IMGs step up to help fill the care gap in underserved areas

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Featured topic and speakers

In today’s COVID-19 update, AMA Chief Experience Officer Todd Unger talks with international medical graduate physicians who are filling a much-needed gap by practicing in underserved areas during COVID-19.

This episode airs as part of AMA’s IMG Recognition Week (Oct. 19–Oct. 23), spotlighting IMGs’ invaluable contributions to health care.

Learn more at the AMA COVID-19 resource center.

Speakers

- Kamalika Roy, MD, assistant professor, psychiatry, Oregon Health and Science University
- Natalia Solenkova, MD, intensivist
- Toms V. Thomas, MD, chief resident, radiation oncology, University of Mississippi Medical Center

Transcript

Unger: Hello. This is the American Medical Association's COVID-19 update. Today we're discussing how international medical graduate physicians are filling a much-needed gap by practicing in underserved areas during COVID-19.


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This episode is airing as part of AMA's International Medical Graduate Recognition Week, taking place October 19 through 23, to spotlight IMG's invaluable contributions to health care. I'm joined today by Dr. Kamalika Roy, an IMG physician and assistant professor in the department of psychiatry at the Oregon Health & Science University in Portland, Oregon. Dr. Natalia Solenkova, an intensivist in Miami, Florida. And Dr. Toms V. Thomas, chief resident in the department of radiation oncology at the University of Mississippi Medical Center in Jackson, Mississippi. I'm Todd Unger, AMA's chief experience officer in Chicago. Dr. Roy, we're going to start with you. I know each of you treat patients in underserved areas. Dr. Roy, can you tell us what it's like in your community right now?

Dr. Roy: Hi. Good morning everybody. And thanks AMA for giving the chance in voicing the strength and opportunities for IMG physicians. IMG physicians mostly work in rural and underserved area. They are disproportionately the only service providers in these areas. And I am proud to be one of them. I work in Oregon, in a county called Marion County, which has an HPSA designation federally. That means which has a patient to provider ratio very low, which also has a low insurability. A lot of people here live under, in the federal poverty line. So I take incredible pride in serving that community and serving the American people that live in this community.

Unger: Dr. Roy, has the pandemic been affecting you in your area?

Dr. Roy: Well, so even before the pandemic, the rural and underserved communities have faced a lot of discrimination in terms of socioeconomic status and the accessibility to care and the accessibility to proper PPEs. But with the COVID-19 pandemic, things have reached an abyss, in terms of many health care facilities closing down, many psychiatric units closing down. Many units had to evacuate their patients, the long-term care facilities mostly, they had to evacuate their patients to somewhere else. And also this problem even got bigger when there was a recent widespread wildfire, very near to the communities in the residential areas.

Unger: That's a lot to deal with all at the same time. Dr. Solenkova, can you talk about your situation?

Dr. Solenkova: Good morning, everybody. I live in Miami, and I guess nobody would think that Miami would be full of underserved people. And it's rather not they're underserved area, it's underserved poor populations of people. We have a lot of immigrants in here, so it's rather serving underserved population. I work in two public health care systems, that one of them is a top one system in the country, largest public health hospital. As well as the second system that I work at is usually graded between number three and number five. So those are largest systems in the country and serving a lot of immigrants. We have a lot of Latin immigrants, we have Haitian immigrants, we have Russian immigrants. And the immigrant populations are usually the ones that are less insured, have less access to health resources, all the social economic battles, maybe undocumented immigrants. And so those are the ones that we serve here in Miami.

Unger: Dr. Thomas, can you talk about your situation down in Mississippi?
Dr. Thomas: Yes. Good morning, everyone. So as you know, Mississippi is one of the states with the lowest access to care. And we rank, unfortunately, the 50th in the state for when it comes to healthcare. I'm at the University of Mississippi Medical Center. And we are the only tertiary care center in the state, economic center in the state. So we take incredible pride in taking care of the Mississippians. I work in Hinds County, which is a very poor and underserved area. Even before the pandemic, we served the poorest of the poor patients. And with the pandemic and being on an oncology training, we see a lot of changes.

