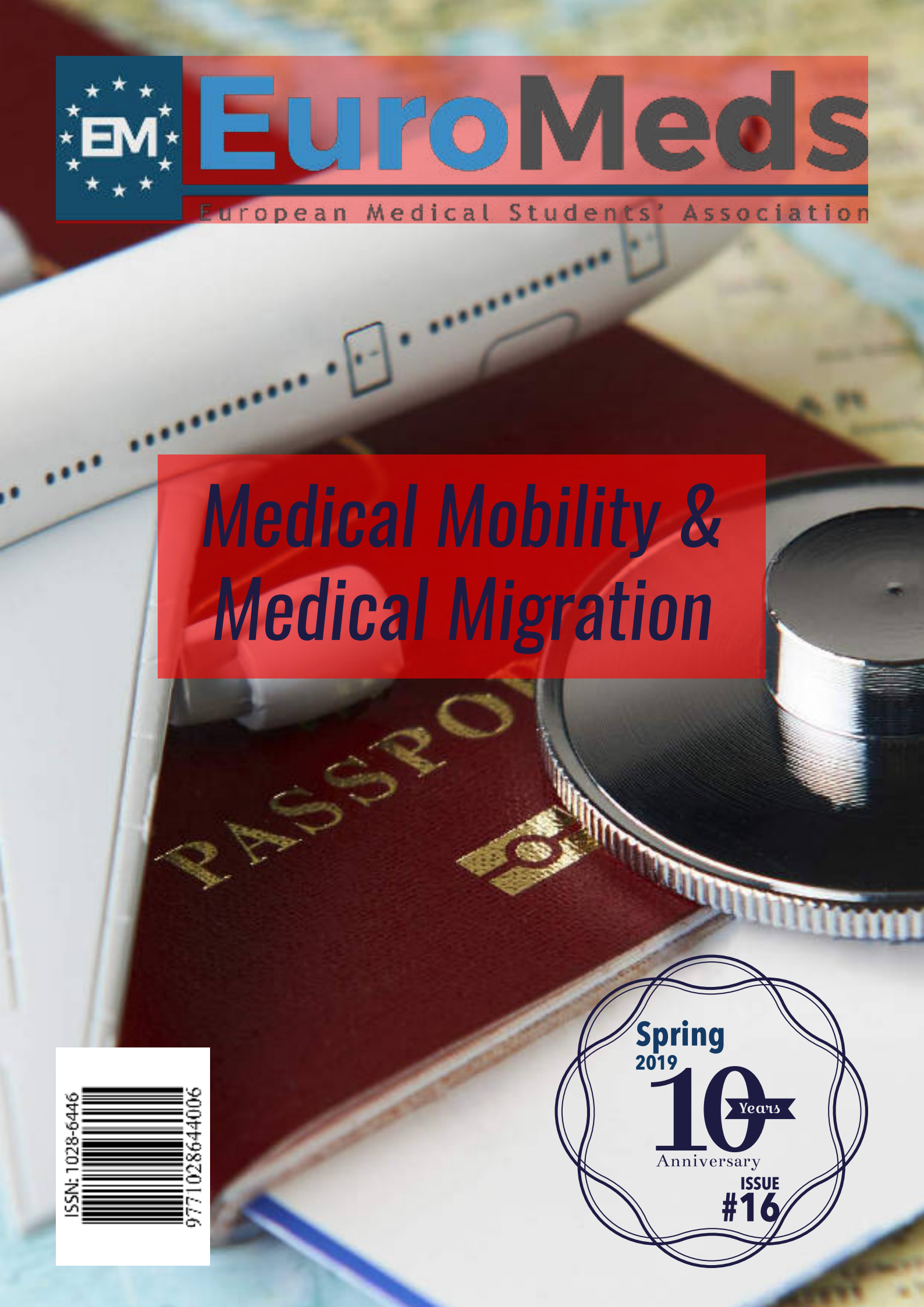


EuroMeds

European Medical Students' Association

Medical Mobility & Medical Migration

ISSN: 1028-6446
9771028644006

Spring
2019
10 Years
Anniversary
ISSUE
#16

EDITORIAL

Dear EuroMeds enhusiast,

On behalf of Editorial Team, it is an honor for me to present the 10th anniversary issue of EuroMeds! Starting from now, you will be exploring different approaches to medical mobility and migration, theme of our Spring Assembly '19 Heidelberg!

In this issue, we have to featured two topics that are highly relevant to healthcare professionals in this highly globalized political climate, Medical Migration and Medical Mobility. As globalisation moves forward, medical professionals have a greater chance for mobility regarding their choice of country to work in. A higher income, better living or working conditions are just some of the many motivations which physicians choose to leave their country for. However, the emigration of medical professionals negatively impacts the health care system in their respective countries of origin. This phenomenon is often called "brain drain". For us future doctors these issues are of utmost importance. The trends outlined above will increasingly shape our professional environment. As we move on in our lives and careers we want to be able to benefit from the freedom of movement in more and more ways. To ensure this, we need to find ways to overcome the obstacles and difficulties arising from that freedom.

As mentioned before, this issue is EuroMeds 10th year anniversary issue, so it is highly special for me to be the Chief Editor. Starting from 2009, many Chief Editors, Associate Editors, Content Designers, Proofreaders, Contributors have been involved in past 15 issue so far. EuroMeds had born to be a voice for medical students and it had evolved different qualifications parallel to its decade, issue by issue; modern design layouts, QR Code Systems for References and Feedbacks, online issues and finally, ISSN number so that our hard great works are certified as it should be. We, current Editorial Team, are working hard to do our best to raise new qualities and improve existing so that medical students' thoughts, feelings and studies will be presented in a marvelous platform. I am quite sure that EuroMeds' evaluation will never even standy, will go further, and will go better.
As we always say there is always room for development, we are waiting for your feedbacks in order to achieve better outcomes so that we can define new objectives for further goodness. You can give us feedbacks by scanning the QR code in "Imprint" page.

While I am coming at the end of my words, I'd like to thank Işıl, Helena and Simon for their overwhelming work, Sinead and Liza for their "eagle-eyes", Berkay, Ataberk and Pat for their aestheticism. You people rock!

I would also like to thank Vice President of Capacity, Ece Çalışan, and Organizing Committee President Sebastian Romann for their understandings and supports during the preperations of the maganize.

Enjoy the Issue, hab Spaß mit deinen Freunden!

İhsan Selçuk Yurttaş
EuroMeds Chief Editor

IMPRINT

CHIEF EDITOR
İhsan Selçuk Yurttaş

ASSOCIATE EDITORS
Işıl Gülseren
Helena Březovjáková
Casian-Simon Aioanei

DESIGNERS
Berkay Akad Ülker
Ataberk Büyükyatıkçı
Pat Lok

CONTRIBUTORS

Nicola Bonadiman, Umut Yücel, Katerina Bujaroska, Bilge Nur Özdemir, Arta Krasniqi, Jernej Vidmar, Aslı Berru Arslan, Kubilay Kaymaz, Bige Özkan, Beatriz Atienza Carbonell, İrem Aktar

Ece Çalışan - *Vice President of Capacity*
Işıl Gülseren - *General Assistant to Department of Capacity*

This publication has been made in collaboration with European Integration and Culture Pillar of EMSA. As the Editorial Team of EuroMeds, we would like to express our gratitude to the director and assistants of European Integration and Culture Pillar for guiding us through the possible subtopics and explanations.

This is a free publication of European Medical Students' Association.

European Medical Stdents' Association (EMSA)
Association Européenne des Étudiants en Médecine

is a non-profit, non-governmental organisation representing more than 150.000 medical students from over 90 faculties across Europe. Founded in 1990, in Brussels, it is the voice of students within the European Commission, the Council of Europe and the United Nations. The association provides a platform for high-level advocacy, projects, trainings workshops and international meetings. Its activities gather around Medical Education, Medical Ethics and Human Rights, Health Policy, Public Health, Medical Science and European Integration and Culture.

OUR VISION
Shaping a solidary and united Europe, where medical students actively promote health.

