Of Pride, Prejudice, and Discrimination

Why Generalizations Can Be Unfair to the Individual

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The categorization of individuals into groups can serve some useful purposes. If the individuals being grouped are heterogeneous, however, the categories used are likely to be flawed. Thus, any resulting generalizations are also flawed, especially when applied to a given individual in a group. The most serious attendant dangers can be misplaced pride, misguided prejudice, and unfair discrimination. The categorization of physicians according to their original medical training and the generalizations that result are examined here. The principles advanced could also be applied to many other forms of categorization.

Annals of Internal Medicine. 1992;**116:**762-764.

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In the pursuit of scientific knowledge, it is often useful to group information into categories. If the categories are carefully chosen, the resulting data can be used to make meaningful generalizations about the system under study. However, if the categories are flawed, the resulting conclusions cannot be generalized without risk for serious error. This principle becomes even more important if the categories consist not of data points, but of individual subjects or patients, each with his or her particular complexities.

A recent editorial described the interaction between two university faculty members and some individuals who had graduated from foreign medical schools (1). Although evidently well meaning, this editorial was met with several negative responses (2-4). In reply, the authors emphasized that no injury was intended and expressed chagrin that their attempt to address an apparent problem was misconstrued as being "paternalistic, simplistic, insensitive, condescending and unfair" (5). Why did this apparently well-intended discussion touch such a raw nerve among some readers? Perhaps the problem begins with the attempt to define and categorize a "foreign medical graduate" ("FMG") as a distinct entity. Using this term to make broad generalizations can result in injustice to some of the persons so categorized.

Why is the term "FMG" used? It likely originates from *pride* ("a reasonable or justifiable self-respect") in the U.S. system of medical education. Because of a century-long tradition of excellence, most graduates of U.S. medical schools can be expected to meet certain basic standards of quality. Thus, it may appear reasonable to compare this relatively homogeneous group with all other physicians graduated from medical schools outside the United States. However, the latter is a heterogeneous group, with widely differing origins, backgrounds, training, and capabilities. This diversity makes the comparison practically meaningless in the context of a given individual.

Although outstanding medical schools exist all over the world, the *average* standards of medical education in many countries are certainly lower than those in the United States. Not surprisingly then, studies that broadly compare U.S. medical graduates ("USMGs") with all "FMGs" (6-9) come to conclusions that are not usually favorable to the latter. Unfortunately, the published (and publicized) results of such comparisons can generate or reinforce *prejudice* ("preconceived judgment or opinion"). Such prejudice, once formed, may be directed against any "FMG," regardless of his or her background, training, or capabilities. The inevitable consequence is *discrimination* ("the quality or power of finely distinguishing" or "unjust distinction . . . against a person or group as compared with others"). The objective embodied in the first of these definitions is a laudable one; it is always valuable to be able to finely distinguish quality. However, an individual labelled an "FMG" is far more likely to encounter the unjust distinction embodied in the latter definition. Such discrimination (real and imagined) has resulted in a reaction from those affected and the consequent formation of associations, activist organizations, and lobby groups by those affected.

The practice of medicine relies on a series of generalizations, each based on data of varying scientific validity. As far as possible, the physician uses only generalizations based on well-designed and valid studies, and is always careful to look out for the patient that does not fit a particular generalization. The generalizations made about "FMGs" are of the broadest possible kind and are based on data open to a variety of interpretations. Some of these common generalizations (not necessarily from the recent editorial) are examined below and the point reiterated that they cannot be accurately or fairly applied to any one individual of this heterogeneous group.

Foreign medical schools are intrinsically worse than U.S. schools. This is certainly true on the average. However, many "FMGs" went to outstanding medical schools, comparable with those in the United States, and some would not trade their original education for any other. Thus, this assumption cannot be applied

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randomly to any "FMG" without risking an incorrect evaluation of the individual's training.

"Foreign medical graduates" are intrinsically inferior. A corollary of the first generalization, this claim is even weaker. We have all encountered outstanding physicians who originally had an "inferior education" (in the United States or elsewhere) because no other choice was available to them. When given the opportunity, such individuals quickly make up any deficit arising from their initial educational experience. The considerable success of many "FMGs" in science and medicine (including Nobel laureates, academic leaders, physician-scientists, clinician-teachers, and community leaders) also speaks to this issue. Again, application of this generalization can result in injustice to the individual.

"FMGs" are to be pitied and need special treatment because they are inferior. This generalization arises from the first two, which are themselves flawed. Thus, it usually amounts to a well-meaning form of condescension, which can generate irritation and indignation from those to whom it is applied.

"FMGs" have no right to be here. Most "FMGs" are in the United States after fulfilling all legal requirements of government and licensing bodies. The Immigration Reform Act of 1965 actively encouraged immigration of physicians to the United States from other countries to fill a perceived need. Thus, many "FMGs" came here as immigrants and have become naturalized citizens. Some have been actively recruited to stay by U.S. hospitals or medical schools (10). Ultimately, each individual has unique personal, societal, economic, philosophical, intellectual, or political reasons for being in the United States. Regardless of the reasons, most have as much right to be here as any other legal resident.