The patients have not been presenting in the beginning of their symptoms. And six months later, they are presenting with incurable cancers. And this is an area that we don't quite see, you don't see upfront, this is an effect which is going to come later. When it comes to the COVID cases, we had an uptick, and then we were able to control with the public health care measures. And now, again, unfortunately, the cases are going up again. The state and the university are doing great work. We are hoping to continue the care for our patients.

Unger: That's a good segue in our next question about what are the unique challenges that you and your patients are experiencing right now during this pandemic? And how have you dealt with them? Dr. Solenkova?

Dr. Solenkova: I would like to say that in terms of critical care delivery, I think that the differences probably are not that obvious as you would think that preventative care. However, the quality of care is different if we're comparing a reach versus resource for hospitals, or again, a high level of care hospitals versus low quality of care hospitals. And unfortunately, I've heard what Tom said, that there are number of 50 in the States. We're number 41, and we were number 48 only a year before. So the quality of care in general that is provided in state of Florida is low. And the ICU care, you will see it. So usually underserved communities get to receive low quality care, lower quality care than communities that don't suffer that much.

Unger: Dr. Thomas, we talked earlier in the segment about the important role that IMG physicians play, especially in underserved areas. Why is it so difficult to get physicians to practice in these areas in the first place? And talk a little bit more about that role that IMG physicians help fill.

Dr. Thomas: So, Todd, I believe that's one of the tough questions to answer, why we cannot get enough physicians to underserved area. That speaks to, I would say, the training we have currently. I think that speaks to that. And I believe even some of the physicians, medical students who came from that area, a lot of them will, some of them overpay. So I will talk more about how IMGs can fill the gap in that care. So I have a lot of friends all over Mississippi. They've been working there for years and years in primary care, nephrology, being the nephrologist, the cardiologist. So again, a lot of the physicians start working at this places because of the visa reasons. But once they establish, they work there for three years, they establish their referral patterns and their patient base, most of them tend to stay there.
So I have friends who have been in this very underserved radiant, which is three hours, four hours from the capital city. They've been living there and working there for 10, 15, 20 years. And their family grew up there, the kids grow up there. And so in that way, the IMG physicians have been contributing to that community. In addition to the health care, again a lot of them, when it comes to how they contribute economically, the hospitals, the clinics, on an average, they give a job to the people in the community, like four or five people in every clinic. And one of the studies I have read, they contribute almost $2 million to the community on an average. So having IMG physicians in these communities, it is important for health care, and it's important for economy. And I believe it is in the interest of the community to keep doing so.

**Dr. Solenkova:** I just wanted to add something about the community care. So I have friends that also work in, IMGs that are working in Texas, for example. I just want to say, this is as an example. I have a friend who is originally from Columbia and the other friend who is originally from Venezuela. One is working in Laredo, Texas, and the other one is in El Paso, Texas. Initially they moved there as a part of their visa waiver, and then both of them stayed there. They have families, they live there now for many, many years. And I think it is extremely important for both of them, the service they provide to the communities. Because they speak the language of the people that live there.

So they understand cultural differences, cultural issues that come with their population. They understand how to serve that population better. So I think this is where IMGs can really make a difference, when they work in the areas that are predominantly immigrant, or they have certain cultural influences from immigration background of their previous ancestors or previous generations that came to that land. So I think that's extremely important, to be able to speak the same language and to understand community you serve.

**Dr. Thomas:** I totally agree with that.

**Unger:** We've talked about the issue of visas has come a couple of times in your conversation. Dr. Roy, let's talk a little bit about the challenging issues for IMGs, of which visa issues are one, and other regulatory burdens. Can you talk about those?