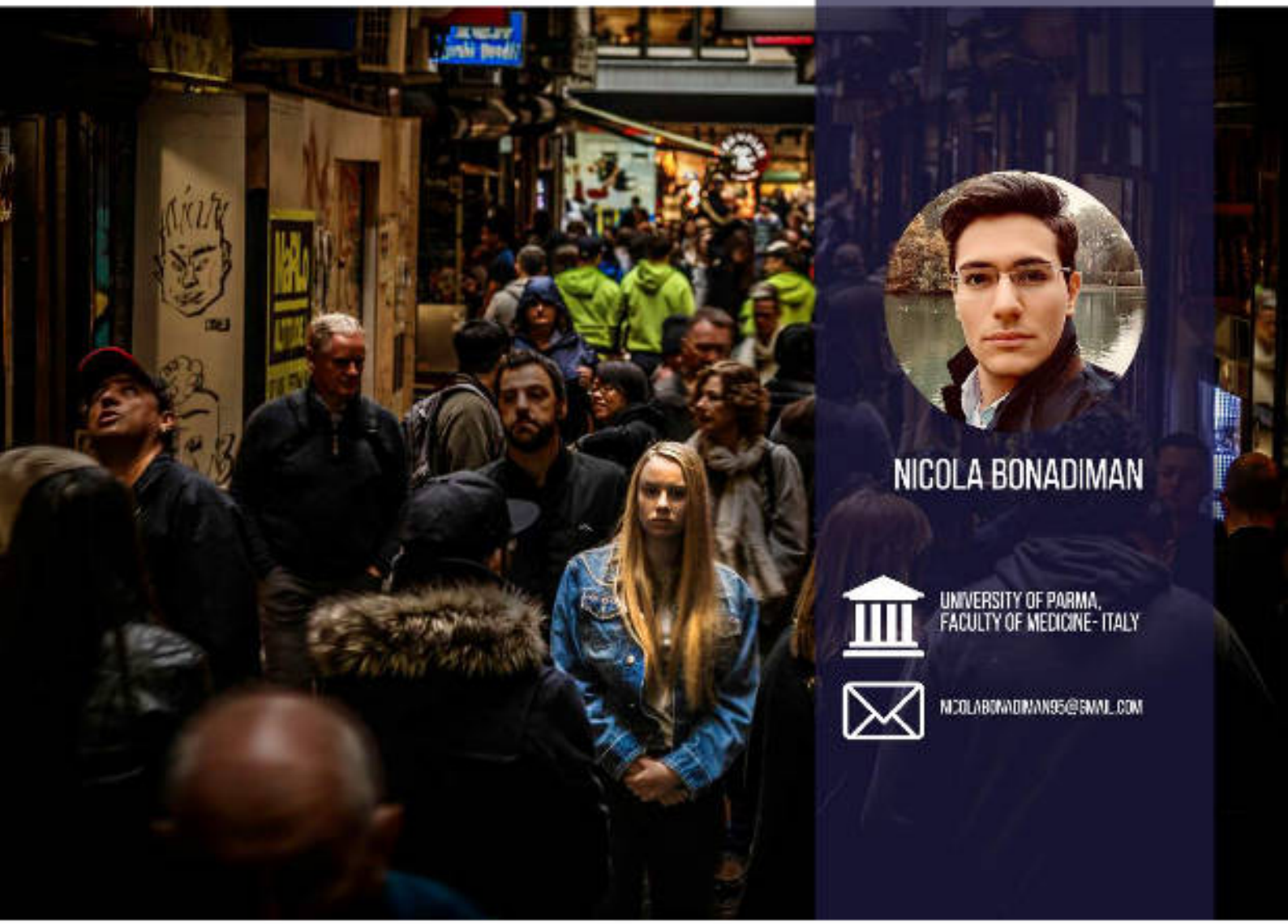
OUR MISSION
EMSA empowers medical students to advocate health in all policies, excellence in medical research, interprofessional healthcare education and the protection of human rights across Europe.

PUBLISHER
European Medical Students Association (EMSA)
EMSA General Secretariat
C/O CPME
Standing Committee of European Doctors
Rue Guimard 15
1040 Brussels, Belgium
Tel. +32 273 272 02
www.emsa-europe.eu
info@emsa-europe.eu

CONTENTS

CONTENTS

MEDICAL MOBILITY: THE SYMPTOM OF A SOCIAL SYNDROME



NICOLA BONADIMAN

UNIVERSITY OF PARMA,
FACULTY OF MEDICINE- ITALY

NICOLABONADIMAN95@GMAIL.COM

Medical mobility is currently a serious issue. The global causes and consequences are too difficult to analyze in a single article, so instead, I will focus on the reasons which have led to this phenomenon in Italy. Perhaps some readers are facing these problems in their own countries, or perhaps they will in the future. If not, well, consider yourselves very lucky!

It is clear that due to the aging population in Italy the number of patients is increasing, while simultaneously the number of doctors is decreasing; looking at this data, it is absolutely evident that in a few years we will have a tremendous lack of doctors if all specialties. Thousands of medical professionals are counting down the years until retirement, and as a result of many changes in the medical profession, very few of them will remain on the wards after this date. The nature of the art of medicine has changed completely: more than an art is a stressful bureaucracy which the old medical class dislikes. The days when a general practitioner could talk for hours with the sufferer are blurred memories; in the present, more time is dedicated towards the computer, and not towards the patient!

Unfortunately, there is a problem: the number of new doctors is too few. Why? In Italy we can find many reasons: the national test to enter medical school, the selection process during university years, another national test to enter residency courses. The result is that it is cheaper to over-work harassed young doctors or exhausted older doctors who already have a contract, rather than hiring new ones. Last but not least, medical migration will decimate even more of these few survivors.

The list of the numerous adversities and the Herculean labors which medical students and young doctors must overcome is as long as an atlas of anatomy, but some points

should help the reader to understand why many recent graduates are fleeing away. For example, it is paradoxically absurd that after years of intense study, there remains a risk that a doctor will not access a specialization course, and even more alarming is the founded fear of the doctors who passed the exam to be tapped, a fear which is justified by the reality of this occurring in the hospitals. We must remember that lots of work don't necessarily mean better professional training. For example, if you have to write hundreds of letters and discharge notes, you may not have the time to stay up to date with clinical training. If you have to report dozens of clinical histories in the database, you probably will not pay particular attention to any of these. But we must notice that it is not only a bureaucracy problem, it is also a matter of bad policy, which leads to poor organization and to an implosion of the health system. The psychological, physical and personal deterioration of the poor doctor is a natural consequence.

We must remember that lots of work don't necessarily mean better professional training.

I would like to mention another issue that pushes young Italian doctors to go abroad: changing patient attitudes. After graduation, many new doctors flatter themselves: they have an enviable culture, the knowledge to save lives, and the competence to preserve a person's health. But often patients' disappoint almost every expectation of the new physician: they do not eat out of doctors' hands as they did up until a few years ago. Frequently they go against medical advice because they have read a different clinical opinion from the internet. Sometimes, even in the absence of an error, they proceed with a legal complaint on the advice of lawyers placed outside the hospitals. Too often the doctor has to work in a climate of distrust and often anger which sometimes degenerates into real physical and verbal violence.

A few days ago I attended a conference organized by the "Ordine dei medici di Parma", the association of doctors in the city of Parma, where many physicians - and in particular representatives of the youngest physicians - denounced the increasing number of cases of violence against their colleagues. What really struck me is that few of the victims reported the episode to the authorities, as the majority of them considered the risk of being attacked as a normal risk in their medical work.

I can't say if in other countries the conduct towards doctors is more respectful, I can't say if in other countries young doctors work less and in a more stimulating way and I can't say that if are better paid. What I can say is that if an Italian doctor leaves his country, it is because "il gioco non vale la candela", which means that his efforts and commitments are not rewarded adequately.

It is incredible that during a period of high demand for doctors in many socio-economically developed countries, Italy and other European countries are doing so little to protect the precious source of knowledge, progress, and welfare which medical students and graduates represent.

In order to not lose this human treasure, it is absolutely necessary to improve working conditions, with the awareness that if a doctor feels safe and relaxed, then his patients will probably become healthier also. We should remember that when we talk about the well being of a worker, we shouldn't refer only to his salary, but to many other elements as well, not least a simple demonstration of gratitude towards him. This gratitude, which is simply a polite expression, is disappearing quickly and little is done to preserve it. On the other side, there have been increasing attacks towards the medical profession from many fronts, in particular when doctors express disapproval of government health policies or projects. The result of this constant aggression is a climate of distrust, which can lead to a reduction of patients' compliance with treatments.

The "oppression" of doctors who remain and the emigration of those who want to find better working conditions will lead to a dramatic worsening of the public health system, so it is urgent to slow down this brain drain. Helping young physicians to find the job they deserve in their own country and improve their working conditions is important, but a deeper political and social solution is required to restore the atmosphere of respect, trust, and friendship between doctors and patients, which is essential for the health of all people.

MEDICAL MOBILITY

UMUT YÜCEL

BAHÇEŞEHİR UNIVERSITY
SCHOOL OF MEDICINE
TURKEY

UMUTYUCEL123@OUTLOOK.COM

Medical students will, of course, be thinking about their future careers as they are studying or even before they begin their university education. They will have hopes and dreams of what they would like their future adult life to look like, and sometimes, they might not be able to realize their dreams in their desired countries. The decision of a medical student to take advantage of the integrating modern world to leave her/his country for another will not portray a comparison of which country is better; such decision wil be based on individual perspectives of the students that actually wish to depart.

