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Disorientation

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There is snow outside the kitchen door. It covers the deck in white sheets, unbroken except for the occasional paw print, and it cascades off the steps in thick, soft layers onto the pine trees in our backyard. Inside, our home hums with the usual Sunday evening flurry of activity. My wife is coordinating dinner with homework—both hers and the children's. In the background, I hear my two-year-old son trying to entice the dog to sit by offering her a treat. This is no small task, given that the dog weighs nearly three times as much as he does. But he has learnt early to stand ground before his three older siblings—my stepsons—who both tower over him and dote on him, and he is practicing this skill on the dog with some flair.

I contemplate the busy week ahead: a looming grant submission deadline, a talk to second-year medical students, a day trip to a nearby cancer center to give a research talk. And, of course, patients. I help run a busy gastrointestinal oncology program (a subspecialty within a subspecialty), and my overflowing clinics threaten to spill onto all other parts of my job.

All of this—a life of academia, of family, of life in snowy upstate New York—is in one sense routine, ordinary even. But when my mind takes pause, it is always with a sense of wonderment at what distances have been traveled, what has been achieved, and what has been left behind

I arrived in upstate New York in the summer of 1996, just a few months past my twenty-fourth birthday. I was eighteen days late for the start of my residency in internal medicine, and, as a consequence, I had missed intern orientation day. Whoever set the schedule didn't seem to view this as being particularly a problem, as my very first weekend in town I was assigned to be the night float intern.

I spent the day preparing for my first night of working in an American hospital. I acquired a stethoscope, scrubs, and a lab coat and went over the resuscitation protocols. Summer in Buffalo—unlike summer in India—is a beautiful season. The trees are full of luscious green leaves, there are flowers in every dooryard, the sun doesn't set until late evening, and there is a certain liveliness to the city—as if it is trying to make up for all those lost winter months. I remember finding this cheery atmosphere somewhat incongruent with the dread that I felt as I walked the short distance across the street from the studio apartment I had just rented and into the stone and glass entrance of Millard Fillmore Hospital.

Entering it that night, I was no different—at least on paper—from the thousands of other interns who had started at hundreds of hospitals throughout the country that June of 1996. I had finished medical school; I had studied for and passed the United States Medical Licensing Exam Steps 1 and 2; I had been interviewed in person earlier that year at multiple residency programs; and, after a rigorous matching process, I had been selected as one of the twelve interns starting that year in the Buffalo program. The only items that set me apart were that I was not a U.S. citizen and that I had graduated from a foreign medical school.

That was on paper.

In terms of practical experience, however, it was an entirely different matter. I had, indeed, completed medical school and even started an internship in internal medicine. But I had done so in a setting so removed from the gleaming U.S. hospital that I was walking into as to belong to a different world. At the time, most students and residents in India received their training primarily in understaffed, inadequately funded public hospitals that provided free care to mostly poor patients. The ward of the public hospital that I worked in until just a few months before was located in a dilapidated two-story building. Its windows were festooned with colorful saris hung out to dry by patients and their relatives. Inside, thirty to forty patients were housed in two large rooms, their beds separated only by a distance of a few feet. The only concession to privacy was separate large rooms for male and female patients. Every week my resident/attending physician team was responsible for one twenty-four-hour period (an "admit day") when all sick patients seen either in clinic or in the emergency room would be admitted under our care. On a busy admit day, even the space between beds would fill up with floor mattresses housing "overflow" patients.

As a first-year resident, I was the person on first call for these patients all day, every night, all 365 days of the year. (The U.S. term "night float" was—for lack of a better term—a foreign concept.) I had exactly two nurses to help me. I would typically spend all day in the ward as outpatients were sent in by my senior residents and attending physician. My day would be occupied writing notes, ordering tests, and performing a variety of procedures, including taps to remove fluid around the chest wall and abdomen, even liver biopsies. On occasion, I would also have to help the nurses with difficult intravenous line or urinary catheter placements. At night, I also doubled as a laboratory assistant, counting leukocytes and looking for malarial parasites in peripheral smears. Early in the morning, having had little to no sleep, I would do rounds on each patient with my senior resident. These rounds, in keeping with the hierarchical Indian system, could best be described as confrontational: I would be challenged on every diagnosis or decision I had made through the night. An hour later, this would be repeated, but with my resident presenting and defending our decisions and our attending physician the one doing the challenging.