**Dr. Roy:** Sure. Before I get into that, I just wanted to kind of finish something Dr. Thomas just said. It's very hard to recruit doctors. Doctors' recruitment is a complex thing nationwide, but it's even harder in rural and underserved communities. And the reasons are kind of complex. One reason is definitely most of these communities do not have all the amenities that urban areas would offer. But the other reasons are the disconnection between academic institutions and community partners. So often there is a lot of disconnection between these two entities that leaves out a lot of doctors working in the academic institutions and not taking part in the community health system. IMGs can fill that gap very effectively, because of their visa requirements that needs them to be in rural and underserved areas. And as Dr. Thomas just mentioned that after we established our practice, after we kind of know our communities and our partners, it's kind of counterproductive for a doctor to move out of that.
So that's how medicine works. And medicine is a practice of consistency. It's not like other professions where we can just change jobs, or we would prefer to change jobs just because of salary and other benefits. Coming to the next question of this visa regulations. That's been a challenge for many years, or I would say decades in this country. But with the current rules, current regulations that happened over the last couple of years, the problem of immigration for physicians have reached a new level. Most recently, the USCIS and the Department of Labor came out with an internal final rule. That means there would be no school for public comments for that rule to be implemented. And the rule actually sets, and I would say it's arbitrary, but it sets the wage level to such a high threshold that many of the physicians, especially the primary care physicians, would not be able to work even if they want, and even if the recruiters want. They would not be able to work in this rural and underserved areas.

Contrary to the popular belief that physicians aren't a lot, actually, there is quite a bit of variation in physicians' salary. It really depends on the geographic area, the specialty and something called prevailing wage in that specific area. So many factors actually determine physician salaries. If there is a salary restriction for physicians who are traditionally paid at a lower level, then it's going to create a havoc in the health care workforce system for the rural and underserved area. And we already started the process, probably unknowingly and probably not thinking through it.

**Unger:** Well, last question. How can our health care system better support IMGs, and in doing so, their patients as well? Dr. Thomas?

**Dr. Thomas:** So I believe, as we mentioned, IMGs contribute a lot into the community, to the health care centers, specifically in the rural and underserved areas. So I believe, even after serving this communities, sometimes we do not get the support that will benefit us, the IMG physicians, and the patients. So one of the bigger issues an IMG position is the visa. And every day you are worrying about the visa situation and the renewal, which happens every other year or three years. And sometimes some of these physicians, when they travel, outside the country, they may not be able to get back because of this, I would say, veered rules that has been coming into place. So I believe if we are contributing in such a great way to the community, I believe the community, the government and the policy makers should be able to support these physicians. It helps.

I would say we need to start number one on the policy levels, a bit better support for the physicians. Number one is the visa. Number two, I would say, the wait time to get to a green card so that they will be able to start their own practice. If you're on a visa, you cannot technically start your own practice, which is a very much need in an underserved primary care city. So I would say we need to start there. And let's make it easier for the patients and the physicians to have access. And let's not make it more and more tough. You don't want that. It's already a tough time.

**Unger:** Yes.
Dr. Thomas: Make it better. Help each other. Let's help each other.

Dr. Solenkova: I want to build on something Dr. Thomas said and basically add to his answer about how the whole medical community can help international medical graduates. I think now there are a lot of, basically, most of institutions and hospitals are implementing diversity, equity and inclusion training and the programs, and they create departments. And I think it is important to understand for the whole medical community that IMGs are part of medical community, and they need to be included. And they are the part of the diversity, and they should be treated equally. As we know that some of the institutions do not like to have international medical graduates on their residencies or fellowships. And I think that's maybe something to look into, to include immigrants, immigrant physicians into their trainees. That's a start. And I think that will give a lot of top medical programs understanding of where immigrants stand, and where the patients that are immigrants, it will bring understanding of immigrant populations of patients as well. So helping immigrant doctors will bring understanding of not only immigrant doctors, but patients as well.

Unger: Well, thank you so much, Dr. Solenkova, Dr. Roy and Dr. Thomas for being here today and sharing your perspectives. And a special note of thanks to all IMGs throughout the pandemic, your work's truly been remarkable, selfless, difference making and greatly appreciated.

We'll be back soon with another segment of the COVID-19 update. For resources on COVID-19, visit ama-assn.org/COVID-19. Thanks for joining us and please take care.

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