There are many aspects of what living in a certain country and its society means. Foadi (2006) asserts that the concorsi system (system of academic appointments based on public competitions) in Italy actually pushes physicians and researchers out of the country, because in reality, it favours locals and those who are inside the system, excluding foreigners. As a result, even though Italy is a member of the European Union and has a highly perceived standard of living, it's presented in the aforementioned research as a source of brain drain, where academics are reported to depart.

This means that, while thinking about medical mobility, one should not imagine doctors flying from poor countries to richer ones, to improve their life standards. Doctors and medical students who opt out of their countries' medical curricula or healthcare systems can chose to do that in many instances: personal issues in which they feel threatened and unsafe in their own working environments, for the sakes of other family members, discontent with the country's research funding, public healthcare or physician appointment laws and policies...

In order to dive deeper into the complexity of medical mobility, one has to consider the paradigm and the changing approaches of different countries to medical mobility, throughout the years. Peppler (2018) approaches to the specific topic of Turkish-German medical migration since 1960s, dividing the approaches to the migrants in three subsequent categories: Migrant 'old' elite, who had migrated

to Germany from Turkey, between the years of 1961-1974; Migrant 'new' elite, standing between the years of 1979-1990 and the migrant 'global' elite, who migrated between 1999-2012.

Below is given a personal statement from a physician who had applied for a special training in a German hospital in 1974:

"And then [the head of the department] said, 'In two months, you can begin your job here with us.' It was that easy ... back then, because when I hear about the difficulties which other colleagues experienced, I am astonished ... recognition, and so on. [...] And in my case, two months after, I received my identity card, passport and such. I didn't visit the aliens' department or any other authority from the government and simply received my residence permit, my occupation permit, and my work permit. Everything came to my desk."

The Recruitment Ban of 1990 (Anwerbestoppausnahmeverordnung) and the Treaty of Amsterdam of 1997 seemingly made it harder for third-world country citizens to migrate into the EU, while facilitating migration in-between EU citizens (Iredale, 2001). Again, Peppler (2018) exemplifies the most recent generation of migrants with the following anecdote from a physician of the age:

"[A] great many Russian-Germans or German-Russians have come here. Many of them were physicians, and unfortunately, their qualifications weren't that good. Then, suddenly, Germany said, 'Everyone who comes from outside the EU needs an equivalence assessment.'"

The law was introduced in 2007, making it mandatory to prove equivalence of medical degrees from Third Countries to German degrees; it caused a significant drop in medical migration between Turkey and Germany (Peppler, 2018).

There are many data like this, available between any given two specific countries in terms of relations in medical migration and how laws and policies mediate the process for medical students and physicians to actually carry out their careers. It is also a major topic of debate, whether the policies published

are based on objective security concerns for both parties and designing of a functional migration law beneficial to all, or complex political manoeuvres designed to act on specific historical relations.

In order to dive deeper into the complexity of medical mobility, one has to consider the paradigm and the changing approaches of different countries to medical mobility, throughout the years.

Leaving that to the conspiracy theorists, it's not only the laws of the countries receiving medical migrants that mitigate the process of medical students' and physicians' mobility, but also their home countries' whose healthcare system is threatened by the brain drain.

Bundred et. al (2000) states that in Zambia, the World Health Organisation (WHO) estimates a need for 1500 doctors for the country's healthcare system, but there are not more than 800 registered with the Zambian Medical Council. The same researchers assert that, out of the 600 medical graduates the medical school in Lusaka has trained, throughout its 23 years of existence, only 50 are currently working in the Zambian public healthcare system.

Apart from the Recruitment Band in Germany, South Africa, a popular destination in the African medical migration process, has banned the recruitment of physicians from other members of the Organisation of African Unity (OAU) to reduce the inflow from poorer countries (Bundred et. al, 2000).

Aside from the data, the process of countries who are, sometimes both trying to keep their medical graduates within their healthcare systems and producing laws to keep out foreigners, creates many dramatic stories all around the world where individuals are affected. Many medical students and physicians get caught up on bureaucracy and sometimes are unable to pay fees to complete their registry, lose their dreams and hopes for the sake of politics.

The elitism created by private companies mediating individual applications for citizenship, residents permit or occupational procedures, demanding great amounts of money during the services provided, is a whole another topic. Through these companies, two students among which, one is richer, may be able to complete her/his migration process even though they are coming from similar academic and extracurricular backgrounds.

CULTURE SHOCK AND CHALLENGES OF PRACTISING MEDICINE ABROAD

KATERINA BUJAROSKA

SS. CYRIL AND METHODIUS UNIVERSITY OF SKOPJE, FACULTY OF MEDICINE - NORTH MACEDONIA

BUJAROSKA.KATERINA@GMAIL.COM

EM Works Cited

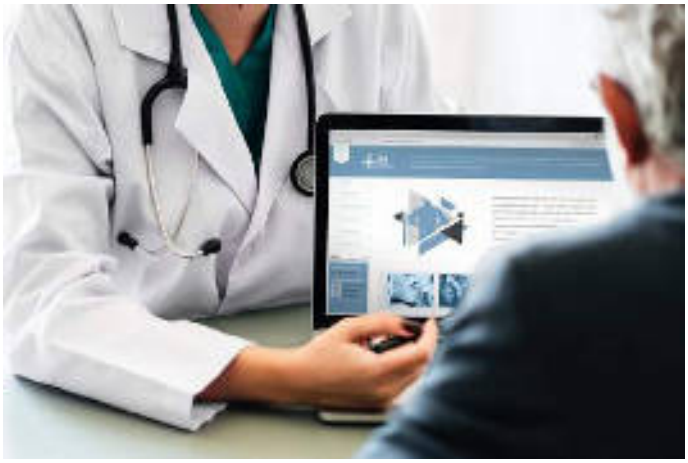
The 21st century is a time of increasing mobility; the faster pace of life, easier spread of information and global mindset can necessitate the migration of professionals, including medical professionals. Particularly within the European Union, where legal regulations enable easier migration, we have become witness to high rates of migration of medical personnel. Namely, large percentages of medical doctors practising medicine in European countries are foreign, peaking at 30% in the United Kingdom. Their motivation for moving may vary from financial rewards and job security to working environment and training opportunities. Nevertheless, expats, and above all ones practising medicine, face great challenges adapting and establishing a work routine abroad. In addition to legal and logistical obstacles, most expats will have to face and overcome the anxiety and discouragement caused by cultural shock as a stage of their adjustment to the culture they are newly exposed to.

By definition, cultural adjustment is the process of adapting to a new culture and cultural shock is the crisis that occurs as a part of that process. It is commonly divided into four stages as proposed by Oberg. In the first stage, or the "honeymoon", the person who is exposed to a new culture is positively overwhelmed by their experiences within it, and the newly acquired knowledge of the differences between the cultures of their homeland and the country they are now residing in, and may feel enthusiastic and euphoric. In the second stage, however, true "culture shock" occurs. The difficulties of functioning within an unfamiliar and sometimes distant culture become more prominent and can cause anxiety, isolation, and frustration. In the third stage, nevertheless, this crisis is resolved. During the "recovery", the person becomes increasingly comfortable with the new culture, feels less isolated and has an increased sense

of belonging. Finally, in the fourth stage, or "adaptation", the person can function fully within the new culture, and begins to adopt traits and characteristics of it, while maintaining some of their original culture.

Along those lines, a medical professional will usually go through these phases of adaptation, including the stage of true cultural shock. However, unlike the average expat, in addition to their everyday experience, the cultural shock can impose great challenges in their work life - in this case practising medicine.

Namely, beside the obvious language barrier and everyday cultural differences, medical professionals will have to adjust to the healthcare system of the new country. They are likely to hail from a country with a different educational system and hence possess a different educational background. Thus, they are likely to encounter discrepancies in expectations regarding their duties and performance. Depending on the country, they might encounter a difference in the hierarchy of medical professionals in the workplace, or even the general population's mindset regarding healthcare. For example, a doctor in a primary healthcare facility can have different duties depending on the public health needs and healthcare system of the specific country, and respectively, the expectations of their patients regarding what necessitates a visit and what level of care they can expect from one.



Moreover, medical professionals have to adapt to new language not only in everyday situations, but also the intricacies of medical jargon and slang. They need not only to become fluent in the language and be familiar with the medical vocabulary, but also be aware of the style of communication between medical professionals, alone or in front of patients, as well as the style of communication they are supposed to use with patients who are unfamiliar with medical terminology. Within all of these interactions at the workplace, medical professionals working in a new country might also find it a challenge to adapt to the body language commonly used in the new culture. This might impede the natural flow of communication, or even lead to a misunderstanding.

Furthermore, medical professionals need to become aware of the general health practices common in that culture. The general population's level of medical knowledge and ability to adhere to proper practices plays an enormous role in the types of issues they will experience and their ability to take doctors' advice.

