

Perceived Biases and Prejudices Experienced by International Medical Graduates in the US Post-Graduate Medical Education System

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Abstract

Purpose – The purpose of this project was to collect qualitative data on the types of bias and prejudices experienced by international medical graduates (IMGs) in the US graduate medical education system.

Methods – We conducted thirty-six qualitative interviews from a single internal medicine residency program in a large mid-western city over a four-year time period. The study population consisted of 33 IMGs and 3 USMGs.

Results – The data aggregated into four major themes; the externship requirements of residency programs for IMGs, difficult interview experiences, US medical students are critical of residency programs with IMGs, and greater difficulties for IMGs finding employment after residency.

Conclusion – The IMGs from one Internal Medicine residency program in the US post-graduate medical system self-reported considerable bias and prejudice.

Many practicing physicians and residents in the United States graduated from foreign medical schools. This group includes American citizens and foreign nationals. In 1994, 23% of all US physicians were international medical graduates (IMGs).¹ The percentage of total residents who were IMGs rose from 14% in 1989 to 23% in 1993.² In the 2006 National Resident Matching Program (NRMP) there were a total of 21,659 first-year slots, with 14,059 being filled with either US seniors, Canadian seniors, US osteopathic seniors or already-graduated US trained physicians. 6,013 slots were filled with IMG's in the 2006 match (28% of filled positions).

Despite an established presence in US medicine, it has frequently been suggested that there may be subtle as well as more overt discrimination directed at IMGs. This discrimination may take numerous forms, including: barriers to obtaining licensure, limited practice options, and lack of acceptance from peers.³ Previous efforts to decrease the total number of IMGs in US residency training could also indicate a bias against IMGs. In the early 1990's proposals were made to congress to limit the number of physicians in training programs to 110% of the number of graduates of US medical schools. Bias against IMGs may be a result of the belief that IMGs practice lower quality medicine than United States medical graduates (USMGs). In Family Medicine, IMGs score lower on the In-training Assessment Examination.⁴ In Internal Medicine, the opposite occurs. Since 1995, IMGs have consistently outperformed USMGs on the Internal Medicine In-Training Examination.⁵ When researched, there

has been no evidence that patient care is significantly different with IMGs compared to USMGs.⁶ However, directors of Internal Medicine residency programs believe that IMGs are at higher risk of being identified as a problem resident.⁷ Additionally, in family medicine, IMGs possess significantly higher attrition rates than for USMGs. IMGs enrolled outside of the NRMP were at the highest risk to leave programs.⁸

USMGs enjoy a significantly higher match rate for PGY-1 positions (93% in 2001) compared to IMGs (52% in 2004).⁹ A survey of 702 fourth-year US medical students about factors influencing residency selection, found that the proportion of IMGs in a residency program was a significant, inversely related factor to program desirability.¹⁰ Data from the match supports this phenomenon. Residency programs that enroll large numbers of IMGs over time, experience an increase in the number of applications from IMGs and a decrease in the number of applications from USMGs.¹¹

There is one published qualitative study on IMGs and bias in the literature. Fourteen residents (10 IMGs, 4 USMGs), in a family practice residency program wrote a brief narrative then participated in a thirty minute videotaped group discussion. IMGs responses indicated that they felt acceptance or rejection might be based on nationality.¹² The purpose of this project was to collect qualitative data on the types of bias and prejudices experienced by IMGs in the US graduate medical education system.

Table 1
Interview Questions

1. Consent for interview
2. Tell me about your medical school training? Where and when?
3. What made you decide to train in the US?
4. Tell me about your application experience to US residencies.
5. How many applications? Interviews?
6. What were your interviews like?
7. Do you feel your experience was different than that of US medical graduates?
8. How was the transition to being a resident in the US?
9. In your opinion, are there differences between the US and IMG residents in this program?
10. Are the USMG's treated differently? in your opinion? By attendings? By nursing staff?
11. Have you experienced any (other) biases or prejudices because you are an IMG in your opinion?

Methods

Study Design and Population - The study population was an Internal Medicine residency program in a large mid-western city. We choose this program because of its easy access and large composition of IMGs. This program has six residents per year, for a total of eighteen residents during any one academic year. We interviewed 100% of the thirty-six residents who were enrolled in this residency program during a four-year time period, (2000-2004). This population included all 18 residents in the program during the first year of the study and then the 6 new residents per year who started the program the following three years. The study population consisted of 33 IMGs and 3 USMGs. No one refused to be interviewed. We obtained permission to conduct and record each interview. Interviews were conducted at the interviewee's site of employment. While we had a working list of basic questions (Table1), each interview was a hypothesis-generating, open-ended discussion lasting typically 60 minutes. We obtained Institutional Review Board approval prior to data collection.

