Foreign Medical Graduates and Quality of Medical Care

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There has been concern about increasing governmental regulations and increasing pressure by insurance companies and other third party payors to reduce medical cost. Ther is also a concern about the oversupply of physicians, whether true or perceived. Instead of trying to resolve the basic issues and investigate the true reason(s) for these problems, organized medicine, notably the Americn Medical Association (AMA) and the American Association of Medical Colleges (AAMC), has unfortunately resorted to unfair competition practices by targeting certain groups of practicing physicains. In particular, they have selected foreign medical graduates (FMGs) to be their target.

First, they have succeeded in lobbying the Congress to limit the immigration of new FMGs (PL 94-484, 1976). Then they tried to limit the chances of FMGs getting into residency training programs. More recently, they have tried and succeeded in some states to impose more restrictions on licensure, thus, making it more difficult for fully trained FMGs to obtain licenses and for practicing FMGs to move from one state to another.

Knowing that these efforts will be labeled discriminating and illegal, they have resorted to devious ways to make their position more acceptable. They have tried hard to initiate and spread the myth that FMGs are less qualified, less competent, and provide an inferior quality of medical care than US medical graduates (USMGs). They are trying to spread these myths by all means, through the media and through their contact with Congress, notwithstanding the fact that several studies which have compard the clinical performance of FMGs to USMGs have found no such difference.

As early as 1979, a study by Saywell et al[1] examined 6,980 medical records with eight diagnostic categories for 1,321 attending physicains: 985 were USMGs and 331 were FMGs from 53 countries. They utilized two types of inpatient hospital audits, i.e., the Payne Process Audit and the Joint Commission on Accreditation of Hospital Performance Evaluation Program (PEP audit).

The Payne Process Audit concentrates on the appropriateness of hospital admission, length of stay, and a physician performance index (see later for explanation of this index). The PEP audit examines: 1) justification for the given diagnosis, i.e., was it appropriate, was the intervention appropriate, was admission justified; 2) outcome; 3) quality indicators including the appropriateness of the level of care, length of stay, the development of complications, what was done about them and what was done to prevent their recurring.

They concluded that there were no significant overall differences in performance between USMGs and FMGs attending physicians.

In a more recent study,[2] the performance of FMGs was compared to that of USMGs in an outpatient setting. Such a setting is more likely to expose practice differences than a hospital setting, because of the lower level of organizational control. Overall, there were 14,203 patient episodes treated by 1,156 physicians.

Optimal criteria items were developed for each of 10 diagnotic categories. The performance at each clinical episode was compared with the optimal management giving them "physician performance index" (PPI).

The overall performance of FMGs was not significantly different from that of USMGs. Indeed for obstetricians/gynecologists and pediatricians, FMGs tended to provide slightly higher quality of care than the USMGs. When the performance was compared after correction for the site of practice (major teaching hospital versus other practice settings), FMGs provided slightly better care overall than USMGs. When the analyses were done separately for internists, obstetricians/gynecologists, and pediatricians, the results showed that FMGs' care was better in each case; however, the difference was statistically significant only for pediatricians.

The analysis was then repeated after controlling for additional intervening variables; patient characteristics (race), physician characteristics, and practice characteristics. FMGs provided a slightly but statistically significant higher quality of care than USMGs. Again, for the three speciality groups, FMGs tended to provide higher quality care than USMGs, but the mean difference was statistically significant only for pediatricians.

Another myth that has been initiated is that FMGs

have a higher incidence of malpractice suits. In fact, an undocumented article in Medical Economics listed FMGs as the number one risk factor for being sued. This article caused the International Association of American Physicians (IAAP), of which the IMA is a founding member, to file a lawsuit for libel and tortious interference with business.[3] It is surprising that such a myth continues to be spread and written despite solid evidence to the contrary. A study done in Queens, New York, demonstrated the fact that FMGs are less likely to be sued.[3]

A recent study analyzed the demographic data on 920 physicians who lost their professional liability (inappropriately labeled malpractice) insurance coverage who applied to a surplus lines company. These companies primarily insure all high risk applicants. It documented that the percentage of FMGs in this pool is virtually the same as that in the US physician population. As a matter of fact, it is slightly less (21.1% vs 22.6%).[4]

FMGs should be proud of their achievements. All available studies have vindicated FMGs, and if anything, have shown they provide better care and are less prone to be sued.

Despite these facts, organized medicine still clings to its position and continues to resist changes to ban discriminatory practices against FMGs.

We should not be complacent. We should continue our just struggle for our cause. We should support the efforts of IMA and IAAP in their lobbying for the passage of the Bill HR-614 in the current US Congress.

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