In addition, medical professionals need to be aware of the principles and practices of the majority religion and how they relate to healthcare. Namely, they must understand how those religious beliefs influence the general population's view on life, health, gender, age, etc. Along those lines, they will need

to know the general stance on medical ethics issues such as abortion, euthanasia, addictive medication, the use of placebo, life support and similar ethical dilemmas. They will also have to take into consideration the family dynamics and perception of age, gender, and class in order to better understand the everyday lives of their patients. Lastly, medical professionals will have to adapt to the level of openness they can expect in the communication with their patients.

In essence, the culture shock medical professionals experience is greater than merely adjusting to the everyday language and culture of the person's new country. The intricacies of medical terminology, openness in communication, religious and ethical values, perception of age, gender, and class, and the expectations attached to the position in the foreign healthcare system make for a deeper understanding of the patients in their new country. It is no doubt that mastering the particulars of the new culture is an arduous task, but it is also rewarding. Ultimately, it is these details that can make the difference in properly understanding and providing for the patients' needs.

A CURSE IN DISGUISE: UNIVERSAL HEALTH COVERAGE & MEDICAL MIGRATION

UNIVERSAL HEALTH COVERAGE: EVERYONE, EVERYWHERE

BILGE NUR OZDEMIR

HACETTEPE UNIVERSITY, FACULTY OF MEDICINE - TURKEY

BILGE.MERVE07@GMAIL.COM

EM Works Cited

At 55th session of United Nations General Assembly (UNGA) 2000, all 189 of UN member states agreed upon trying to achieve The United Nations Millennium Development Goals (MDGs) by the year 2015. The United Nations Millennium Declaration, signed there to seal the deal, committed global leaders to fight the major problems of modern world like poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women.[1]

15 years later, participating countries were assessed, with different methodologies, on their success rate of MDG interventions. Within those 15 years, over 1 billion people have been carried above the poverty line, child mortality and the number of out of school children has dropped by more than half, HIV/AIDS cases decreased almost to 40 percent, and living standards have risen all over the world. Undoubtedly, most of these success stories were attributable to the actions taken in the light of MDGs.[2]

A huge improvement was achieved, but something better is always possible. After harvesting the tangible fruits of the hard work done in pursuit of MDGs and realizing the enduring need to implement the procedures even further and advancing them,

in September 2015, heads of state and governments of all of 193 member states agreed on 17 Sustainable Development Goals (SDGs) and 169 targets to guide global development until 2030, at the Seventieth (70th) United Nations General Assembly (UNGA).

By this significant decision, MDGs have been superseded by the SDGs, a set of 17 integrated goals that are built on the achievements and lessons of the MDG legacy with a broader and far more ambitious scope.

Health is core to all targets. Therefore almost all of the SDGs are somewhat related to health, directly or indirectly. But one of them, SDG 3, is dedicated specifically to health and has nine main and four additional targets. One of these targets is the achievement and sustainability of Universal Health Coverage (UHC). UHC takes its roots from 1948 WHO Constitution, which states health is a fundamental human right and provisions for countries to provide the highest approachable grade of health for all. UHC is substantial among SDGs; it underpins other targets and is the key to the achieve all others.

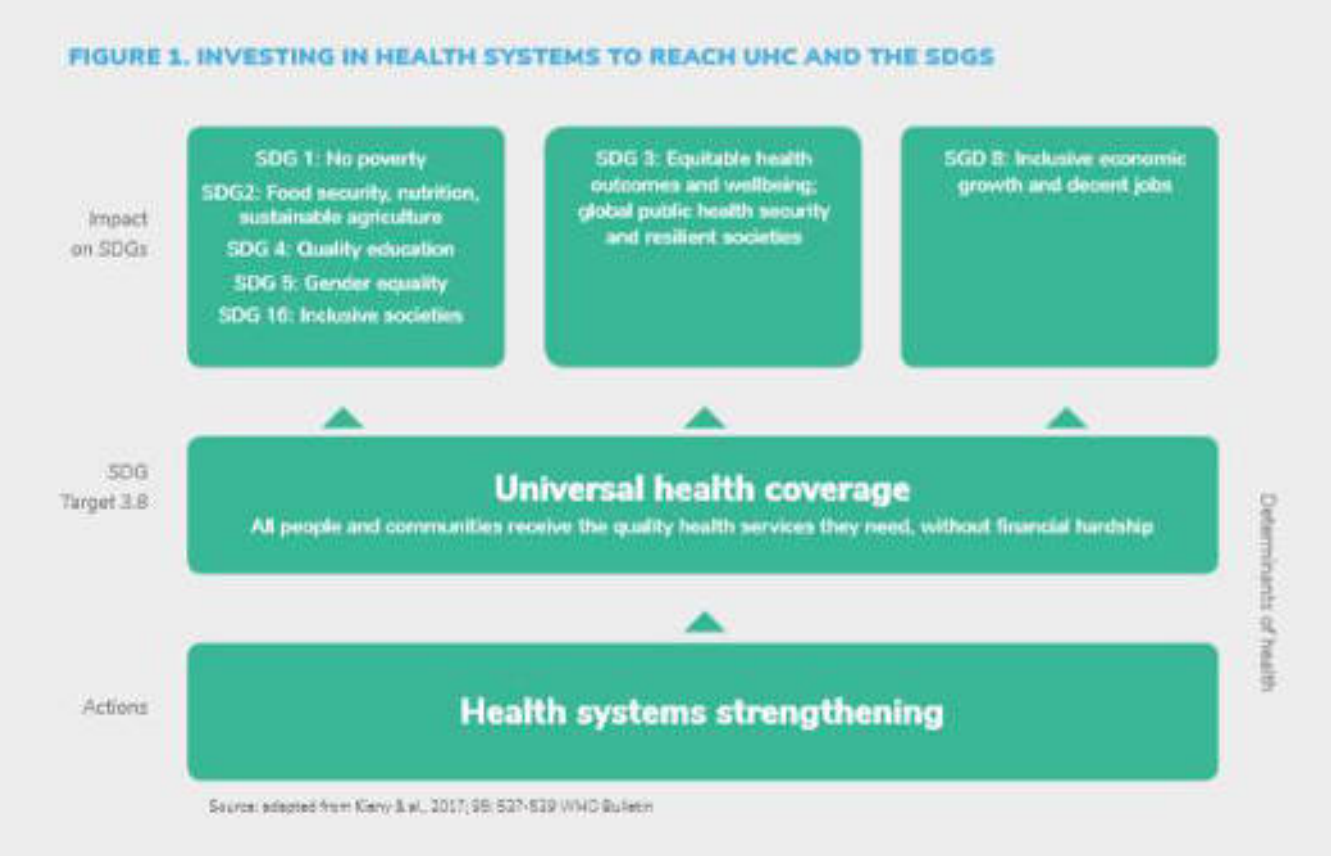
UHC is primarily built upon three important pillars: high quantity and quality of health care service by means of health care personnel and equipments (qualifications of health care systems), equity in the distribution of health services providing each and every person with the health care they need, and financial resources to ensure the previous two. In order to succeed in our way to UHC and to meet the requirements, we have to make sure all three pillars are sturdy enough to carry the burden.

There are representative examples provided by research on preliminary work done in different countries showing that it is possible to meet the UHC needs by underpinning these pillars. After increasing their efforts for capacity building in terms of quality and quantity of the health workforce by boosting the amount of competent health-care workers, increasing health-related investments in rural areas, and increasing the financial support to health service overall, countries like Ghana, Mexico and Brazil are known to get closer to their UHC target. [3]

Health workforce is the backbone of health systems. An adequate number of competent health care workers is the indispensable core to achieve any health-related goal. By being more quantifiable, adequacy of personnel in number is easier to evaluate than any other variables of health system capacity.

There is already an enormous global discrepancy between the supply and demand for health workforce, and the demand is expected to double to 80 million by the due date of SDGs, 2030, which would create a shortfall of 18 million.[4]

Realizing this huge problem, Global Health Workforce Alliance (GWHA, which has transitioned into Global Health Workforce Network) organized The Third Global Forum on Human Resources for Health (also known as The Forum) and leaders from all around the world focused on Human Resources for Health. The Forum adopted a political declaration named as 'The Recife Declaration', by which global leaders renewed their approach and policies for tackling the shortage health workforce before such shortage turns into a 'healthcare worker famine'. Commitments made here were carried



forward with many other gatherings and declarations, such as the WHO's 2030 Global Strategy on Human Resources for Health, which was adopted at the 69th World Health Assembly in May 2016.

The acquisition of UHC, as discussed earlier, does not only depend on the quantity of workers, it also depends on their competence and the distribution of total workforce. The latter one actually affects the health systems overall more than expected. With researches on brain drain, we see the job's news quickly.

