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Professional Challenges of Non-U.S.-Born International Medical Graduates and Recommendations for Support During Residency Training

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Abstract

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Purpose—Despite a long history of international medical graduates (IMGs) coming to the United States for residencies, little research has been done to find systematic ways in which residency programs can support IMGs during this vulnerable transition. The authors interviewed a diverse group of IMGs to identify challenges that might be eased by targeted interventions provided within the structure of residency training.

Method—In a qualitative study conducted between March 2008 and April 2009, the authors contacted 27 non-U.S.-born IMGs with the goal of conducting qualitative interviews with a purposeful sample. The authors conducted in-person, in-depth interviews using a standardized interview guide with potential probes. All participants were primary care practitioners in New York, New Jersey, or Connecticut.

Results—A total of 25 IMGs (93%) participated. Interviews and subsequent analysis produced four themes that highlight challenges faced by IMGs: (1) Respondents must simultaneously navigate dual learning curves as immigrants and as residents, (2) IMGs face insensitivity and isolation in the workplace, (3) IMGs' migration has personal and global costs, and (4) IMGs face specific needs as they prepare to complete their residency training. The authors used these themes to inform recommendations to residency directors who train IMGs.

Conclusions—Residency is a period in which key elements of professional identity and behavior are established. IMGs are a significant and growing segment of the physician workforce. Understanding particular challenges faced by this group can inform efforts to strengthen support for them during postgraduate training.

International medical graduates (IMGs)—defined as physicians who did not attend medical school in the United States or Canada—make up 25% of the physician workforce in the United States.[1] They play a significant role in primary care,[2-6] care for vulnerable populations,[7,8] and care in health professional shortage areas.[7,9,10] IMGs generally enter the U.S. physician workforce through graduate medical education, and nearly 80% of IMGs are not U.S. citizens when they begin their residency training.[1,11]

Our prior work characterizing the professional experiences of non-U.S.-born IMGs practicing in primary care fields showed that these physicians find transitional periods significantly challenging.[12] Residency training, a critical juncture in a physician's career and identity development, is a particularly important transitional period. Although all residents face stressors such as long work hours, financial strain, and the need to quickly absorb large amounts of medical information,[13,14] IMGs face additional, unique challenges.

For IMGs, residency training marks the intersection of immigration, acculturation, and the beginning of training within the U.S. health care system. Existing work indicates that, in residency training, IMGs are more likely than U.S. medical graduates (USMGs) to report experiences of discrimination.[15] Additionally, IMGs in residency have reported both linguistic and cultural barriers to providing patient care.[16] Many of these challenges persist beyond residency, extending throughout the careers of IMGs.[12] Yet, residency is also a period with existing structure for support, mentorship, and guidance. Therefore, in this analysis, we focus on professional challenges faced by IMGs throughout their careers that are amenable to interventions during residency.

Method

Study design and sampling

We contacted 27 non-U.S.-born IMG physicians with the goal of conducting qualitative interviews[17] with a purposeful sample[18] of these IMGs. All the physicians we contacted were from countries classified by the World Health Organization as having fewer than 2

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physicians per 1,000 individuals in the population (the United States has 2.56 physicians per 1,000 individuals).[19] We excluded U.S. citizen IMGs (USIMGs)— defined as U.S. citizens who attend medical school abroad—because previous work has indicated that their practice patterns are very similar to those of USMGs[20,21] and, as U.S. citizens, they are less likely to face many of the cultural challenges faced by non-U.S.-born IMGs. Our sample was limited to practicing physicians as opposed to physicians-in-training because practicing physicians are best able to fully reflect on their residency and subsequent career experiences. We also focused on physicians in family medicine, internal medicine, and pediatrics because those outpatient primary care specialties have large proportions of IMGs.[2-6] We identified participants through the American Medical Association's IMG Section, state licensure board databases for Connecticut, New York, and New Jersey, and department chairs at regional institutions. We recruited participants and collected data until we had achieved thematic saturation.[18]

Data collection

One researcher (P.C.), a pediatrician, second-generation immigrant, and member of an ethnic minority group, conducted all in-person interviews between March 2008 and April 2009. The interview guide (List 1) consisted of open-ended, "grand tour " questions.[18,22] Probes were used to encourage clarification and elaboration on specific sources of support. Interviews were audiotaped, professionally transcribed, and reviewed to ensure accuracy. Interviews lasted an average of 45 minutes, and participants completed an anonymous demographic survey at the conclusion of the interview.

Analysis

To analyze the data, we formed a six-person multidisciplinary team, which comprised a pediatrician, a family physician, two internists (including one IMG), an organizational psychologist, and a health services researcher, all of whom have expertise in qualitative methods. In accordance with principles of grounded theory,[23] we developed a code structure in stages, using systematic, inductive procedures to generate insights grounded in participants' views.

