Clinic Focuses on Refugee, Immigrant Groups

BY JANE M. ANDERSON
Contributing Writer

Joicelyn Gregory

Dr. David Gregory talks with an Asian immigrant patient. Today, 80% of his patients are refugees or immigrants.

Nancy West/Siloam Clinic

Dr. Gregory's clinic receives funding from Medicaid, federal grants, donations, and foundations.

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 some 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 that care was available at Siloam at a nominal charge—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 specialty care. The clinic receives funding from Medicaid, federal grants, donations, foundations, private insurance, and patient fees.

"Establishing trust [with 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 to a new, debt-free, 12,000-square-foot building with 12 exam rooms and a chapel.

The need for this type of community service has soared since 1991 as the population of uninsured and underinsured has grown, Dr. Gregory said. He offered some advice for physicians who want to help.

"What's a doctor to do in the face of these daunting challenges?" he asked.

The first thing Dr. Gregory suggested for physicians who want to open a similar clinic is to examine motivation.

"Why are you doing it? Is it altruism? Faith-based? An intellectual challenge? Be honest about why you want to be involved," he said.

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 chancy, 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 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 lab 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 tip. 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 then 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 Grads 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 study.

"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.

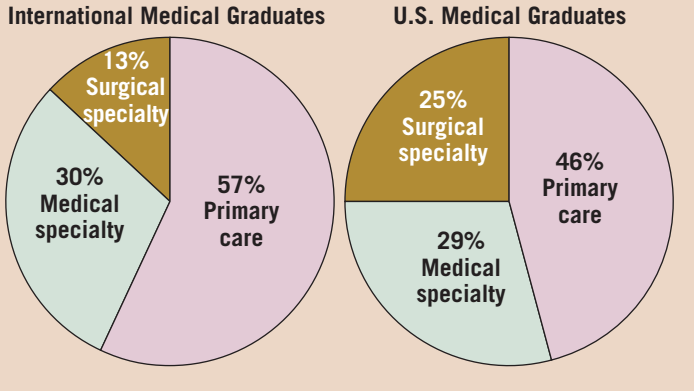
The survey showed that IMGs make up 25% of office-based physicians. They also tend to be a little older that U.S.-trained doctors, with an average age of 52 years, compared with 50 years for physicians trained in the United States. The racial and ethnic differences were more pronounced: 71% of U.S. medical graduates were non-Hispanic white, compared with 26% of IMGs. Asian/Pacific Islanders made up 32% of IMGs, compared with 5% 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 continues to rely on IMGs to address shortages in primary care," Ms. Hing said at the conference, which was sponsored by the Association of American Medical Colleges and Harvard Medical School. "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 policy makers." ■

Most International Medical Graduates Work as Primary Care Physicians



Note: Based on 2005-2006 data from the National Ambulatory Medical Care Survey for 2,390 physicians in office-based practices.
Source: Ms. Hing

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