Medical brain drain is a pretty self-explanatory term which refers to the 'draining' of competent health care workers, 'the brains', mostly from low income to high income areas. If it was done with the aim of increasing intercultural activities and exchanging healthcare workers, medical migration could have created exactly that without causing any problems. But, it is not the case. Hence, health-worker migration, or 'medical brain drain', is a crucial part of an important problem: global health workforce crisis, meaning, the unbalanced distribution of the health workforce. As WHO stated, healthcare systems with less than 23 health-workers per 10000 people are unable to deliver essential health services. Numbers in 57 countries, mainly around Sub-Saharan Africa, are not even close to this threshold, which was set for the worst possible situation. This inequality in health workforce distribution is closely associated with the unequal density pattern of disease burden: Africa, carrying almost one-fourth of the global burden of diseases, hosts only 3% of health care professionals all around world while US, the address to 37% of healthcare professionals, carries 10% of the burden. To meet SDGs, Africa desperately needs to bump-up the amount of workers by 140% while some countries hire triple of their needs.[3]

There are two sides of 'emigration of health workforce' coin: "pull" and "push" factors of destination and source countries respectively. Emigration of competent healthcare workers are in fact, a crucial threat for equity in health. It creates a huge imbalance by affecting both sides of the equation differently, and it is impossible to equalize without understanding the labour market dynamics, which is the key to forge an efficient and useful map to overcome issues related.

Although the reasons for emigration are manifold, most of them follow three common and interrelated patterns: remuneration, conditions in working places (mostly, hospitals), and career possibilities. Battles or any other issues threatening general safety of source country, poor infrastructure of workplaces (mostly, hospitals), and hope to provide a better future for their families and a qualified education for their children, are also among the reasons why health workers prefer to emigrate.

Results of the brain drain are multilayered, and the loss of competent health care workers is not the only outcome. After attrition of the workforce, remaining staff gets overburdened, which causes burn-outs and a vicious cycle of brain draining. Losing skilled workers also diminishes the pool of teachers and supervisors, which in turn damages the institutional capacity even further by destroying the knowledge transfer. Costs made for emigrants' professional training become a financial loss for the country.

Showing no mercy to the source country, brain drain is not that bad for the destination country. It saves a destination country from millions of euros that would have been spent on the training of health workers otherwise, increases intercultural abundance, boosts competition by widening the candidate pool, and creates a skilled workforce in the most important area of all, health!

Another type of brain drain is the internal one. While city centers or popular areas are being highly popular amongst healthcare workers, rural areas are usually left to their own faith. If UHC or any other health-related target is to be achieved, measures have to be taken by overseeing equity in all around the country and the world.

So, what can be done by both source and destination countries to end inequalities in healthcare workforce distribution and hit the targets of UHC? There are some policies adopted by many countries."Return of talent" programmes asking for exit requirements such as tax burdening or compulsory services, shortening the visa periods of healthcare students who wants to study abroad and allowing their exit/entrance just long enough to cover the education programme they've been accepted are some examples of such policies. Although the results have varied among different cases and some was quite successful, none of these strategies have provided an ultimate solution and developing a policy and creating a solid structure is still on to-do lists of countries.

When developing the 'ideal' policies, it should always be kept in mind that there are huge variations between countries, and that one-size-fits-all approach would not work in this case. Nevertheless, in terms of source countries, raising standards of healthcare systems should be the focus point of all actions planned. Instilling workers' loyalty before graduation through the effective usage of "hidden curriculum", decreasing demand by improving public health (which underlines the importance of overall development of the country once again), making deals with destination countries, and eliminating "push factors" could be the second step in preventing brain drain. If none of these work in spite of huge efforts, staff retention measures, only then, may be considered as a third step.

As for the destination countries, becoming self-sufficient in their health workforce, only accepting healthcare workers numerus clausus, minimising the "pull factors", quitting de facto perverse subsidies, and assisting the source countries to increase the capacity in health systems would contribute to solve the problem.

Putting all that to aside, while policies are being adopted in order to reduce brain drain, human rights of healthcare workers must not be violated under any circumstances. Universal Declaration of Human Rights (UDHR) from 1948, under article 25, states "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family." and in article 13, "Everyone has the right to leave any country, including his own, and to return to his country." Hereby, it is the workers' fundamental right to make the needed changes to meet their own standards of living when status quo is not providing it, and leaving their country is not an exception. Thus, any actions hindering it and blocking healthcare workers' free will are human rights violation prima facie.

Code of Practice on the International Recruitment of Health Personnel, "The Code", that was endorsed at 63rd World Health Assembly 2010, serves as a detailed and well-designed framework for the ethical aspect of healthcare workers' migration, which highlights concerns and provides a guideline for administration of migration of healthcare workers.

In occasions like brain drain, solutions do not come from where they have been created; in our case, source countries may not solve this problem by themselves without barring a miracle, unless there is an external help. This is why, brain drain is not only the problem of source countries. It is the problem of us all if we were to achieve UHC, and as the bigger picture, SDGs. Moving beyond unilateral endeavors, even the reciprocal ones, all countries should behave as one piece it already is and strive for the future of human existence. We all are citizens of planet Earth, afterall. Using the synergy that we will create by working hard together, let's leave the next generation something bigger than the summation of us all!

With the hope of 'leaving no one behind'..

IS THERE ANY GAIN IN BRAIN DRAIN?

ARTA KRASNIQI

JERNEJ VIDMAR

UNIVERSITY OF MARIBOR, FACULTY OF MEDICINE-SLOVENIA, BACHELOR OF ARTS IN ENGLISH AND PHILOSOPHY-SLOVENIA

ARTA.KRASNIQ.95@GMAIL.COM
J.VIDMAR@OUTLOOK.COM

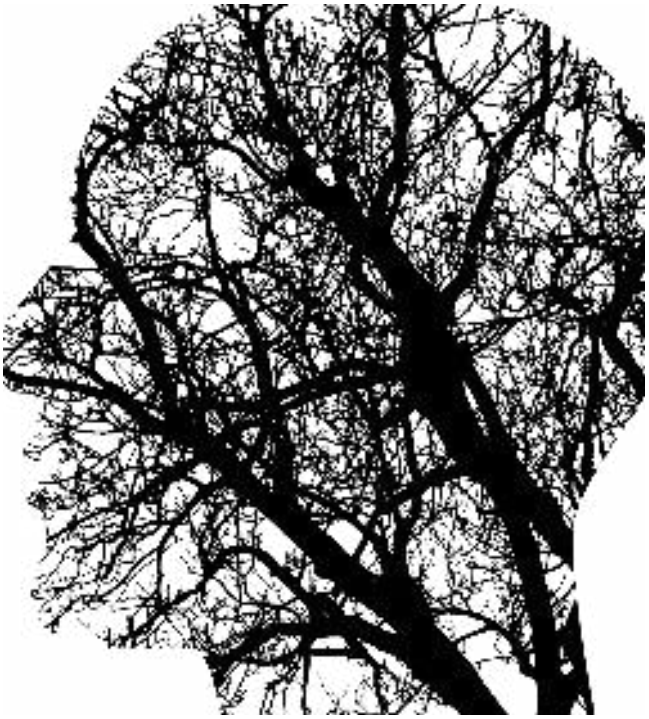
EM Works Cited

Globalisation, a term of today's era intertwined with migration affecting virtually every country, rich or poor. There is a significant portion of the migration discourse that is mainly concerned with how such migrations affect migrant-receiving countries. On the other hand, migration's effects on migrant sending countries remains widely undiscussed.

If we decide to stick with now almost stigmatic term "brain drain", we must inevitably ask ourselves who or what is getting drained. The main perception seems to follow one line of reasoning: I am a member of a country called A. In order to reap the benefits of being a member of A I must contribute to it by paying taxes. These taxes are then used to keep me safe, fed and healthy. A certain amount of the taxes I pay is used to train medical professionals. My contribution to the country A is wasted if a trained medical professional migrates to another country without compensation. Not only that, country A will now also be poorer for that highly trained person and there will be a deficit of expertise in the medical field. It seems that A is indeed being drained of funds, drained of qualified workers and drained of the level

So is there any gain in the brain drain? It is a social phenomenon for sure, tapping into the very core of human nature. It is fed by our fears that we are somehow deprived of common goods to which we believe we are entitled.

of expertise. Is it though?
Suppose A trained one of the best physicians in the world, capable beyond what A is able to offer them in terms of realising their potentials. A is not able to give them the best possible equipment for their research and growth. Should their potentials be limited to A's capabilities to meet their needs? And if not, could A be somehow compensated for losing them? Now suppose A trained a fairly capable physician, specialized in a field that is currently overcrowded, who is unable to get a job. What is the difference between them migrating to another country and wasting their education in A? And again, could there be any positive consequences if they migrate?



In reality it is almost impossible to ignore the fact that there is a phenomenon perceived as brain drain. According to Docquier and Rapoport the skilled emigration rate is substantially higher than the average emigration rate. This means that poor countries have experienced a huge outflow of skilled personnel since the 1960s [1]. There is a visible trend that the developing countries have spent more on education, merely because of the migration incentive. When emigration is understood in terms of the immediate brain drain it looks very gloomy for migrant-sending countries. But it is a mistake to understand emigration in this way. Contrary to the intuition of brain drain, the long-term interaction between emigrants and their countries of origin has huge potential for the development of migrant-sending countries [2]. A study based on a natural experiment found that an increase in the rate of emigration of tertiary-educated Fijians caused an increase in the stock of tertiary-educated people. The results of this study suggest that there are tangible positive consequences to otherwise negatively perceived "brain drain". Even if nations lose a fraction of their educated populace to the immediate brain drain, the net effect can be positive due to an eventual increase in education levels across the country [3].

