Dr. Mahamud Jimale was working as a general and thoracic surgeon and teaching at Somali National University’s medical school in Mogadishu when civil war tore his country apart in 1991. After spending four years at a refugee camp in Kenya, where he worked alongside physicians from Doctors without Borders and other volunteer organizations caring for his countrymen, Jimale and his family made their way to the United States in 1996.

They eventually settled in Rochester, where Jimale found work in the general clinical research center and later as a medical and cultural consultant at Mayo Clinic. Hoping to one day practice medicine again, he also began studying for the USMLE exam.

Along the way, Jimale learned of a program offered by the University of Minnesota department of family medicine and community health to help immigrant and refugee physicians prepare for residency in the United States—something they need to do to practice medicine here. The Preparation for Residency Program (PRP) taught them about the American healthcare system, the culture of medicine in the United States, the types of conditions and patients they might care for, ethical issues that arise in practice, concepts such as team-based care and how to use electronic medical records. The goal of the program was to help these physicians get into residency so that one day they might provide primary care in underserved communities in the state. “We helped refugee doctors earn a ticket to the tryouts,” says Will Nicholson, M.D., a hospitalist at St. John’s Hospital and assistant professor of family medicine and community health at the University of Minnesota who directed the PRP.

After passing the licensing exam, Jimale applied to the seven-month-long program in 2011 with the idea of getting into a family medicine residency program. “The first group of physicians [to go through the program] were all Somalis, and the good thing was they all managed to get into residency,” he says. Today, Jimale is applying to programs including those at the University of Minnesota, the University of Wisconsin and the University of Iowa. He

The graduate glut
Why it’s getting harder for international medical school graduates willing to take primary care jobs to get into residency.

BY KIM KISER
will find out in March whether he matches with one of them.

Getting into residency in this country has always been more of a challenge for graduates of foreign medical programs than for those of U.S. programs. Now it may be even tougher. For one thing, residency program directors are relying more on their applicants’ performance on standardized tests than they used to.

“The hard reality,” says John Andrews, M.D., associate dean for graduate medical education at the University of Minnesota, “is that many people who’ve trained elsewhere don’t meet certain objective standards of performance on standardized tests, so they never get their application fully reviewed.” In addition, growing enrollment in medical schools, a federal cap on residency slots and changes to the residency matching process are converging to create a bottleneck in the physician production process.

All this is occurring at a time when the need for primary care physicians has never been greater. (A recent report in the Annals of Family Medicine estimates the United States will face a shortfall of 52,000 primary care physicians by 2025.)

The residency bottleneck

In 2006, the Association of American Medical Colleges (AAMC) called for a 30 percent increase in first-year medical school enrollment between 2002 and 2015—from 16,488 to 21,434—in order to prepare for a projected physician shortage. As of 2011, enrollment stood at 19,230—a 16.6 percent increase over 2002. Most of the growth (2,175 positions) has occurred at the 125 schools that were accredited as of 2002. The rest (567 slots) came from 12 new schools that have since become accredited (seven more have applied for accreditation). The size of the first-year class at the University of Minnesota Medical School’s Twin Cities campus has remained fairly steady—166 in 2002 and 170 in 2012; enrollment on the Duluth campus increased from 53 in 2002 to 60 today. Mayo Medical School has increased the size of its first-year class from 42 in 2006 to 50.

At the same time, the federal government, which funds a significant portion of residency training through the Medicare program, has held the number of residency slots steady at approximately 115,000, according to a 2012 Health Affairs policy brief. “The number of residency positions was capped by the federal government at the 1996 level and hasn’t changed,” Andrews says. “We should be concerned that we might be graduating more medi-

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The AAMC is supporting legislation introduced last year that calls for 3,000 new Medicare-supported residency positions a year between 2013 and 2017 and that half of those positions be for primary care or other specialties in which there are shortages.

But numbers don’t tell the whole story. Changes to the National Residency Matching Program (NRMP) have also made it more difficult for graduates of foreign medical schools to get into residency. Last year, the NRMP eliminated the “scramble,” a process used to fill slots that went unfilled during the Match (physicians who went through the Match as well as those who did not could participate in the scramble). “It was chaotic,” Andrews says. “Your phone rang off the hook, your fax machine ran like a ticker tape, and your email box would soon exceed its quota as a crush of people tried to secure a spot.” The NRMP replaced the scramble with the Supplemental Offer and Acceptance Program, which attempts to fill unmatched positions only with those people who participated in the Match.