Prior to data collection, each interviewer was instructed on the basic principles and practices of qualitative data collection. The primary author then gave each interviewer examples of qualitative data, as well as practiced a few short scenarios with each interviewer. Each interviewer then conducted two complete, practice interviews, and received feedback about the quality and quantity of data they were collecting. After each interview, the primary author gave feedback to the four interviewing residents.

The Interviewers - During the four-year period there were five interviewers. Four of the five interviewers were family practice residents at the time of data collection. These four residents consisted of two IMGs and two USMGs. The primary author is an attending USMG, with a degree in education emphasizing qualitative research. The interviewers did not know the thirty-six internal medicine residents being interviewed. In addition, each interviewer was not aware of the data or the trends found by previous interviewers.

Data Analysis - After the recorded interviews were transcribed, an impartial party compared the data to the audiotape for accuracy. Qualitative data analysis was conducted using Non-numerical Unstructured Data Indexing Searching and Theorizing computer software (NUD*IST, QSR International, Victoria, Australia. www.qsr.com) which codes and examines the data, discovering patterns. A search tool function was used to identify emerging ideas and theories and to highlight data for reporting results. We conducted the qualitative analysis after completing the entire data collection.

Results

The thirty-three IMG's were composed of nineteen men and fourteen women with a mean age of twenty-nine. All three USMG's were male. The data aggregated into four major themes; the externship requirements of US residency programs for IMGs, difficult interview experiences for IMGs, US medical students are critical of residency programs with IMGs, and greater difficulties finding employment after residency for IMGs.

Externship requirements - of residency programs for IMGs - Of the 33 IMGs interviewed, 18 expressed frustration with the difficulty getting clinical externships in the US. Ten of the 33 IMGs had a friend or family member that was able to provide or arrange an externship in the US.

- Dr. D (IMG 2nd year) "A lot of programs request clinical experience in the US from IMGs. This is even more difficult because a lot of residency programs do not give IMGs the opportunity for an externship."

- Dr. H (IMG 1st year) “They (residency programs) don’t give externship opportunities at all....at the same time they request the experience in addition to good (board) scores.”
- Dr.Y (IMG 1st year) “No one would give me an opportunity to prove myself.”

Difficult interview experiences - Of the 33 IMGs interviewed, 20 expressed some difficulty with the interview process that was due, in their opinion, to the fact that they were an IMG. The remaining IMGs expressed no difficulties, however all thirteen purposely limited their interviewing to programs that possessed a favorable match history toward IMGs. 26 of the 33 IMGs interviewed exclusively with internal medicine residency programs. While five of the IMGs interviewed with both internal medicine and family practice residency programs. None of the USMGs (N=3) that we interviewed expressed any difficulty during their interview process.

- Dr. B (IMG 1st year) “They would ask you medical questions and give you patient scenarios and....they made me examine and talk to a patient.....It was awful. They asked all kinds of questions and gave you labs.....it’s like an exam. It was horrible.”
- Dr. J (IMG 3rd year) “I ended up getting 3 interviews out of 200 applications.... I think they sent out reject letters because of my foreign degree.....they were looking for American graduates, some of them stated that politely and some...were not so polite.”
- Dr A (IMG 3rd year) “I’m not certain which is worse....getting lots of rejection letters for interviews or interviewing with a program when they clearly have no interest in you.”

US medical students are critical of residency programs with IMGs - Two of the three USMGs interviewed self-reported experiencing criticism from fellow US students and/or medical staff because of their decision to attend an IMG dominated residency program.

- Dr. S. (USMG, 1st year) “A lot of my friends raised their eyebrows when I went to this program dominated by IMGs. A lot of my friends were very critical of my decision to go to this program.”

- Dr T. (USMG, 2nd year) “I was and I am aware that my program does not enjoy as good a reputation as the other hospitals among medical students and house staff....I think that this reputation was based in large part upon prejudice against folks from other countries.”

Greater difficulty for IMGs finding employment after residency - Ten of the 33 IMGs interviewed reported some difficulty securing a position post-residency. The remaining IMGs that graduated or were close to graduation during the study period, had jobs secured frequently with IMG dominated medical groups. None of the USMGs we interviewed expressed any difficulty.

- Dr. A (IMG 3rd year) “When you finish....and you want to get a job, your chances are going to be the same situation as getting into residency.....applying for a job will depend on whether you’re an American graduate.”
- Dr. M (IMG 3rd year) “I think you get more interviews and more calls if you were a US graduate.”
- Dr. V (IMG 3rd year) “I’m a good resident....and I have several publications, but it’s still unlikely I will get a cardiology fellowship....it’s frustrating.”