So is there any gain in the brain drain? It is a social phenomenon for sure, tapping into the very core of human nature. It is fed by our fears that we are somehow deprived of common goods to which we believe we are entitled. These fears however are often unsubstantiated or misplaced. There are several examples of good practice to follow in order to promote a healthy flow of highly trained individuals where both the sending and the receiving countries reap the benefits of such migrations while allowing individuals to reach their potentials and personal goals. To conclude, rather than causing brain drain, skilled migration is preventing "brains" from draining away in unproductive environment.

A MINI REVIEW: CULTURE-BOUND SYNDROMES

ASLI BERRU ARSLAN

ISTANBUL UNIVERSITY, FACULTY OF MEDICINE - TURKEY

ASLIBERRUARSLAN@OGR.IU.EDU.TR

Works Cited

Introduction

Cultural diversity all around the world challenges the mental health field to consider the further integral approach. The integral approach can be referred to combining the physiological outcomes with the sociocultural background of a patient and making this the core element of research on mental health and mental health services. As a natural result of the challenge, culture-bound syndromes appeared earlier as exotic psychosis; emphasizing their unique, indigenous, locality-specific features.(1) Currently, International Classification of Diseases-10 (ICD-10) by World Health Organization (WHO) includes them under 'culture-specific disorders',(2) whilst in Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-V) they are referred as the 'cultural concepts of distress.'(3) One of the more comprehensive definitions of culture-bound syndromes by DSM-IV-TR (4; p.844) reads as follows:

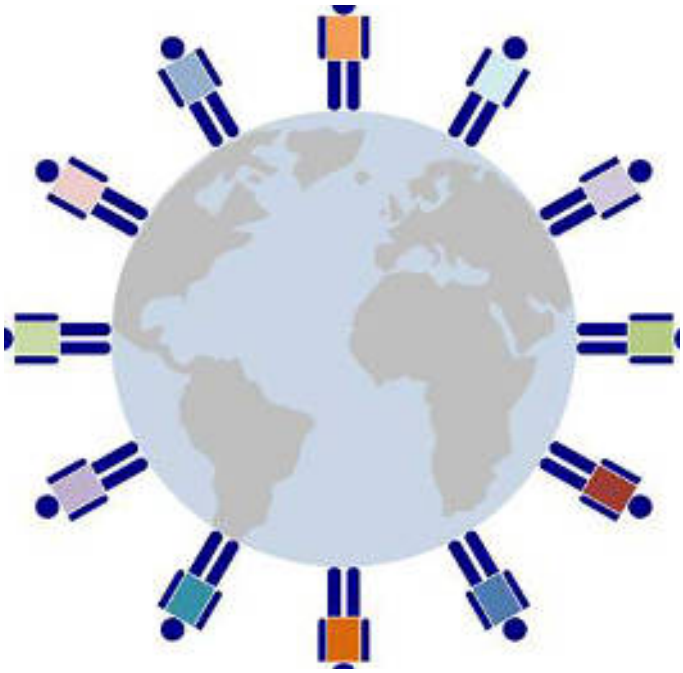
"The term culture-bound syndrome denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category…. culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations"

In summary, the culture-bound syndrome can be understood as a psychosis caused by the different types of distress such as familial conflicts, fear of sexual dysfunction, etc. It is also

important to reckon its unique patterns, being limited to specific societies and cultural backgrounds.

Cultural Background Upon Psychopathology

The perplexity of culture-bound syndromes can cause certain conundrums. Firstly, these syndromes are to be evaluated predominantly within the context of anthropology and psychiatry. Therefore, discerning the the social characteristics of each sufferer of culture-bound syndromes could be a core element.(5) Secondly, the symptoms of those syndromes, considered as 'idioms of distress', profoundly depend on the basic sociological structure of different societies. In a study on cultural psychodynamics in health, it is proposed comparing India and Euro-America as examples of Eastern and Western culture, respectively, to model prototypes of these culture types. Despite not being able to generalize these two specific examples to represent all the personality configurations around the world, their potential to represent large societies can be utilized for research intention.(6) Collectivist personal traits are observed overwhelmingly more frequently among the Indians, while individualist people are likely to comprise the societies in both Europe and North America.(7,8) In these circumstances, we are exposed to two contradictory social concepts: collectivism versus individualism. As it is concluded in a meta-analysis(9), collectivist society refers to an in-group and mutualist group of people. In these societies, the common fate of the group and common values are the main focus of the members. Since the superiority of the group over the individual members is emphasized in collectivism, each individual's identity is determined by the social role in society itself. Those perceived social roles form a part of the society's expectation. From that point, any sacrifice for the common good and maintenance of the peaceful in-group relationships among the members become communal highly valued personal traits. More importantly, "restraint in emotional expression, rather than open and direct expression of personal feelings"(9) is likely to be in favor of ensuring such 'highlighted' personal traits.



On the other hand, individualist societies tend to centralize "the personal goal, personal uniqueness and personal control-".(9) Furthermore, individualism depicts that "open emotional expression and attainment of one's personal goals are an important source of well-being and life satisfaction".(9,10) Restraint emotions and feelings, as it is stated within the concept of collectivism, could create an opportunist atmosphere for personal distress and inevitably cause the phenomenon of culture-bound syndrome. In addition to that, the difference between the concepts, that is about the self-expression of an individual, could point out the variable influence of the different societies on its individuals. The difference between the two concepts might be also enlightening for the unspecified regional prevalence of culture-bound syndromes.

In the frame of a collectivist mindset, it is also typical to signify the constitution of a family, contributing to the hierarchical social units. (11) People who would try to fulfill the expectations of their families might feel such high levels of pressure that this would trigger their anxiety. In a quest to find a way to relieve this, their ego defense mechanisms would be in charge.(9) Interestingly, some of the psychopathological conditions may occur as an ego defense mechanism. What is even more amusing, a person can also utilize 'cultural defense mechanism' as suggested by Varma, "provided in a form of institutions, customs, traditions, rituals, sanctions, prohibitions, folkways and symbolism". (7) It is further explained that cultural defense mechanism is ready-made and approved by the society, in which previously mentioned institutions, customs, traditions, rituals, sanctions, prohibitions, folkways and symbolism are exhibited. And that is why it may be applied more often.

In a case report of two pregnant women from India, it is reported the women have a fear of miscarriage due to their previous fetal death experience. During their second pregnancies, in order to overcome their fear, they are reported to be identifying themselves with religious figures that have had similar experience to them - religious figure of a mother having difficulties during pregnancy. Although the study does not include adequate data to question a new culture-bound syndrome, it might be guiding to evaluate the pathway of a cultural defense mechanism. (12) Apart from this example, there are a few more frequently focused syndromes such as Koro in Malaysia, Dhat in India, Amok in Malaysia, and Ataque de nervios in Latin America/Latino Caribbean. Especially, Dhat syndrome, or semen-loss anxiety syndrome, has ascending popularity in the literature. Yet, a lot of research on this topic

is not broadly recognized. There is some apprehension that might explain the lack of interest. Western physicians and medical practitioners trained in the Western system of medicine are not quite familiar with culture-bound syndromes since the differences in cultural orientation may appear to be disabling.(14) However, the influence of Western culture over the standardization of classification of the syndromes and their definition is a major determinant. (15)

The nature of the phenomenon causes the previously mentioned changes defined in DSM-IV-TR as well as its classification. The number of the syndromes was 25 in DSM-IV-TR, it is now reduced to 9 in DSM-V. In fact, such reduction might be doubted since both definition and classification of culture-bound syndromes have not been standardized so far. Lack of standardization is already a reason for confusion in diagnostic manners. Since perception of the predominant symptoms is not based on a standard classification, for some syndromes such as koro and latah, it is a quite matter whether they are somatoform, anxiety or another disorder. One of the most crucial points is that the unsettling process of diagnosis is likely to get the clinicians to revise the process of treatment. And such uncertainty on behalf of the treatment is not preferable for the benefit of a patient.(5) On the other hand, taking classification into consideration, the core concept, depending on more universalist or more relativist system, is to be discussed. The lack of "evidentiary criteria that permit us to delimit the range of psychiatric diagnoses related to cultural syndromes" is just another concern. (5)

Conclusion

It is considered that WHO's description of culture-specific disorders in ICD-10 and the recent changes in DSM-5 point out a significant issue. Globalization and rapid industrialization enable the cultures to diffuse into each other (5). The impact factors of the 'culture-related syndromes' in such porous atmosphere could cause an inevitable consequence of the syndromes' being slightly related to the specific cultural backgrounds. Today, it is known that culture-bound syndromes cross the boundaries and they are observed in different countries.(15) Last but not least, lacking such limitation on the behalf of these syndromes, might enable the further amendments, reduction, as it is applied within the nosological timeline, or even question the problem of standardization.

