Preoperative Angiography for Gastrointestinal Bleeding

Cohn et al concluded that ongoing diverticular bleeding after 4-unit blood transfusion requires subtotal colectomy without localization by angiography. Their conclusion was based on record review, including 4 successful subtotal colectomies, and on review of the literature. By the same devices, we reached the same conclusion in 1972.

In 20 years of testing this hypothesis, I have learned that record and literature reviews are deceptive because they miss nondiverticular bleeds that, while actively bleeding, would have followed an algorithm to an inappropriate and failed operation. In a subsequent report, I excluded without details 22 patients who underwent transfusion for lower gastrointestinal tract bleeding, were studied, discharged with diagnoses of diverticulosis, and later proved to have bled from other sources. Ten cases exceeded the 4-unit threshold and might have had useless colectomies: 2 for missed varices, 2 for ulcers, 2 for arteriovenous malformations with coagulopathy, 3 for colonic polyps, and 1 for ulcerative colitis. More impressive than these unreported numbers is the memory of patients undergoing blind subtotal colectomies in which surgeons missed bleeders that rebled; several of these patients died of complications of ineffective operations.

From these experiences I have relearned the axiom that a surgeon cannot stop or prevent an acute bleed without precisely identifying its source. For bleeding from a colonic diverticulum, sure surgical hemostasis requires a definitive scintiscan or a positive mesenteric arteriogram.

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The International Medical Graduate in US Academic General Surgery: Is the Truth Out?

We read with great interest the recent article by Dr Arana highlighting the placement of international medical graduates (IMGs) in US academic general surgery. We think this is a timely article that provides an insight into the appointment of physicians in a field of medicine relatively hostile toward IMGs, especially since the end of the Vietnam War. However, there are several issues in this article that need clarification.

The objective of this article was to identify IMGs who are academic surgeons solely in the field of general surgery. However, if one looks at the original Table 2, it identifies physicians not only in the field of general surgery but other surgical and nonsurgical specialties. Many disciplines, such as surgical oncology, vascular surgery, research, colorectal surgery, endocrine surgery, surgical endoscopy and laparoscopy, surgical trauma (emergency department), and surgical nutrition, are routinely included as a part of general surgery. Other disciplines such as oral surgery and transplant surgery are free-standing specialties. However, in many institutions transplant surgeons do take care of general surgical problems and may be considered a part of the department of general surgery. Therefore, the correct number of physicians in academic general surgery is 282 and not 572 as indicated by the author—a drop of 51%, and certainly not a very encouraging figure for IMGs who are pursuing general surgery as an academic career in this country.

At present the number of IMGs appointed in the field of transplant surgery is increasing because this specialty is attracting enough US medical graduates (USMGs), simply because it is the most demanding of all the surgical specialties. In a recent article by Kaufman et al, the number of IMGs appointed to fellowship positions in this specialty jumped from 26% in 1996 to 49% in 1997. During the same period the number of IMGs appointed as transplant surgeons in the United States also increased by 19%. Therefore these positions will continue to be filled by IMGs. It is entirely possible that the number of IMGs working in this specialty will surpass those in general surgery in the very near future.

A pertinent issue that the author has not clarified is: Where are the majority of IMG academic surgeons placed? Are they working in “big guns” such as Johns Hopkins, Mayo Clinic, Cleveland Clinic, and Emory University? If not, why not? It is important to provide this information so one can compare the surgeons’ academic achievements with their placement into these big centers. It will further highlight the attitude of so-called prestigious institutions in hiring IMGs on the basis of their merit.

The comment that most of the physicians were at the appropriate rank for their services is subjective and lacks data. How did the author come to this conclusion? Did he compare the time of promotion of the IMGs following completion of surgical training with USMGs? It would be astonishing to see no disparity in this issue! Furthermore, was the previous surgical training of these IMGs in their home countries taken into account when considering promotion? Moreover, did the promotion of the IMGs back in the 1960s and 1970s, a time of acute physician shortage in the United States, differ significantly from the 1980s and 1990s, when there is a surplus of physicians in the United States?