Discussion

IMGs play an integral role in the US post-graduate medical system. Without IMGs thousands of residency positions annually would go unfilled.⁹ Approximately twenty-five percent of all physicians in the US are trained internationally.¹¹ IMGs are also significantly more likely than USMGs to practice among the under-served including rural critical access hospitals¹³ and inner-city areas of high poverty.¹⁴

These data are especially important for family medicine programs due to the increasing presence of IMGs in family medicine since 1997. In the early 1990’s, IMGs composed approximately 10% of medical school graduates matching in family medicine.¹⁵ The percentage increased to 28.6% in 2001. In addition, this rise corresponds with a drop in the total percentage of family medicine residency slots filled in the NRMP, from 91% in 1996 to 78% in 2004. IMGs also account for an increasing percentage of post-match fills from 17% in 1996 to 48% in 2001.¹⁶ In July 2001, 29.4% of all first-year family practice residents were IMGs.¹⁶ In 2006 the number of NRMP slots in family medicine declined to 2711, down

from 3293 in 1998. US senior medical students filled only 1117 of the family medicine positions in 2006, down from 1817 in 2000. Non-US seniors filled 1158 family medicine positions in 2006, up from 767 in 2000.⁹

Much of the published evidence for discrimination against IMGs is anecdotal. However, very similar to our self-reported data, there is evidence of discrimination against IMGs when applying for residency training and when seeking post-training employment in their specialty. Nasir found that, compared to a USMG, IMGs received fewer replies to requests for information from family practice residencies.¹⁷ In addition, many programs had application criteria for IMGs which were more demanding than those published by the ECFMG, and one program refused to consider IMGs. Balon et al. report similar findings in a study of psychiatry residencies.¹⁸ The responses from psychiatry programs to IMGs tended to include additional qualifications needed, while responses to USMGs included inviting materials including information on the surrounding area or a personal handwritten letter. Similar to our self-reported data, Miller et al. found that, compared to USMGs, IMGs reported more difficulty finding clinical positions after completing residency.¹⁹

Our findings that US medical students are critical of residency programs with IMGs is consistent with the student survey data from the literature citing the proportion of IMGs in a residency program as inversely related to program desirability.¹⁰ It is also consistent with the research finding residency programs with higher proportions of IMGs experience an increase in the number of IMG applications and a decrease in USMG applications.¹¹

There are some important limitations of our study that need to be considered. First, we interviewed individuals that matched into one Internal Medicine program. Our results may have been different had we interviewed a larger population, from different programs and from different geographical locations. There are other geographical areas that traditionally have been more congenial to IMGs. Second, these interviewees were from an Internal medicine program, results may be different from other medical specialties. Third, this is self-reported data and the interviewees may be biased. For example, interviewees who had one bad experience during one interview may strongly emphasize that experience disproportionately during our data collection. And finally, we only interviewed three "control" USMGs for our study. It is possible that if we had interviewed twenty-seven USMGs that we would still have been able to report examples of bias or prejudice.

In lieu of the events of September 11, 2001, it is likely that IMG's from countries such as Iran, Iraq, Afghanistan and others are looked upon with added concern and scrutiny. In 2006, all Americans, including Congress are appraising their attitudes about immigration and the role of foreign-born individuals in the United States. Since the war in the middle-east may continue for some time, the climate for some IMG's may continue to be marred with bias and prejudice for many years. Each residency program will need to contemplate how valuable IMG's are to their success and treat them in a professional manner accordingly.

Although we are certain that residency programs exist that embrace IMGs, treat them with full respect, reflect on their potential and value their unique experiences, they may not reflect the status quo in the US graduate medical education system. The majority of programs directed and dominated by USMGs may have biases about IMGs. These appear to be overtly or covertly taught to students in our medical schools,^{d10} propagated by some residency programs^{e17,18} and practicing community physicians.^{f19} For about the last three years, the Accreditation Council for Graduate Medical Education (ACGME) has been stressing the importance of general and specific competencies for all physicians in-training.^{g20} This includes the general competency for all residents on professionalism. The ACGME states "residents are expected to demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest. Residents are also expected to demonstrate sensitivity and responsiveness to a patient's culture." Although the ACGME competencies are directed at patient care, it is difficult to believe that such an environment can be cultivated in medical schools and residencies programs with strong prejudgmental beliefs about international colleagues. Certainly strong prejudiced beliefs about potential residents based on age, gender, sexual preference, obesity, religious beliefs or race would never be openly tolerated.

Conclusion

The IMG's from one Internal Medicine residency program in the US post-graduate medical system self-reported considerable bias and prejudice.

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