"FMGs" constitute a "brain drain" and have deserted their country of origin in its hour of need. These generalizations are undoubtedly true in some instances. However, the actual situation in most cases is far more complex. Some developing countries produce more trained physicians than their medical systems can absorb. Physicians may leave such a situation because of a lack of opportunity, and find their way to the United States by legal means. Others may come in search of higher education and return when they are ready. Some may stay on when opportunities at home do not materialize or when they are actively recruited by U.S. institutions that have realized their worth. However, individuals who stay in the United States often return financial, technical, and practical resources to their country of origin, even if they themselves do not eventually return. Some may not feel a debt to their country of origin, perhaps because they financed their education entirely from personal resources or because their medical education was received in a country other than their own. Others are "world citizens," whose background and upbringing do not allow them to identify with a particular country of origin.

"FMGs" score more poorly than U.S. medical graduates in standardized tests. Many negative generalizations are fueled by published studies comparing the performance of "FMGs" in various qualifying examination with that of "USMGs" who answered the same questions during National Board examinations. At first glance, this type of comparison may appear scientifically valid. However, many "FMGs" take these exams several years after their medical education (which may have had different methods of testing), whereas "USMGs" take them soon after completing a medical curriculum that may tend to enhance performance in such tests. Further, no amount of stratification can divide the "FMGs" into uniform categories that can produce valid and meaningful data regarding their test results. The modern physician-scientist insists that valid clinical studies should compare relatively homogeneous groups of patients with a minimum number of confounding variables. Would we consider worthwhile a study that compares all patients who have chronic arthritis with all those who have acute arthritis? Or one that compares all medical graduates from East of the Mississippi river with those from West of the river? Can we then justify continuing to publish "scientific" studies comparing graduates of U.S. medical schools with an impossibly complex and heterogeneous group called "FMGs"?

This discussion is not meant to be a rebuttal to the previous editorial, nor is it meant to treat lightly the feelings of those who responded. Rather, it has taken an alternate view of the issue, focusing on the injustices to the individual that can arise from the use of the term "FMG." The general principles advanced here could apply equally well to other categorizations that can result in prejudice and discrimination. In many other such situations (for example, racial minorities), however, there exists a publically stated intent to help those being categorized. In categorizing the "FMG," the only possible outcome is the risk for prejudice and discrimination.

The recent attempt to replace "FMG" with "International Medical Graduate" may help to some extent but does little to address the roots of the problem. This comment is not intended to demean the efforts of many who have lobbied and fought for the rights of "FMGs." However, these efforts can also serve to emphasize and perpetuate this flawed categorization, and thus could hurt as much as they help. On the other hand, one cannot simply ignore the fact that large numbers of graduates of foreign medical schools are in this country, many of whom are here to stay. In an era in which the medical profession as a whole is under increasing attack from many external quarters, we have much more to gain by embracing what is best about each individual and by working together toward common goals in patient care, teaching, and research.

Finally, the medical profession may be unique in its systematic categorization of graduates of foreign schools. One does not, for example, routinely hear of Foreign Engineering Graduates ("FEGs"), Foreign Chemical Graduates ("FCGs"), or Foreign Biological Graduates ("FBGs"). Perhaps it is time to completely dispense with the term "FMG," except as it is needed for the internal statistics of licensing bodies and examining boards. Reputable peer-reviewed journals should no longer publish flawed studies comparing "FMGs" with "USMGs." Instead, each physician with accredited educational requirements who is legally licensed to practice medicine should be evaluated on the strengths

of his or her own background, training, abilities, accomplishments, and track record. Given the frequency with which we are called on to evaluate individuals for positions, promotions, or awards, such unbiased evaluation presents by no means an easy task. But then, fairness and justice have always required much more effort than prejudice and discrimination.

Acknowledgment: The author thanks many colleagues and members of the Editorial Board, for their comments and suggestions on this sensitive issue.

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Medicine was his life, and his gossip was shop. Duane or MacCarthy or some other local doctor would drop in on an evening to discuss a case—which by some process I never was able to fathom had become Fitzgerald's case—and over drinks he would grow gloomier and gloomier about our ignorance till at last, without a word to any of us, he got up and telephoned some Dublin specialist he knew. It was part of the man's shyness that he only did it when he was partly drunk and could pretend that instead of asking a favor he was conferring one. Several times I watched that scene with amusement. It was all carefully calculated, because if he hadn't had enough to drink he lacked the brass and became apologetic, whereas if he had had one drink too much he could not describe what it was about the case that really worried him. Not that he rated a specialist's knowledge any higher than ours, but it seemed the best he could do, and if that didn't satisfy him, he ordered the specialist down, even when it meant footing the bill himself. It was only then I began to realize the respect that Dublin specialists had for him, because Dwyer, who was a terrified little man and hated to leave home for fear of what might happen to him in out-of-the-way places like Cork and Belfast, would only give out a gentle moan about coming to Dooras. No wonder Duane and MacCarthy swore by him, even if for so much of the time they, like myself, thought him a nuisance.

Frank O'Connor
The Collected Stories
Vintage Books, 1982
from *A Great Man*, p. 572