As a first step, after each team member had independently coded three transcripts, we met to negotiate a consensus where we had coded differently. We used the constant comparative method[23] to identify novel concepts, consistently classify emergent themes, and refine or expand existing codes. Next, P.C., S.B., and A.G. independently coded all remaining transcripts, meeting regularly to achieve consensus. M.N.S., D.B., and L.C. participated in code meetings, and the entire team finalized a comprehensive code structure that captured all of the data concepts. P.C. then systematically applied the final code structure to all transcripts that had been analyzed using previous versions of the code structure. Finally, at several stages throughout the iterative process of data collection and analysis, we conducted participant confirmation,[18,23,24] asking participants to review summary results and confirm that the themes being developed accurately reflected their experiences. We used qualitative analysis software (ATLAS.ti 5.0, Scientific Software Development, Berlin, Germany) to facilitate data organization and retrieval.

Results

Demographics

Our sample comprised 25 IMG physicians (see Table 1), a 93% participation rate. We achieved broad representation with regard to age, specialty, geographic region of origin, and years of clinical experience in the United States.

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Themes

Our focused analysis revealed four recurrent and unifying themes, which we detail below with accompanying illustrative quotes.

Respondents must simultaneously navigate dual learning curves as immigrants and as residents—Just like all residents, IMGs are expected to master the clinical practice of medicine. But, despite the shared global knowledge base in terms of physiology and disease processes, clinical practice often differs from practices in IMGs' home countries because of differences in resources, technology, and epidemiology. Additionally, as immigrants, they are faced with a new culture of medicine, in which they must adapt to the expectations of patients, colleagues, and supervisors and learn appropriate behavior and practices in the workplace. As noted by a pediatrician from South Asia:

> I had to adapt to so many things: the new terminology, the language … the technology…. The basic foundation of knowledge was there, but the remaining application of knowledge … was intimidating…. Catching up with all these things at once was overwhelming, but somehow I got through.

An internist from South Asia described the cultural differences with which he struggled.

> We like to say we know American culture … because of movies and songs and media and TV shows. So in that sense, interviewing patients wasn't a challenge…. [We didn't have] to say, what are you talking about? What is a hot dog? We knew those things. But I think the finer points … as far as the cultural interaction of a physician who has trained and practiced in a different environment where … patients' expectations [differ]…. You don't know…. That and the health care establishment's expectations from you…. You are in the position of authority, but also you are at a disadvantage because you don't really know these things…. Patient-centered interviewing, ethical issues, empathy … sometimes are lost in other countries because of the fact that health care is just practiced at a very, very different level.

IMGs face insensitivity and isolation in the workplace—Isolating workplace experiences span a range from cultural misunderstandings to frank discrimination. A family practitioner from the Middle East described the difficulties that occurred when his residency class, including several IMGs, entered a residency program that had not historically accepted many IMG trainees.

> When we came … on-board the first year, the second years were all American and [there was] some kind of cultural clash…. We were perceived to be different…. That created a lot of problems … and created conflict with the program director…. It was a very turbulent year…. They related it all to incompetence…. Some of us were even called antisocial…. [I think] it's all cultural. We were all from different countries…. Sometimes people … that's just their way of talking and you would think that they're either being rude or either they're screaming at you or they are mad or, you know?

This physician ultimately left this residency program for another program that, incidentally, had not historically accepted many IMGs either, but where he did not experience the same difficulties.

In other cases, the unwelcoming environment and subsequent isolation were the result of more subtle marginalization and discrimination. An internist from Sub-Saharan Africa recalled:

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> I had really lifelong friends, some of the American-trained colleagues … from residency. For some reason … many colleagues let off their guard and sometimes … [they would say] "he's an FMG" (foreign medical graduate) in … a negative kind of manner … talking to me about somebody else and then of course, they realize what I am: "but you are not like them … you're better" … which is actually insulting, you know.

Among the themes we identified in our analysis, insensitivity and isolation was the only one for which respondents could describe specific support that helped mitigate the challenges. This took the form of mentoring, both peer and intergenerational, which created a support network of people who could empathize and help navigate the process of transition. An internist from Sub-Saharan Africa described how intergenerational mentoring had strengthened the supports and decreased the isolation among IMGs who immigrated after him.

> Subsequent generations are … really a little more confident…. They have some others to look up to of their own culture, their own background, who have made it in this country and can give them a bit of advice and tell them about their rights. So we were just really blazing the trail.

An internist from Latin America described the role of peer mentorship.

