

Letter from . . . Chicago

Strangers at the gates

GEORGE DUNEA

Man is a territorial animal, who will defend his domain as tenaciously as most species of tigers, monkeys, lizards, and rats. When pressed hard he will growl, charge, brandish weapons, or hurl missiles. Under more civilised circumstances he will amend immigration laws and impose restrictive quotas. He will likewise set up stiff examinations and licensing requirements to protect the standards of medical care against a perceived flood of ill educated doctors coming from abroad.

This heritable form of behaviour, firmly encoded in his genetic make up, accounts for the predicament of more than 6000 foreign doctors presently trying to break into the American system. They work as lift drivers, microbiologists, laboratory technicians; or as medical assistants writing up histories and physical examinations in hospitals without interns. They spend their time filling in applications for hospital posts, following up every possible clue, contacting people believed to have influence, or offering to work without pay in the hope of eventually getting a job. Some attach themselves as observers, spending their days on rounds in the teaching hospital, while in the evenings they do blood counts at the local jail or urine analyses at the little hospital down the road. Some are desperate and all are having a rough time, deriving little consolation from the thought that in their own countries foreigners would have an even harder time obtaining a licence to practise.

These foreign doctors come from all parts of the world, notably from India, the Middle East, eastern Europe, and Central America. Some are brilliant, some middle aged or even older, some speak poor English, and some are for ever contending with exams. Some are just in the wrong place at the wrong time. Many have passed a whole array of exams—educational council for foreign medical graduates, visa qualifying examination, federation licensing examination—but now cannot practise because they need a pre-registration post as a prerequisite for licensure. And while the hospitals are cutting back on these training posts the foreign graduate now must also compete with 15 000 Americans studying abroad and coming back at a rate of 3000 a year.¹ At any rate, he finds most preregistration jobs filled by the hordes of local graduates now being turned out in response to the perception, some 10 to 15 years ago, that this country was suffering from a shortage of doctors.

And a shortage indeed there seemed to be, or at least a severe maldistribution. There were few doctors at the time in the ghettos of the inner city or in many parts of rural America. Indeed, whole counties in down state Illinois had nice little hospitals with sweet matrons, modern nurses, and efficient administrators, but not so much as even one doctor from Mindanao or Kashmir to remove an appendix or take a history.

Now some of this goes back to the days of the great society, when government money was plentiful and President Johnson had

declared that every American had the right to decent medical care. Having doctors come from all over the world seemed a godsend, specially as the medical schools were unable to fill the need. Most local doctors, furthermore, had little inclination to work in the ghetto or in that nice Appalachian town where every man was either unemployed or on welfare. So the foreign doctors came, often entering the country as exchange visitors but subsequently changing their type of visa and thus being allowed to stay. Yet they too had no desire to practise in that part of town where you had to carry a gun to feel secure in your front store office. So they filled up the fashionable inner suburbs, then the outer suburbs, and by the mid-'seventies they began to take jobs in the city itself. Here they were joined in the late 'seventies by the growing output of American graduates, and then came the Reagan cuts and the recession, so that by now the business of many private practices is down by a half, and even the once despised casualty department jobs go for a premium. Many doctors have had to resort to making house calls, and the last thing that they want is another boat load of young energetic doctors arriving from Bangladesh.

Questions to be answered

Indeed, they are no longer sure even about the Americans studying abroad. Listen then to a doctor from Michigan, fed up about all these foreign medical graduates, and asking why there should even be such a thing as a foreign medical graduate coming to practise in the United States altogether. What other trade, profession, craft, or organised group would even consider licensing people from abroad? Could you imagine carpenters, bricklayers, or plumbers allowing graduates from a Caribbean trade school coming to practise here? His position is that "rejectees from American schools" going to Montserrat, Dominica, Granada, Mexico, and St Lucia should be told in no uncertain terms that it is there that they will be expected to practise.² His letter, moreover, seems to reflect a growing sentiment, indignant letters from Caribbean deans or from students at Guadalajara notwithstanding.

Listen then also to an angry mother, deploring that her son must study abroad because "real foreigners (not Americans) stay on here in our country and we treat them as physicians and allow them to practise medicine and surgery. Why don't they go home to their own country and help their own people. . . ? I see the foreign physicians, who cannot speak our language in the hospitals, trying to make themselves understood, and having absolutely no rapport with the nurses or patients."³ And judging from the overall comments and the resolutions introduced periodically in the meetings of the American Medical Association, neither foreign graduates nor Americans studying abroad are welcome anymore. Thus, as early as 1982, the American Medical Association house of delegates had voted to stop the influx of "inadequately trained doctors" seeking licensure in the USA in order to "assure quality care for the people of the United States." Then there have been periodic reports that foreign graduates perform poorly in various examinations, and there have also been questions about the teaching in some of the foreign schools, especially those in the Caribbean. Some schools

Cook County Hospital, Chicago, Illinois

GEORGE DUNEA, FRCP, FRCPED, attending physician

have excessively large classes, rely mainly on lectures, and farm out their students on elective clerkships to small private American hospitals. Here the students often receive no teaching, but wander about aimlessly and spend most of their time sitting in the doctors' lounge reading their textbooks.

