Letter from . . . South Illinois

Red tape

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The legislative machine grinds away, producing laws as fast as it can. But, given the choice between two ways of doing a thing, the lawmakers and bureaucrats have a habit of choosing the most confusing. With this in mind, some of the recent United States legislation affecting the immigration of doctors needs explaining.

Until early this year, all a doctor had to do to obtain a permanent resident visa for the USA was to pass the Educational Commission for Foreign Medical Graduates (ECFMG) examination, apply to the embassy, and wait patiently to have a physical examination and a brief interview. At relatively short notice the United States government established new rules. The Immigration and Nationality Act¹ required that, from January 1977, foreign doctors should pass parts I and II of the National Boards of Medical Examiners as well as an English test before obtaining a visa for permanent residence. In the USA each State has its own equivalent of the General Medical Council, which issues licences to practise medicine. None of these bodies accepts an MD or MB, BS from a medical school as evidence of competence, so that all graduates must take either the National Board's Examination or Federation Licensing Examination (FLEX).² Parts I and II of the National Boards are usually taken during the undergraduate course, and the mainly clinical part III is taken about a year after graduation. The FLEX examination is a three-day horror taken by some US graduates and most foreign graduates. Its marking system is weighted in favour of clinical competence. None of the examinations can be taken outside the USA.

The "Catch 22" of the new law was that, although it was necessary to pass the first two parts of National Boards before obtaining a residence visa, graduates of medical schools outside the United States and Canada are not eligible to take the examination. The whole ludicrous situation was succinctly expressed in the advertisement pages of the *BMJ* under the title "Appointments in the USA."³ The US embassy in London had, until mid-April, stated the facts but offered no solution.

The new law does not apply to an already lawful permanent resident of the United States, an American citizen who has trained in another country, or a doctor who has another right to residence, such as a spouse who is a United States citizen. It is important to note that the new legislation relates to obtaining a resident visa. It does not affect the process of obtaining a

licence to practise. In most States one still has to take the FLEX examination to obtain a licence.

After an undignified rush to distribute as many visas as possible to potential medical immigrants before the new law came into effect in January 1977 there was a period of confusion. Did it mean that, apart from exchange visitors staying no more than two years, no foreign graduates would be admitted at all? There is a shortage of doctors in many parts of the country.

Visa qualifying examination

The Secretary of Health, Education, and Welfare (HEW) realised the problem. He therefore provided that a special two-day Visa Qualifying Examination (VQE)⁴ should be prepared and offered by the National Board of Medical Examiners. It will be of value to a prospective immigrant only so far as it is equivalent to parts I and II of the Boards for the purpose of obtaining a visa, but it will not help him obtain a licence to practise. The examination will be held annually in September, in Europe, in London, Rome, and Frankfurt.

To stop the process of obtaining a visa from becoming too easy, the Secretary of HEW has also deemed that to be eligible to take the VQE, foreign doctors must have passed an English test not more than two years previously. The English test is given by ECFMG twice each year as part of their certification examination. The result must be in before application for the VQE is made. The only acceptable alternative is the Test of English as a Foreign Language (TOEFL) given four times each year at several places in the world by the Education Testing Service of Princeton, New Jersey. Unless one took the ECFMG before 1976, however, there is no advantage in TOEFL.

ECFMG certificate

Although there will be considerable overlap between the VQE, the ECFMG, and the FLEX examinations, most doctors wishing to work here will have to obtain all three certificates (and pay for all three). The ECFMG certificate is required for appointment as an intern or resident in an American hospital, and is necessary, together with the FLEX, for application for a licence to practise in one's State of residence in the USA. There are a few exceptions: doctors intending to confine their activity to pure laboratory research, for example, need not possess an ECFMG certificate (but must still pass an English test). This will restrict them, and all doctors are well advised to obtain the certificate, whatever work they intend to do.⁴ Candidates who pass the VQE need only do the ECFMG language test to obtain an ECFMG certificate.

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If one's desire to uproot family and home is strong enough, and one is patient enough to cope with the bureaucratic maze, compulsive enough to fill out a mountain of forms, and industrious enough to swot up the basic sciences and all for three lengthy examinations, then it only takes a few hours to cross the Atlantic. Negotiating the red tape is good practice and will ease one's acclimatisation to the American way of life. Could that be why it's done this way?