> Mentoring can be not only done by someone that is above you, but someone at your same level. So … if I am an intern, it could be someone who is in the second year, so it can give you a different perspective. "I have this problem, did you face that when you were an intern?" or "They made this change this year, what do you think I should do so I can do okay?"

Mentors need not be limited to IMGs from the same home country. Merely sharing a common identity as an immigrant can enable others to empathize, as described by this family practitioner from Latin America.

> The attendings … immensely helped…. I would say out of 15 attendings … 10 were immigrants or … their parents were immigrants…. Eight were actually foreign medical grads…. It was easy to communicate [with them]…. They understood exactly where I was in terms of the transition into the U.S. health care system.

IMGs' migration has personal and global costs—A pediatrician from Sub-Saharan Africa reflected:

> You can do very good here … but there's a lot of bounds. Me being here doesn't do anything for my people, actually because even after acquiring this knowledge, I can't help my people. I'm frustrated…. Back home there are not many people who can do the same thing I do. It is … taking away from what I could be doing back [home].

Importantly, although participants acknowledged that their feelings of guilt accrued over time, it was not until later in their careers that they were able to begin thinking about ways to contribute to their home countries. This internist from South Asia, now midcareer, described how his priorities had changed over the course of his career.

> I was just too busy [before]…. We are [now], many of us … in the position where we can … talk about doing something to help back here. Because part of the reason we left was because it was not what we wanted it to be. So I think now we are going to close that loop and say, what can we do now to see if we can change it?

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IMGs face specific needs as they prepare to complete their residency training—Although many postresidency anxieties, such as searching for jobs or fellowships, are not unique to IMGs, they have to account for other factors, particularly related to their immigration status. This pediatrician from Sub-Saharan Africa recounted:

> My main fears were … always with the Green Card … I wasn't really at liberty to just go off and do a fellowship…. I very much wanted to get a job and make sure I was sponsored and could stay. To go off and do another fellowship … I might have had to change my visa status and become a student … I was just afraid…. You've got a lot of limitations.

Similarly, another pediatrician from Sub-Saharan Africa described the restrictions of J1 waiver positions.

> You have to go to an underserved area…. You know the conditions for a waiver…. It is a job in an underserved area where an American has not been found to do the job. That is the criteria…. You have to do at least three years…. You usually need that job to process your Green Card in the first place…. There are a lot of restrictions…. You cannot moonlight for three years…. You cannot travel…. If you travel there's always the risk of getting stuck…. There are a lot of restrictions in addition to working in a place where *they* don't want to work.

Discussion

In an in-depth, systematic exploration of the experiences of a diverse group of non-U.S.-born IMG physicians practicing primary care in the United States, we identified pervasive challenges they faced in their careers that could be addressed through interventions during residency training. Specific challenges arose from cultural differences, insensitivities in workplace behavior, difficulty finding ways to give back to their home countries, and the need for relevant career guidance in light of their status as immigrants. These challenges can serve as a starting point to begin considering targeted supports during residency, a critical transition period with an existing framework for support.

The following recommendations for potential supports are grounded in our analysis of the data and may inform approaches to graduate medical education. Given the heterogeneity among IMGs, these recommendations are intended as a point at which to begin discussions about strategies to support IMGs in residency training. They are meant to be broad. Any application should be tailored to the context of specific training programs.

Upon beginning residency

The participants in our study experienced culture shock on beginning residency; few had previously interacted with the U.S. health care system. Residency programs should consider integrating workshops on such important topics as patient-centered care, cultural sensitivity, and patient interviewing into their orientation programming or existing educational lecture series for interns and residents early in the year. These opportunities should be open to all residents, not only IMGs.

During residency

As IMGs experiencing multiple simultaneous transitions, the participants found peer and intergenerational mentoring an important source of cultural and logistical guidance. Residency program directors and others involved in graduate medical education could use both local connections and Internet resources such as social networking sites to cultivate relationships with the wider IMG and immigrant communities, thereby providing their IMG residents with a pool of mentors and support. Additionally, they should review and, if

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needed, revise policies within their institutions and programs to reduce the potential for workplace discrimination and to foster an inclusive and welcoming climate. Efforts to raise their organizations' cultural awareness should include the issues of IMGs, and protocols should be put in place to address discrimination, both explicit and subtle, in the workplace.

Transitioning to postresidency

Residency program directors who train and mentor IMG residents should become familiar with the visa and immigration issues that IMGs face. This would allow them to help IMGs focus on postresidency options in a timely fashion, to appropriately advocate on their behalf, and to understand the context in which their career decisions are made.