In many ways, therefore, I was better prepared than most U.S. medical students starting a residency program. I was used to being independent, I had already performed more procedures than most trainees would conduct through the course of their entire residency, I had confidence in my physical examination skills because we'd had to "make do" without access to expensive diagnostic tests, and I had learnt to think quickly on my feet.

But I had never worked a single day in a U.S. hospital.

I had never used a pager or answered a page, never looked up labs on a computer screen, never dictated a note, never been exposed to American patients' expectations of privacy and medical information, never dealt with discharge planning or nursing home placement or insurance issues.

So it was with trepidation that I walked that night into the physicians lounge in Buffalo and paged the on-call intern to let him know that I was here. Ian showed up a few minutes later looking a little harassed. "It's been a busy afternoon," he said, "Here's the sign-out."

I didn't know what a sign-out was, but it appeared from the crumpled sheet in his hand that it was a list of patients who I would be responsible for through the night. "Cool," I said, acting as if I had done this a hundred times before.

Ian went quickly through the list of patients, and it was pretty apparent that these were not the diagnoses I was used to dealing with; the list included patients with emphysema, acute bronchitis, stroke, and even a few chronic ventilator dependent patients. I confessed to Ian that it was my first night working here, although I didn't tell him how different the hospital and its patients were from anything I had ever experienced before.

"Well," he said, with only a hurried note of sympathy in his voice, "ask the nurses for advice—they've been doing this way longer than you or I have. Make sure you use your intern survival guide and pocket drug manual. Good luck."

And he was gone before I could summon the courage to tell him that, having missed orientation day, I possessed neither handbook.

I used Ian's advice on the first page I received, a call about ventilator settings on a chronic ventilator-dependent patient.

"What do you suggest?" I asked the nurse who had called me, and then agreed with her recommendations. There were a couple more pages that I also dispensed with relatively successfully, and I felt myself grow a little confident in my answers.

Then I got called to the floor to see my first patient. She was in her seventies, had recently undergone surgery, and was complaining of pain at the operation site. The discussion that ensued with the nurse was the low point of my night, and possibly of my entire intern year.

"She needs something for pain," said the nurse.

"How about ibuprofen?" I suggested, trying out an authoritative tone.

"She's allergic to ibuprofen," replied the nurse, patiently. "Says so right in front of the chart."

At this point, I decided to forgo my newly acquired authoritativeness and fell back on Ian's advice.

"What do *you* suggest?"

"How about Tylenol?"

Tylenol. Tylenol. It was something in the way she said it, how easily the word slipped off her tongue, or perhaps the tone of her voice, that implied an obviousness to the suggestion. Trouble was, although the term seemed vaguely familiar, *for the life of me I couldn't remember what Tylenol was*. In my defense, I should point out that the popular brand name for acetaminophen in India is Crocin, and Tylenol had never been marketed there. I had seen commercials on American television for Tylenol when I did my residency interviews a few months earlier, but I hadn't paid close enough attention to see what generic drug was being advertised. I hadn't bought any in the short time I had been

in the U.S. because, like any good immigrant physician, I arrived with my suitcase packed with a variety of drug samples designed to meet any foreseeable calamity.

I fought the voices in my head that were screaming at me to drop the ruse, quit pretending that I could do this—be an American doctor—and board the first flight back home. And I came up with a gem of an excuse.

"I don't have my pocket drug manual; I'm not sure what the dose is."

"Its 650 milligrams PO q 4–6 hrs PRN, *doctor*," she replied. She said it with a twinkle in her eye, though.

Which wasn't much reassurance a few minutes later when I located a drug compendium and discovered exactly how much of a faux pas it was to ask about "dosing" a Tylenol tablet.