References

- ¹ *Health Professions Educational Assistance Act of 1976* (United States Public Law 94-484). Washington, Government Printing Office.
- ² McGuinness, B W, *British Medical Journal*, 1976, 2, 518.
- ³ *British Medical Journal*, 19 March 1977, 1, xi.
- ⁴ *Visa Qualifying Examination 1977*, Philadelphia, Educational Commission for Foreign Medical Graduates, 1977.

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Today's Treatment

Diseases of the Urinary System

Haematuria

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"The discharge of blood or of bloody fluid from the urinary passages is almost always observed as a sign and sequence of some disease."

Robert Willis, MD, 1838.

Frank haematuria can be produced by mixing less than half a ml of blood with 500 ml of urine. The resulting colour will be dark or light depending on whether the urine is acid or alkaline but, regardless of whether the urine is "smoky" or "red," patients will usually surmise correctly that there is blood in their urine. Haematuria, therefore, represents an almost unique early warning system for urinary tract disease. A similar volume of blood may be lost without notice from the gastrointestinal tract. Unfortunately, the importance of haematuria as a symptom is not always recognised either by patients or doctors. The quotation above, which is taken from a medical textbook of the early nineteenth century, needs even more emphasis today for we have now the knowledge and techniques to cure some of the diseases that 140 years ago could be treated only palliatively.

Diagnosis

The management of a patient with haematuria depends firstly on confirming the symptom. Acute porphyria should be excluded. Dietary factors and drugs may produce changes in the colour of the urine that excite the patient's alarm. Red urine from eating too much beetroot is relatively common and phenindione, phenazopyridine, and nitrofurantoin are among the drugs that cause urinary discoloration. Haemoglobinuria may also be misleading, for the urine will be positive for blood on chemical testing as well as being frankly blood-stained. The diagnosis is made when this urine specimen fails to disclose red blood cells on microscopy.

Once haematuria has been confirmed, attention should be directed towards establishing a diagnosis. There is no substitute for a carefully

taken history and a thorough examination. The final diagnosis may not be reached without special and at times complicated investigations but a careful history is essential in deciding priorities and will soon serve to demolish the often-quoted and much-believed principle that painful haematuria is due to infection and may therefore be discounted, while painless haematuria results from a renal tract neoplasm. Haematuria of any nature must be regarded as a warning of neoplasia, and many a patient has been hurried towards an early and unnecessary grave with repeated courses of antibiotics prescribed for painful haematuria.

The doctor should record the duration, frequency, and severity of the haematuria and ask about any relation to other symptoms, such as loin or suprapubic pain. He should ask the patient whether the haematuria is initial, mixed, or terminal. Initial haematuria will suggest a urethral source for the bleeding, mixed haematuria a renal or ureteric origin, while terminal haematuria implies that a bladder lesion is responsible. The passage of worm-like ureteric clots shows the bleeding to originate from the upper urinary tract. A history of time spent in other countries may be important, as schistosomiasis can easily be contracted where the disease is endemic. In patients of African or, rarely, Indian extraction sickle-cell disease may be responsible—in the homozygous form or as the trait. Excess ingestion of phenacetin may cause papillary necrosis. A family history of renal troubles may help, as a tendency to renal calculus formation may be hereditary, and tuberculosis may be transmitted within a family. A clear-cut diagnosis may emerge from the history alone. An example is the young woman on honeymoon who neglects to seek treatment for a cystitis that rapidly becomes haemorrhagic and who is soon cured by antibiotics. If the result of the examination is normal such a patient can be assured with some confidence that her haematuria is of no great significance and that she may safely forgo radiological examination and cystoscopy.

Examination of the patient with haematuria must include a general examination and a detailed urological examination. The doctor should record the temperature, pulse and blood pressure; auscultate the chest and heart, identify any lymphadenopathy, and note any petechiae or abnormal bruising. He should then carefully palpate the abdomen, examine the external genitalia, and perform digital examination of the rectum. Particular attention should be paid to enlarged kidneys, liver, or spleen, and a palpable bladder will probably denote bladder outflow obstruction. Carcinoma of the prostate may be suggested on rectal examination.

Causes

The causes of haematuria are numerous, particularly with regard to non-neoplastic renal parenchymal disease. The exact nature of