This year, the NRMP is instituting what it calls the “all in” policy for the first time. Under this policy, all first-year residency positions must be offered through the Match. Previously, residency program directors could offer positions to promising international graduates outside the Match. “Graduates of allopathic medical schools in the U.S. had to use the Match to apply (continued on page 28)

The distribution problem

In addition to their concerns about the number of available residency training slots, graduate medical educators are concerned about the distribution of those positions. Because of the way Medicare funds graduate medical education, most residency programs are based at teaching hospitals, and most of those are in metropolitan areas. A Health Affairs brief notes that most residents go on to practice where they do their residency. “The system’s ability to create incentives to pursue GME in primary care disciplines and influence where [physicians] choose to go to work after finishing residency is really important,” says John Andrews, M.D., associate dean for graduate medical education at the University of Minnesota. “We need to train people to work in primary care settings, rural areas and underserved inner-city areas.” —K.K.
are inviting educators and employers from across the state to help find new ways to get these doctors into health professions jobs. “The skills these doctors have are desperately needed in our state, and there are plenty of other opportunities for them,” Nicholson says. Among the options the group is exploring are working in the public health sector, in emergency medical services, or as physician assistants or nurse practitioners.

“The shortage of residency opportunities shouldn’t keep these talented people out of health care,” he says. “We need all hands on deck. Someone who can treat sick people in a state with a shortage of physicians shouldn’t be stuck driving a taxi.”

Kim Kiser is senior editor of Minnesota Medicine.

Bruce W. Young, M.D., Ph.D.

One of the biggest influences on my decision to go into primary care was a family physician I met while doing a rotation in medical school at the University of Calgary. Dr. Sheila Malm was a very bright, caring woman who showed me how, as a primary care doctor, you have to be able to see the whole patient and put together a lot of diverse findings and symptoms to make a diagnosis. She really impressed me, and primary care came across as a very challenging and enjoyable way to practice medicine.

I’ve found you have to have an investigative knack. In a given day, I see so many different patients coming through the door with so many different problems. Primary care is very challenging intellectually.

One of the challenges we have in America is the cost of health care. It’s going to become more and more important to have someone involved in patient care who can make sure things are being done in the most cost-effective and appropriate manner. We’ve de-emphasized primary care in our country for many years. With the way we’re going, with accountable care organizations and a movement toward preventive care, we’re going to see a bigger focus on primary care in the future.

Bruce Young practices family medicine at Allina Medical Clinic - Brooklyn Park.

The graduate glut

(continued from page 17)

for residency positions, but someone who graduated from medical school outside the U.S., say France or Somalia, didn’t have to go through the Match,” Andrews says. “If you were interested in an international graduate, you could offer them a position and reduce the complement of positions offered through the Match.”

Further contributing to the bottleneck is the fact that graduates are applying to more programs than they once did, thus ramping up competition for spots. “People are anxious about their prospects when graduating from medical school,” Andrews says, adding that this year the pediatric residency program at the University of Minnesota, which he formerly directed, saw a 25 percent increase in applicants over last year. “The irony is that more applicants may be more of a curse than a blessing. When students make a conscious decision to apply to more programs, they may not be applying to your program because of a focused interest. As a program director, you need to be selective about whom you interview. The best applicants have many options, and you may not be their first choice.”

The challenge for residency directors is to make sure that the pool of applicants yields a highly qualified residency class.

Getting back in the game

The impending residency bottleneck led to PRP’s suspension this fall. As a result, Nicholson and others involved with the program, including representatives from the university’s department of family medicine and community health, HealthEast Care System, local groups representing international physicians and even some recent PRP graduates, have launched a new effort—the International Physician Workforce Initiative.

Trying to increase the number of career options for immigrant and refugee physicians, they are inviting educators and employers from across the state to help find new ways to get these doctors into health professions jobs. “The skills these doctors have are desperately needed in our state, and there are plenty of other opportunities for them,” Nicholson says. Among the options the group is exploring are working in the public health sector, in emergency medical services, or as physician assistants or nurse practitioners.

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