A statement that only 8.8% of physicians with foreign degrees are working in the academic setting needs further scrutiny. Does it represent something sinister? Is there a fear amongst the IMGs that their services might not be properly rewarded and recognized? Such a fear is not uncommon amongst the IMGs both at the attending and training levels. Such fears may continue to keep the number of IMGs at low levels in academia.
Lastly, the comment that the number of persons coming to the United States for surgical training has decreased is not true at all. Kaufman et al. have clearly shown in their article that the number of IMGs appointed as transplant fellows has sharply increased. Similarly, from our personal experience, we can vouch that the number of IMGs who want to pursue surgery as a career in this country is on the increase. However, because it has become exceedingly difficult to get into categorical surgical programs, the number of IMGs pursuing surgery in this country has drastically reduced and will continue to decline in the future. The reasons for not obtaining these positions are multiple and include (1) the perception by the majority of the program directors that IMGs are inferior to their USMG counterparts even though a number of these graduates score very highly on the USMLE; (2) the unwritten rule of not entertaining IMGs because of the abundance of USMGs competing for these programs; and (3) a very prevalent belief of the program directors that, by having USMGs only, their surgical residency program somehow remains prestigious and well sought after. However, the same program directors use IMGs in the preliminary spots from year to year without offering them a categorical position; quite a few of them end up leaving surgery following these unpopular jobs, which very few USMGs would accept or tolerate.

The number of IMGs who are department chairpersons at present (9) is also shamefully low and certainly very discouraging for IMGs. The majority of present chairpersons who are of foreign background came during the Vietnam War era. What is more important is to see how many of the IMGs who came after this era will become department chairpersons even after doing their residencies in this country.

In conclusion, the future for IMGs in academic surgery looks bleak not only because of the changing dynamics of the market forces, but also because of the hostile environment created by a selective group of persons who consider IMGs an inferior counterpart to USMGs. However, they continue to use their services in posts not readily accepted by USMGs, such as preliminary positions and transplant surgery. The conclusion of this article that “the experience of IMGs in US surgery has been quite favorable” needs to be viewed with skepticism.

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In reply

I thank Dr Muhammed Memon and Breda Memon, RN, for their letter regarding my article. They have raised several points that I will try to clarify.

The main point of my article was to identify IMGs who are academic surgeons in departments of general surgery here in the United States. I stated in the article that in some parts of the country, cardiac surgery, orthopedics, urology, otolaryngology, and neurosurgery are free-standing programs. Therefore, rather than dropping the number by 51%, the number of IMGs in academic surgery would actually be higher.

Clarification was requested as to where the IMG academic surgeons are placed. Of the total respondents, 88.5% said that they had at least 1 IMG on their faculty and these did include several of the “big guns.” A look at Table 3 of my article would suggest that several of the departments of surgery in the so-called big guns referred to by Memon and Memon were headed by IMGs.

I do agree that the data on IMGs being at the appropriate rank for their services is subjective. These data were arrived at by a simple means. The questionnaire asked the department to list the name of the individual, his or her present academic rank, and the date he or she was first appointed. The number of years an individual was on the faculty was correlated with his or her present rank in arriving at a decision as to whether that rank was appropriate for services. It is my understanding that the average length of time between promotions from one rank to the other, eg, assistant professor to associate professor, is 3 to 5 years. In my own case, full professorship was achieved in 9 years.

Memon and Memon state that because only 8.8% of IMGs were working in an academic setting, this might represent something sinister. This is far from the truth. If they had used the numbers given in my article, they would have found that of the 36,672 US medical graduates, 4827 (13%) were working in an academic setting. The difference of 9% of IMGs and 13% of USMGs working in academic surgery does not seem to be significant. In both cases, the majority of individuals obviously prefer to be in private practice.

I do agree that the number of IMGs who are department chairpersons is low. The reasons for this are most likely varied. It would be interesting to know how many IMGs applied for the position of department chairperson and were turned down. My article did not address this issue.

Memon and Memon state that the number of IMGs being appointed as transplant fellows has risen to 49% in 1997. They state that this is because the specialty is not attracting USMGs. I prefer not to take a negative view, but rather look on it as a heartening event, giving IMGs a chance to come to the United States for training.

Memon and Memon also state that IMGs are usually given only preliminary positions and thereafter not given categorical positions. This is not entirely true. I know from firsthand experience that in more than one instance an IMG was given a categorical position, even though it meant asking a USMG to leave the program. It is true that as long as there are large numbers of USMGs competing for surgical programs, the chances of IMGs obtaining such positions will suffer.

I do not agree that the majority of program directors believe IMGs are inferior to their USMG counterparts. Several directors in their reply to my questionnaire on IMGs said that they felt fortunate to have these individuals on their faculty.

Finally, I am pleased to note that despite his skepticism, Dr Muhammed Memon has chosen the United States for his further training and practice of transplant surgery.

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