In addition, although IMG residents are typically not yet able to articulate the guilt that many eventually feel over having emigrated, residency may be the ideal time to begin addressing their need to find systematic, sustainable ways to give back to their home countries. IMGs should be encouraged to establish connections abroad early in their U.S. professional careers, thus forming a sustainable foundation for postresidency volunteerism and advocacy. In light of increasing interest in global health among USMGs,[25] residency programs should take advantage of their IMG residents' international experiences when developing programs such as international health electives or global health interest groups. Having IMGs share their knowledge about disease processes and cultural customs in their home countries with U.S. medical students, residents, and attending physicians planning to work abroad could foster cultural and educational exchange between IMGs and USMGs within an institution or region while also allowing IMGs to contribute in a meaningful way to their home countries. Finally, such a cadre might even facilitate culturally sensitive care for immigrant populations in the United States.

Our findings are consistent with findings of studies on support structures for IMGs in other nations, where similar efforts are ongoing.[26] Canadian programs are using innovative methods to introduce IMGs to professional norms[27] and have been shown to advance IMGs' knowledge and understanding of the workplace. In Australia, a pilot peer mentoring program has been created to support IMGs,[28] and more structured opportunities for observerships have been implemented.[29,30]

Our findings must be interpreted in light of the study's limitations. We focused on IMG physicians in outpatient primary care specialties because of the concentration of IMGs in these fields. We also geographically limited our study to the largely metropolitan region of New York, New Jersey, and Connecticut, where a significant share of practicing physicians and residents-in-training are IMGs.[5] Other geographic regions, particularly rural areas, may present different challenges for IMGs.

Our study also has a number of strengths. First, our participants were diverse in age, specialty, geographic regions of origin, and years of clinical experience in the United States. Despite this diversity, their common experience as IMGs was reflected in the recurring and unifying themes they reported. Second, we used a number of recommended strategies to ensure rigor: consistent use of an interview guide; audiotaping and independent transcription; standardized coding and analysis; use of researchers with diverse racial/ethnic and professional backgrounds; an audit trail to document analytic decisions; and participant confirmation.[18,24,31-33] Findings of our study are also consistent with research on the experiences of trainees from other minority groups in medicine.[15,34-36] Finally, our high participation rate suggests that this is an issue IMGs are motivated to discuss in a research context, despite the potentially personal and sensitive nature of the topic.

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Conclusion

Residency is a time when physicians establish critical elements of their professional identify and behaviors. It is also a period with a preexisting framework for support and education. By improving supportive strategies for IMGs during residency, we can foster an environment in which all physicians in our increasingly diverse workforce can learn to provide culturally relevant patient care.

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List 1

Standardized Questions and Potential Probes Used to Interview 25 Participants in a Study of Non–U.S.-Born International Medical Graduates (IMGs) in Primary Care Practices in Connecticut, New York, and New Jersey, 2008–2009

1. Tell me about your experiences working in the United States as an IMG physician.
    - What is good (and/or challenging) about being an IMG physician?
    - How has being an IMG physician influenced your professional life?
    - Have you ever felt that your career choices were expanded (or limited) because you are an IMG physician?
2. Could you talk a little about sources of support during training and throughout your career?
    - Were there many other IMG physicians where you trained or where you work now and how does that affect your experience?
    - Can you talk about your experience with formal and informal support networks?
    - Were there any particular pieces of curriculum in your training that were helpful/unhelpful?
    - Could you talk about sources of support that you think should exist for IMG physicians?
3. How are your professional relationships (with patients, other physicians, support staff) affected by your status as an IMG physician?
    - Have your workplace relationships differed in the various places where you have worked; if so, how?
4. Please share your thoughts on the phenomenon of physician migration either on a personal or a population level.
    - Current relationship with home country, feelings about migration.
    - Individual versus collective identity as an IMG physician.

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Table 1

Characteristics of 25 Participants in a Study of Non-U.S.-Born International Medical Graduates in Primary Care Practices in Connecticut, New York, and New Jersey, 2008–2009

Characteristic	Value
Age in years: average (range)	46 (30–65)
Specialty	
Family practice: no. (%)	7 (28)
Pediatrics: no. (%)	8 (32)
Internal medicine: no. (%)	10 (40)
Region of origin	
Sub-Saharan Africa: no. (%)	6 (24)
South Asia: no. (%)	8 (32)
East Asia: no. (%)	5 (20)
Latin America: no. (%)	2 (8)
Middle East: no. (%)	4 (16)
Years since completed residency	
0–5 years: no. (%)	5 (20)
6–10 years: no. (%)	6 (24)
11–15 years: no. (%)	7 (28)
16–20 years: no. (%)	3 (12)
21–25 years: no. (%)	1 (4)
>25 years: no. (%)	3 (12)
Home countries' rate of MDs per 1,000 population: average (range)	0.74 (0.03–1.88)