Clinic Focuses on Refugee, Immigrant Groups

BY JANE M. ANDERSON
Contributing Writer

WASHINGTON — When Dr. David Gregory worked to open a health clinic for the uninsured in Nashville in 1991, he thought that he would be treating residents from the nearby housing projects. But Siloam Clinic is the treatment center of choice for a large population of refugees and immigrants from 100 nations, ranging from Afghanistan to Vietnam.

“One morning, in walked a Vietnamese man. He had spent 9 years as a prisoner of war, and survived torture and forced labor,” said Dr. Gregory, of the division of infectious diseases at Vanderbilt University, Nashville, Tenn. “It turns out that there were about 4,000 Vietnamese refugees in the area.”

Before Dr. Gregory knew it, word spread among that refugee community— and the clinic had many new Vietnamese patients.

Now, 80% or so of Siloam’s patients are from Nashville’s expanding refugee and immigrant population, he said. The clinic’s scope of practice includes health screenings, immunizations, primary care, patient education, and mental health care. The clinic receives funding from Medicaid, federal grants, donations, foundations, private insurance, and patient fees.

“Eventually, you want to incorporate all these individuals and their communities—is dependent on integrity and honesty,” Dr. Gregory said.

A faith-based endeavor that takes its name from biblical references to the Pool of Siloam, the clinic has grown from humble beginnings in a renovated apartment with a nominal charge—and the clinic had many new Vietnamese patients.

Today, 80% of his patients are refugees or immigrants. Dr. Gregory said. He offered some advice for physicians who want to help.


Next, he advised, “do not go alone. If you start talking about it, you’ll find people who share this passion.” Then, assemble a board and delegate tasks. Developing a mission statement is critical “to avoid institutional drift,” Dr. Gregory said.

Money obviously is important. “Probably the biggest mistake we made at Siloam was being undercapitalized at the very beginning,” the clinic started with an annual budget of $30,000, he said. And depending entirely or almost entirely on volunteers can be dangerous, because they don’t always show up to work, he said. Therefore, a clinic of this type should hire paid staff.

As Siloam, patients are expected to pay something. “We’re not a free clinic,” Dr. Gregory pointed out. “Patients make a $5.00 donation. The rationale was to encourage some sense of participation and avoid a sense of this being charity,” Dr. Gregory said. The clinic also asks for patients to pay half the cost of routine lab and test fees—for example, a routine complete blood count costs $3.00, so patients pay $1.50, he said, adding, “we get very good wholesale labs prices.”

However, obtaining images and other diagnostic tests has proven more challenging, although Siloam has some testing donated each month, Dr. Gregory said. And to cover patient hospitalizations, the clinic approached Vanderbilt Hospital, which agreed to provide 12 hospitalizations each year; the first year, it cost the hospital $300,000, Dr. Gregory said, but “it keeps the patients out of the emergency room.”

But the patients make it worthwhile. Dr. Gregory spoke of one, Abraham, a 25-year-old Sudanese refugee who presented with a week-long history of fever, headache, nausea, vomiting, and weakness. Abraham— a Tennessee resident for 4 years—recently had returned from a 1-month stay in Uganda, where he was searching for family members.

Physical exam showed a temperature of 102 degrees, no jaundice, but a palpable spleen. Dr. Gregory said he started Abraham on mefloquin and confirmed his malaria diagnosis through a peripheral smear that showed falciparum malaria.

One week after treatment for malaria, Abraham felt well but had been fired from his job at a poultry packing company because he was late returning from his Uganda trip, and then was sick for 7 days, Dr. Gregory said, adding the young man subsequently found a better job.

Another patient was a young Vietnamese woman, who arrived at the clinic unable to speak any English. Dr. Gregory said. “We didn’t have a translator—we have lots of them now—but we finally figured out that what she wanted was a Pap smear.”

It turned out that the woman had had a Pap smear in Vietnam and had been told she had cervical cancer. But the repeat Pap was clear. “She was so, so grateful to know she did not have cancer,” he said.

International Medical Graduates Fill Gaps in Physician Supply

BY JOYCE FRIEDEN
Senior Editor

ARLINGTON, VA. — International medical graduates have become an integral part of providing medical care in federally designated physician shortage areas, according to results from a recent analysis of U.S. Health Resources and Services Administration data. “Compared to U.S.-trained physicians, IMGs provide more primary care and more [overall] medical care to populations living in primary care shortage areas” as well as to minorities, immigrants, patients in poor areas, and Medicaid recipients, said Esther Hing of the National Center for Health Statistics, in Hyattsville, Md.

Ms. Hing and her colleague Susan Lin, Dr.P.H., studied 2005-2006 data from the National Ambulatory Medical Care Survey. The survey was nationally representative, and included information from 2,390 physicians in office-based practices. Surveyors performed a face-to-face interview and abstracted medical records for about 30 office visits. Ms. Hing presented the survey results at the 2008 Physician Workforce Research Conference.

The survey showed that IMGs make up 25% of office-based physicians. They also tend to be a little older that U.S.-trained doctors, with an average age of 52 years, compared with 50 years for physicians trained in the United States. The racial and ethnic differences were more pronounced: 71% of U.S. medical graduates were non-Hispanic white, compared with 26% of IMGs. Asian/Pacific Islanders made up 32% of IMGs, compared with 15% of U.S. medical graduates. Hispanic and Latino physicians accounted for 7% of IMGs, compared with 2% of U.S. graduates.

More of the IMGs than U.S. medical graduates were working as primary care physicians—57% vs. 46%—a statistically significant difference, Ms. Hing noted. IMGs also practiced more often in counties that included primary care shortage areas than did U.S.-trained physicians—87% vs. 79%. And IMGs more often saw patients during evening and weekend hours than their U.S.-trained counterparts. IMGs also were more likely to accept new patients and to accept Medicaid—nearly one-third of IMGs surveyed derived 20% or more of their incomes from Medicaid, compared with less than one-fourth of U.S.-trained physicians.

“This study illustrates how the U.S. health care system faces challenges if the future supply and use of IMGs is constrained by recent changes in visa policy that reduce the number of incoming [medical graduates]. This is an important consideration for policymakers.”

Most International Medical Graduates Work as Primary Care Physicians

Most International Medical Graduates U.S. Medical Graduates

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<th>Specialty</th>
<th>International Medical Graduates</th>
<th>U.S. Medical Graduates</th>
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<tr>
<td>30% Medical specialty</td>
<td>13% Surgical specialty</td>
<td>29% Surgical specialty</td>
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<tr>
<td>57% Primary care</td>
<td>46% Primary care</td>
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Note: Based on 2005-2006 data from the National Ambulatory Medical Care Survey for 2,390 physicians in office-based practices.

Source: Ms. Hing