Disaccredited Caribbean schools

Added to this has been much unfavourable publicity about incidents of downright fraud. Last year some 17 000 candidates had to retake the educational council for foreign medical graduates examination because stolen copies of the exam question had allegedly been sold to candidates. It also turned out that graduates from some of the Caribbean schools had been coming with false medical transcripts and diplomas. Last year a 58 year old Peruvian was imprisoned after being unmasked by an undercover nurse: he had paid nearly \$20 000 to obtain falsified papers and transcripts; and it seems that this man had sold false certificates to some 165 people for a total of \$1.5 million. In response to reports about inadequate training and fraud several states, notably California and Florida, disaccredited certain Caribbean schools and adopted new tough rules against registering foreign graduates. In Illinois, where a court had forbidden the state to discriminate against Caribbean schools, the department of registration responded by deciding to evaluate all foreign medical schools whose graduates wanted temporary licences. All this, combined with the difficulties in obtaining preregistration posts, indicates that foreign graduates coming to the United States will find the going increasingly difficult, as excessive budgetary cuts are shrinking the pie and the pieces available to go around are getting smaller each year.

What about, then, the nearly 100 000 foreign doctors already settled in practice in the United States? Most are doing well, but for some life is no picnic, specially if they are latecomers who had to settle in the less desirable parts of the country. They do not always like foreigners in some of the remote communities, if for no other reason than that they look different, speak differently, and are so hard to understand. Some foreign doctors have settled down successfully in Apalachia, in Mississippi, and in West Virginia, and some work seven days a week to fulfil a real need.⁴ They are gradually being processed by this extraordinary melting pot, and their gum-chewing children will soon be indistinguishable from their classmates. Yet I often think of the young doctor practising in a small mountain town but most anxious to move to Chicago. He wanted to get married, and his parents had arranged a suitable match with a lady from Calcutta. But his prospective bride, while willing to come to Chicago, had definitely ruled out living in the mountain town where her fiancé was carrying out his lonely practice.

Yet he may consider himself fortunate, this young man, compared with the thousands languishing at the foot of the mountain. For the medical schools are large and their machinery is ponderous, not easily slowed down in midstream. In the foreseeable future these schools will continue to pour out their products into an already oversaturated market. And so long as this goes on the prospects of the foreign medical graduates will remain depressingly dim.

References

- 1 Stimmel B, Graettinger JS. Medical students trained abroad and medical manpower. *N Engl J Med* 1984;310:230-5.
- 2 Mozen HE. *American Medical News* 1983 December 16:6.
- 3 Deckler IR. *American Medical News* 1984 February 10:6.
- 4 Carey S. Foreign doctors fill a medical-care gap in backwater towns. *Wall Street Journal* 1984 May 23:1.

Communicable Diseases

Prevention of malaria in pregnancy and early childhood

Prepared by the Public Health Laboratory Service Malaria Reference Laboratory

During pregnancy and early childhood protection against malaria is essential in risk areas. Some of the antimalarial drugs are contra-indicated, but it is usually possible to recommend a safe and effective schedule which will provide satisfactory protection.

The reasons why malaria is specially hazardous in pregnancy have recently been reviewed by Bruce-Chwatt and in a leading article in the *Lancet*, which emphasised the risk to the fetus caused by malaria in pregnancy.^{1,2} For these reasons, and for the general one that it is better to abstain from all drug treatment during pregnancy and early childhood, exposure to malaria is best avoided; but if a woman decides that a visit to a malarious area is unavoidable protection is essential. Probably the best way to make a decision about the correct prophylaxis for these special groups is to determine firstly what would be recommended for the normal adult, and then to consider whether any of the chosen drugs are contra-indicated in pregnancy or early childhood.^{3,4}

In deciding on the advice to be given it is, as usual, necessary to balance the risk of malaria against the risk of the antimalarial drugs recommended. The visitor to tropical Africa and coastal New Guinea is at considerable risk, and protection should be as complete as possible. In other parts of the world more detailed information may show that there is little or no risk in parts of some of the countries classified as malarious.⁴

Pregnancy

Proguanil is generally recognised as being safe during pregnancy but has the disadvantage that in many places the malaria parasites, especially *Plasmodium falciparum*, are resistant; it is still effective against most strains of *P. vivax*.

Chloroquine in the doses used for malaria prophylaxis is considered safe. The much larger doses used in treating collagen disease are contra-indicated in pregnancy, and as a result some authorities are unwilling to use it at all during pregnancy. This restriction should not apply to the smaller doses used for prophylaxis. For preventing vivax malaria and susceptible strains of *P. falciparum* chloroquine is probably the drug of choice.

Problems arise when there is resistance to chloroquine. The generally recommended complementary drugs to prevent infection with *P. falciparum* are combinations of pyrimethamine with dapsone, a sulphone (Maloprim), and with sulfadoxine, a sulphonamide (Fansidar). Fears about the teratogenicity of pyrimethamine in early months of pregnancy are based on studies in rats; there is no convincing evidence that this occurs in man. Well reasoned arguments suggest that both drugs are safe during early pregnancy and that the theoretical objection to Fansidar in late pregnancy (that sulphonamides compete with bilirubin for plasma proteins and may