their American colleagues they must deal with an unfamiliar culture that is complex and potentially overwhelming and in which they and their families must learn to live and work on a daily basis.

While this first research report begins to identify some of the areas in which cultural differences may have the potential to affect the IMG’s approach to medicine, a second article goes a step further and looks at what may be one example of an actual impact on practice. “International Medical Graduates and the Diagnosis and Treatment of Late-Life Depression” by Kales et al. compared the frequency with which IMGs and USMGs made a diagnosis of clinical depression based on videotapes of elderly standardized patients who had been trained to clearly portray symptoms and behaviors of depression. It also reported the likelihood of both groups to recommend treatment with antidepressants. The authors’ findings indicated that IMGs were significantly less likely to make the diagnosis of depression and also less likely to recommend initiation of management with an antidepressant. The study was small and used a convenience sample and the significance may be stronger statistically than clinically, but it raises serious questions.

The authors conjecture, and reasonably so, “Because of cultural differences in the manifestations and acceptance of mental disorders, depression may be less recognized as a syndrome in the countries where IMGs trained than in the United States.” This is entirely consistent with Searight and Gafford’s findings, but now there is an additional, worrisome element. The IMGs participating in Kales et al.’s study were all currently in practice and had by definition completed residency programs in the U.S. accredited by the Accreditation Council for Graduate Medical Education (ACGME). They were either psychiatrists or family medicine physicians, both specialties for which the recognition and treatment of depression should have been a core part of residency training. Yet despite their training in ACGME-accredited residency programs, some IMGs apparently continue to carry a cultural perspective that may suggest a negative and potentially dangerous impact on their practice.

Taken together, the two Research Reports not only confirm some of the long recognized cultural differences that non-U.S. IMGs bring with them into GME, but also suggest that failure to directly address these issues, even in the face of good clinical training by American standards, may leave residua of cultural biases or misperceptions that could at best lead to continued discomfort on the part of physicians and patients, and at worst lead to potential serious misdiagnoses, or diagnoses missed altogether.

My own observations and communications attest to the existence of these cultural differences as well. For instance, the Clinical Skills Assessment conducted by the ECFMG from 1998 through 2004 (and now replaced by the very similar United States Medical Licensing Examination Step 2 Clinical Skills examination) was designed to emulate a typical American clinic practice setting. While there were some unavoidable artificialities, and every examination brings some element of test anxiety to bear, it was also evident from the questions posed by IMGs just prior to the examination’s start that they often had lingering uncertainties about the way in which the doctor would be expected to interact with the patient, particularly around communications issues. This in sharp contrast to USMGs, who typically act and feel very at home with the scenarios and settings. It is quite clear that the familiarity with the environment being simulated has a definite impact on performance and is likely a factor in the consistently lower scores and pass rates on the part of IMGs compared to USMGs.

International medical graduates coming to America from diverse cultures around the world are and will continue to be a permanent part of GME and ultimately of the American health care delivery system. Given that reality, the time has come for GME to begin to systematically and effectively address the cultural challenges that IMGs face not only within the context of American medicine and GME, but in the larger context of American culture. Specific programs and strategies need to be developed and put in place early in the GME experience—or even before entry into GME—to assist IMGs in understanding issues that may not even be apparent to USMGs, which if not directly addressed may continue to be baffling to even the most intelligent and fluent IMG. The structure and hierarchy of American medicine, the role of nurses and other health care colleagues, the concepts of informed consent and shared decision making, issues of confidentiality and documentation—these are but a few of the broader topics that need to be clearly explained in a context where IMGs not only receive information but also have the opportunity and time to ask questions and to discuss their understanding of these issues. Academic medical centers need to develop the resources to facilitate such education. Funds must be made available to program directors and institutions to facilitate this process and time must be identified in orientation programs and in ongoing conference schedules to ensure that the process of acculturation receives the attention and priority that it deserves.

A series of initiatives is already underway to catalyze these efforts. The ECFMG, along with the Association of American...
Medical Colleges and other interested groups, is developing resources that will be made available to IMGs, program directors, hospital staff, and patients. Some will be Web-based, while others will form the basis for formal acculturation programs to augment the more traditional approach to new resident orientation. Still other “packages” of resources will be developed to meet other specific needs or users. While this work is now only in its earliest phases, the ECFMG and its collaborators are committed to dedicating increasing resources as the project matures; collaborative input from all stakeholders would be welcome. The goal is to assist IMGs as quickly as possible in becoming comfortable and conversant with colleagues and patients in order to provide the highest-quality care in a manner that maximizes the incredible resource that America has in its IMGs, that makes those IMGs feel comfortable and effective in their daily practice, and that instills confidence in the patients for whom they care.

References
2 Appendix II, Graduate Medical Education, Table 1. JAMA 2005;294:1131.

Teaching and Learning Moments

Always Follow What You Preach!

“Sir,” my student Bishnu Rath Giri said in an excited tone, “It is not correct on the part of the department to use the trade name of the drug in a test question. You emphasize so much on the rational use of medicines and on prescribing by generic names.” He was a diplomat and stopped short of saying that the department did not follow what it preached.

In South Asia, the student–teacher relationship is hierarchical and authoritarian. Students do not commonly question their teachers’ statements and behavior. However, Bishnu was a notable exception, hailing from Gaidakot in the lowland terai region of Nepal; he refuses to be bound by the straitjacket of tradition. Yet he is the perfect gentleman, soft-spoken and unfailingly courteous—even when questioning our ethics.

Bishnu was in the midst of taking a pharmacology and therapeutics course in the Department of Pharmacology at our institution, the Manipal College of Medical Sciences in Pokhara, Nepal. The rational use of medicines and prescribing by generic names is strongly emphasized throughout the course. Bishnu’s comments stayed with me long after the class ended and prompted me to be careful when setting test questions in the future. However, it wasn’t just during this course that Bishnu challenged our department’s position on this issue.

The department runs a drug information center (DIC) in the teaching hospital. The facility is used for teaching our students and providing evidence-based information to the clinicians. At the DIC, we used to keep drug samples, pens, and writing pads that were given to us by medical representatives, but Bishnu put us on the right track. During a visit to the DIC, he chanced upon a writing pad and a pen set with the name of a particular drug company prominently displayed on them. He told department faculty that pens, writing pads, and calendars with the names of drug companies had no business being used in a DIC. Drug promotion is such an integral part of life for doctors in South Asia that we never realized that we were defeating the very message we were trying so hard to instill in our students.

When I am teaching, interacting with other colleagues, or attending conferences, I always keep the ideals expounded so powerfully by Bishnu in the back of my mind. As a teacher and a role model for students, I do not carry or display in my office any material from the pharmaceutical industry. I always assess myself against Bishnu’s high standards. For doctors who teach, disentanglement from the pharmaceutical industry is a matter of daily practice. I always remember the lesson that Bishnu taught me: it’s important to practice what one preaches.

Bishnu is now in the clinical years of training and continues to be involved in upholding the high ideals of medical practice and promoting the more rational use of medicines. I am quite proud of him. Nepal needs more doctors and medical students like Bishnu!

P. Ravi Shankar, MD

Dr. Shankar is assistant professor, Department of Pharmacology, Manipal College of Medical Sciences, Pokhara, Nepal.