LEARNING WITH THE MEDICAL TOURIST

KUBILAY KAYMAZ

KOÇ UNIVERSITY, SCHOOL OF MEDICINE - TURKEY

KKAYMAZ@KU.EDU.TR

EM Works Cited

Introduction to medical tourism

Medical tourism can be defined as the mobility of patients across borders with the intention of receiving health care, usually through out-of-pocket payments - however there is still no standard definition agreed upon by the international community. Medical tourism is a phenomenon that is becoming tremendously common. The lack of agreed definition makes it difficult to track medical tourism numbers, however it is estimated that in 2017 over 60 million people arrived in the European Union (EU) for medical tourism purposes, which is about 5% of the total number of international trips to EU that year.1 Medical tourism is considered a subtype of cross-border mobility and does not include temporary visitors who fall ill while abroad, long-term residents, outsourced patients or those who make use of their EU rights.

The reasons why patients elect to go abroad for healthcare has been questioned more than ever in the last decade. To shed light on the motives of medical tourism, researchers have used the 'push' and 'pull' factors model. Push factors drive patients to seek health care outside their country of origin; pull factors attract patients to the country of destination. The most common pull factors are lower medical costs, quality of service, accreditation of the medical facilities and shorter wait times; the most common push factors are recommendation from doctors, friends, and family, lack of insurance coverage, and desire for privacy and confidentiality of treatments.2

Estimates of medical travelers to certain European countries are reported in the literature. Although these are just estimations, they indicate the size of medical tourism and its growth potential. The estimated number of medical travelers

to Turkey is 15,000 annually, whereas Germany received around 50,000 medical travelers in 2008.3 These numbers are predicted to be increasing each year. The number of international patients in Turkey has steadily increased from less than 100,000 in 2009 to around 500,000 in 2014.4
The expanding phenomenon of medical tourism is a reality and globalization of healthcare is unpreventable. However, to the best of my knowledge, the ways in which medical tourism impacts the education of future health professionals has not been taken into account in the literature. In this article, I am going to touch upon certain practical and ethical implications of medical tourism for medical education.

Implications of medical tourism for our learning

With the increasing number of medical tourists in our countries, we are exposed to more and more international patients in our teaching hospitals. For instance, we always had one to two international patients in the surgery inpatient ward and certain professors were seeing a few international patients every day at the outpatient clinic. We also had a number of international patients in the emergency department. It was inevitable that I had to 'learn with medical tourists' in the clinical years of my undergraduate medical education. This brings about many challenges and opportunities at the same time.
While having medical tourists was a good opportunity to practice medicine in English, which is what we are prepared to at my medical school where the teaching is completely in English, it felt like we were not able to connect with those patients as closely as local patients. Moreover, a significant number of patients came from the Balkans and the Middle East, and did not speak English, which further affected the communication unfavorably. Even though a translator was present most of the time, we were not taught and prepared to deal with such situations.
Despite the fact that we felt less connected with the medical tourists, it was obvious that we were building our intercultural understanding even just by trying to care for patients from various backgrounds and cultures. Recognizing their cultures and developing respect for medical tourists was the starting point for improving our intercultural understanding. We interacted and tried to empathize with patients of different nationalities, and finally reflected on our experiences with them. Interacting with the international patients at an early stage of our career is vital to achieve cultural competence, which is an important asset especially if we strive to become global citizens/doctors. Taking into account that mobility of doctors is also a growing phenomenon, building cultural competence is of importance for current medical students.
Most of the medical tourists treated at our teaching hospital spent the much of their time in their hotels, limiting the inpatient care to a minimum since the cost of staying at the hospital was much higher than that of staying at a hotel. This causes impaired continuity of care which in turn might result in more medical complications and decreased quality of care. From the medical student perspective, lack of continuity of care and follow-up for medical tourists decreases our training opportunities in these stages of medical care.
A patient travelling abroad in times of need is vulnerable and may be easily exploited. Therefore, medical tourism is also an industry which has huge potential for financial gain. Some countries (e.g. Turkey) consider this industry as a financial source for economic growth.5 While we are still in training, we get to see how the healthcare industry works by observing how countries attract medical tourists and how the medical and service needs of medical tourists are met in our hospitals. Seeing this face of health care during undergraduate medical education, some of us might think that healthcare is a commodity, which might have serious consequences for our patients' care and doctor-patient relationships when we graduate and start practicing medicine.

> ...without some form of regulation on how medical tourism takes place in teaching hospitals, medical students - the future healthcare workforce - might be misled to consider medical tourism as unethical and something that commodifies health care.

Conclusion

Medical tourism is an expanding phenomenon which paves the way for more interaction between medical students and medical tourists. While interacting with medical tourists can improve certain skills of future health workforce, such as communication, empathy and cultural competency, it might hinder medical education and prevent medical students from practicing a holistic approach to patient care. Furthermore, without some form of regulation on how medical tourism takes place in teaching hospitals, medical students - the future healthcare workforce - might be misled to consider medical tourism as unethical and something that commodifies health care. Therefore, more information on implications of medical tourism for medical education is needed.

RESIDENCY IN THE US THE MATCH: 101

BIGE OZKAN

MARMARA UNIVERSITY, SCHOOL OF MEDICINE - TURKEY

BIGEOZKAN16@GMAIL.COM

EM Works Cited

There is a rising trend of graduates of foreign medical schools, known as international medical graduates (IMGs), seeking residency positions in the US. The increasing number of foreign medical doctors' immigration to the US may stem from financial, social, cultural, political and personal reasons. These factors themselves may also hamper the IMGs' match experience during the residency application, interview and selection periods. Therefore, in order to improve their likelihood to get matched into their desired program, all the applicants, especially the IMGs, should do their residency research in their medical school years to be prepared to meet the programs' expectations.

Each year the National Resident Matching Program (NRMP) releases that year's match results and statistics. These documents can facilitate both US and non-US medical graduates' paths towards making better ranking to their preferred specialty and securing their way through residency. Since the first "match" in 1952, the number of registrants has increased seven-fold: from 6,000 to 43,909; whereas the number of positions increased three-fold: from 10,400 to 33,167.1 This dramatic increase in demand caused a mismatch between the number of applicants and the number of positions available, which resulted in a subsequent decrease in the chances of an international medical graduate (IMG) getting a postgraduate year 1 (PGY-1) position.

In 2018, the total number of foreign-trained physicians (both US and non-US) who got matched into PGY-1 positions was 6,862 out of 29,040 total physicians who got matched. Non-US IMGs constituted 3,962 of those 6,862. The most preferred and matched specialty was Internal Medicine with

Specialty	Positions filled by non-US IMGs	Mean Step 1 score of matched non-US IMGs	Mean Step 1 score of unmatched non-US IMGs	Approximate match probability with mean step 1 score +/- 5%
Emergency Medicine	1.3%	229	219	35%
General Surgery	5.3%	242	236	30%
Internal Medicine	28.2%	236	222	65%
Neurology	28.7%	236	224	60%
Ob-Gyn	3.3%	231	228	35%
Orthopedic Surgery	0.4%	239	239	25%
Pathology	32.6%	230	219	70%
Pediatrics	11.6%	230	213	65%
Psychiatry	8.6%	222	216	35%

Table showing non-US IMGs' match results, deduced from NRMP's "Charting Outcomes in the Match: International Medical Graduates" document. 2

2,076 IMGs getting PGY-1 positions, followed by Family Medicine (330) and Pediatrics (315). These percentages were coherent with the total number of positions offered by different specialties. The least preferred and matched programs were Obstetrics-Gynecology (1.5% of IMGs), Emergency Medicine (1.6%) and Surgery (2%).2

Unfortunately, the percentage of US graduates who got matched is considerably higher than those of foreign graduates. In 2018, 94.3% US seniors matched, whereas only 57.1% US IMGs and 56.1% non-US IMGs did so. According to program directors 3; higher USMLE Step 1 scores, strong letters of recommendation in the specialty, dean's letter and grades in required clerkships are amongst important factors in determining which applicants to interview. As evident, these prove that the applicant has been consistently involved in the field and has been a good candidate for residency throughout their medical school training. However, after the interview, the interpersonal skills and the interactions with faculty and house staff are at the top of the list whilst ranking the applicants.