I made it through that night, and none of my patients died or went to the intensive care unit, which is the definition of a successful intern, as Ian pointed out to me the next morning. The nurse who had provided me with the Tylenol recommendation was discreet; no rumors about the doctor who didn't know how to dose Tylenol followed me on my next rotation. (She would, periodically, tease me about it—and she brought it up again on my last day as a resident three years later. So clearly that night left quite an impression on her. I never did confess to her—or to anyone but my wife before now—that it wasn't just the dose of Tylenol that I was unaware of.)

It is important to note that I was hardly alone in undergoing this transition to becoming an American physician. Indeed, arriving in the mid-1990s, I was part of a massive wave of immigrant physician trainees, many of whom stayed on and are practicing in the United States. In 2006 nearly a quarter-million U.S. physicians were international medical graduates, or IMGs, accounting for 25.3 percent of the total physician count. By one estimate, as many as 44 percent of all foreign health care workers arrived in the U.S. after 1990, as did I. Also, I was fairly representative: I had graduated from a medical school in India (Indian physicians account for one-fifth of all IMGs), specialized in internal medicine (one-third of all internists are IMGs), and settled in New York State (42 percent of physicians in New York are IMGs).

Yet despite these large numbers, most residency programs do not have formal orientation or acculturation programs in place for IMG residents (nor did they then). In part, this might be because programs wish to avoid the appearance of discrimination, and selecting out IMG residents for special training is at odds with this goal. But so much of medicine relies on verbal and nonverbal communication. It is not difficult to imagine minor miscommunications leading to errors: some simple, others causing physician mistrust, and even some with major health consequences. Only recently, the Educational Commission for Foreign Medical Graduates (ECFMG) and some residency programs—often at the urging of IMGs who later joined as faculty or IMG leaders within the American College of Physicians—have begun to institute orientation programs specifically for IMGs starting internships. This standard needs to be widely adopted across all residency programs, perhaps with a national mandate from the Accreditation Council for Graduate Medical Education (ACGME) working jointly with the ECFMG.

Life got easier over the successive weeks and months. I discovered that American patients expected competence and compassion from their physicians. And, in this, they were no different than the patients in India that I had taken care of. Life also got easier on a personal level: I found friends among the other interns, nurses, and attending physicians on the hospital staff—both American and immigrant. It really gives you a sense of our shared humanity—how much we are like each other—when an Indian intern, a Jordanian intern, and an American intern can meet for coffee after rounds and have the exact same gripe about their resident.

I have now completed more than a decade in the United States since that first night as an intern. This past decade has been marked by the usual upheavals of life magnified by my decision to call two places, separated by half a globe, home. The successive deaths of my parents and my inability to be there for them have been especially hard. But there have been rewards. In particular, my American wife and the blended American family that we raise together have allowed me to be open to the world and to others in ways that were previously closed to my insular way of thinking. My patients, too, have made me feel part of a family, trusting me with intimate details of their lives, sharing in my own highs and lows, writing notes and calling when I lost my father, bringing gifts for our newborn.

Have there been less welcoming aspects to my immigrant story? Yes, of course; some felt more keenly than others. Such as when I discovered that institutional regulatory authorities record the percentage of IMGs in training programs as an adverse quality indicator. Or the time when I was passed over by a certain prestigious medical center for fellowship training, yet a less qualified European IMG physician was welcomed. Even amongst IMGs, there are degrees to foreignness, as physician-author Abraham Verghese has pointed out. But episodes like this have been, for the most part, minor irritants. When I have been assessed by the faculty at my residency and fellowship programs, when I have been offered faculty positions or promotions,when my grant applications have been evaluated on their scientific merits and demerits, I have never felt unfairly judged.

We don't say this often enough as immigrants.

We don't say it primarily because if you're trying to assimilate, it is almost a requirement that you adopt the cynical, ironic American conversational tone. But the truth of the matter is that—unlike most other nations—America always has been and, almost as important, perceives itself to be, an immigrant nation. What this means is that, for us immigrants, the United States is a generous and welcoming country, and Americans are, for the most part, a generous and welcoming and forgiving people.

Forgiving, even of a doctor who doesn't know what Tylenol is.

Authors and Disclosures

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