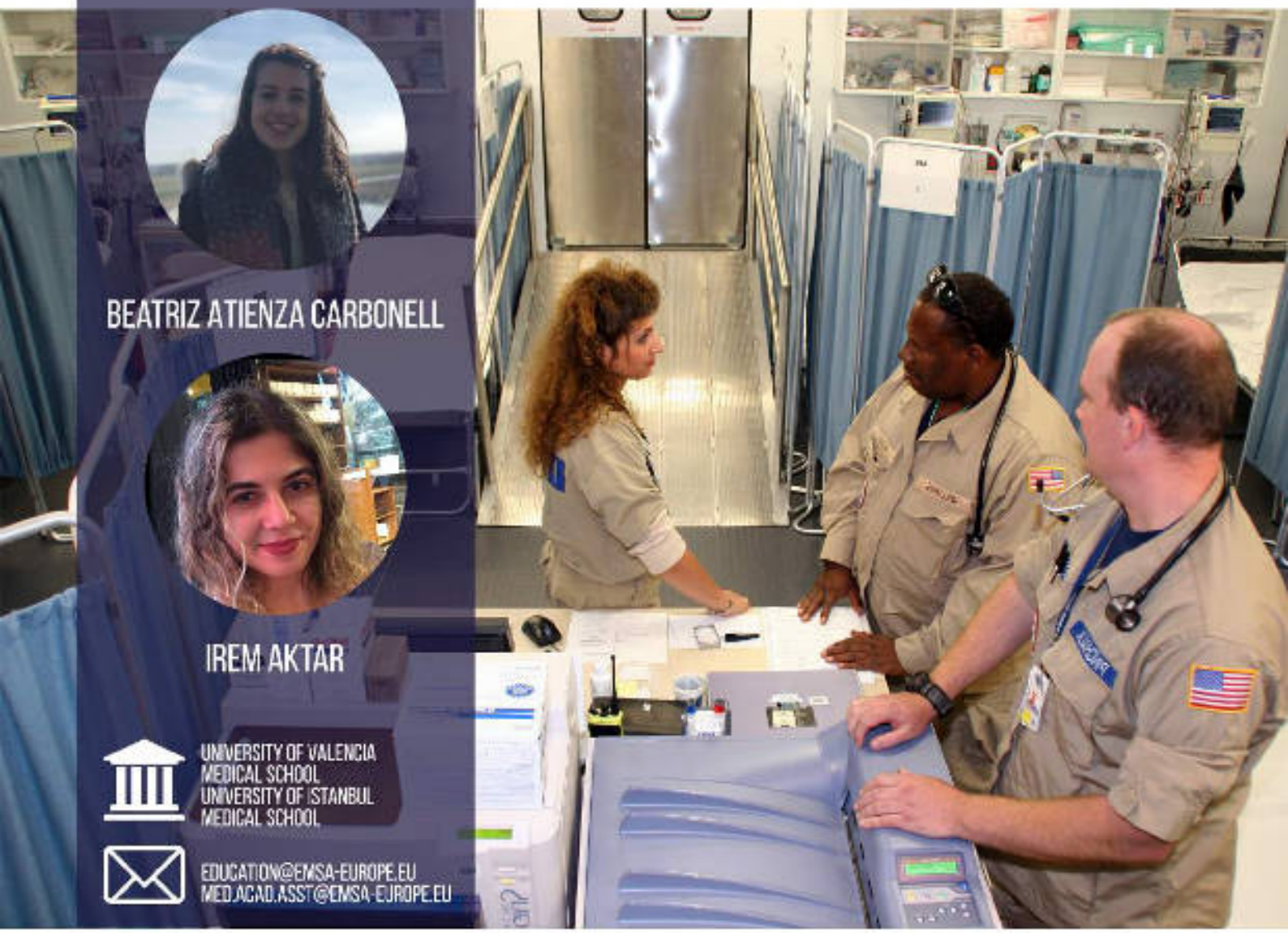
...the increasing number of foreign medical doctors' immigration to the US may stem from financial, social, cultural, political and personal reasons. These factors themselves may also hamper the IMGs' match experience during the residency application, interview and selection periods.

In conclusion, a foreign medical student who wants to practice or pursue their residency in the US should be prepared to overcome many obstacles. Because the US medical system is not accustomed to the foreign medical education system, IMG applicants need to prove that they are qualified physicians. Overcoming the language barrier by reading books, watching TV series, and accustoming oneself with the US culture has benefits during the electives and the interviews. Making the decision of doing residency in the US early on would be helpful for arranging observerships, doing research and having some publications. The letters of recommendation (LoR) are integral parts of an application and US clinical experience is always encouraged, sometimes required. Getting these letters from a US medical doctor in the desired specialty who knows one well and has worked closely with the applicant would be of great use. Because the medical school curriculums can differ so much, and the language of instruction in foreign countries is usually in their native language, USMLE Step 1 can be a big challenge for non-US IMGs. Obtaining the English versions of essential textbooks for both basic and clinical sciences would be great to get used to the terminology. Familiarizing oneself with the Step 1 examination materials early in medical school would be smart in order not to freak out when the time comes for real Step 1 preparation. Visa is probably another issue waiting for non-US IMGs, but Educational Commission For Foreign Medical Graduates (ECFMG) sponsors J-1 visa after successful completion of Step 1 and Step 2 (Clinical Skills and Clinical Knowledge) exams.

The key here is: decide early, start early. Study hard, do the best that you can, learn the requirements and build your career according to your talent and interests. After all, becoming an MD in the US may seem tedious especially for an international medical student, yet any challenge can be overcome through ambition to succeed, consistency, dedication and diligent work.

USMLE Exam Preperation Class. IMGs work hard to be matched in a program.

THINKING ABOUT MOVING TO THE USA?



BEATRIZ ATIENZA CARBONELL

IREM AKTAR

UNIVERSITY OF VALENCIA
MEDICAL SCHOOL
UNIVERSITY OF ISTANBUL
MEDICAL SCHOOL

EDUCATION@EMSA-EUROPE.EU
MED.ACAD.ASST@EMSA-EUROPE.EU

The medical education programmes in Europe have a very similar syllabus and adhere to the EU Directive 2005/36/EC: "Basic medical training shall comprise a total of at least six years of study or 5 500 hours of theoretical and practical training.". Yet, medical education is not just limited to undergraduate training. As for post-graduate training programmes in which medical doctors who completed basic medical qualifications develop different competencies in a field, UEMS (European Union of Medical Specialists) contributed significantly to the improvement of them particularly through the development of European Curriculum in each medical specialties as well as the elaboration of Training Standards with the adoption of its 'Charter on Training of Medical Specialists'. With these efforts, there has been progress on the way of reaching high qualified and standardized medical education across Europe. This situation in Europe makes it easier for doctors to move to a different country to obtain residency and work later on.

In the United States, more than 247,000 doctors graduated from foreign Medical Faculties practicing, meaning more than

> ...we should call the European Union to recognize the significance of recognition of our qualifications internationally.

one-quarter of all doctors. These doctors play a key role in providing healthcare for millions of Americans especially with their practice in underserved, lower-income communities and primary health care which makes their presence inevitably significant since most of the US-trained doctors do not prefer dealing with jobs that foreign-trained ones do. Mostly, they fill in positions like family medicine, internal medicine, and pediatrics.The special report published by the American Immigrant Council clearly demonstrates the important position of foreign doctors in the American health system for many communities living in US.

The Educational Commission for Foreign Medical Graduates (ECFMG) is the organization that regulates the homologation of the qualifications of all non-US educated doctors. The process can be hard in terms of examinations that an applicant should take step by step and ensuring the involvement in a good programme for training. The competition among doctors is quite high for many specialty fields. However, the quality of medical training is excellent and the salary per month is higher compared to most countries in Europe. It is certainly an exciting idea to move to the USA as a doctor but it is a decision that should be made after considering all possible pros and cons to be successful ultimately. In these days,there is one other question that you should think about before building your medical career. Do you imagine wanting to go to the US and that the ECFMG doesn't recognize your Medical Degree?

The ECFGM has officially announced that beginning from 2023, physicians applying for ECFMG Certification will be required to graduate from a medical school that has been appropriately accredited by a National Agency accredited by the World Federation for Medical Education (WFME).

Nowadays, just an Agency from The Netherlands and another from Turkey are officially accredited by the WFME in Europe. Did you study in a different country? Are your plans changing now?

To sum up, we should call the European Union to recognize the significance of recognition of our qualifications internationally. Moreover, the European Association for Quality Assurance in Higher Education (ENQA) could change their criteria to comply with the World Federation for Medical Education (WFME) criteria for Medical Schools accreditation to solve this issue.

ENQA
EUROPEAN ASSOCIATION FOR QUALITY ASSURANCE IN HIGHER EDUCATION

ECFMG®

wfme | WORLD FEDERATION FOR MEDICAL EDUCATION

Turkish National Accreditation Organization

tepdad

Dutch National Accreditation Organization

nvao
accredited programme

lets talk about

Medical Migration

from 24.4. until 29.4.2019

European Medical Students' Association
EMSA
EMSA HEIDELBERG

EMSA 2019
SPRING ASSEMBLY
HEIDELBERG

HEALTH.EUROPE.TOGETHER