



PERSPECTIVE

LEAVING AMERICAN HEALTH CARE:
WHAT TO KNOW TO BECOME A
PHYSICIAN EXPATRIATE

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I left American health care, a single fish swimming upstream against the usual flow of international medical graduates into the United States. International medical graduates (IMGs, formerly called foreign medical graduates) make up more than 25% of the practicing American physician workforce and about one of every seven resident physicians.¹

Now, I am a sort of IMG, but in the Netherlands. Here, I'm a *buitenlands gediplomeerde arts* in Dutch: I am American-born and medically trained, and now seek a European medical license. I have yet to encounter another North American who completed the Dutch medical licensing procedure; only three have succeeded between 2005 and 2015.²

Barely two years ago, I never would have thought I would be where I am. My husband, a non-clinician researcher and a true global citizen, once dreamily suggested that moving anywhere in the world is possible—and that I would always have a career. The deceptively simple reasoning followed: Everyone needs health care.

Intrinsically, I already possessed a dormant seed of curiosity about working in another healthcare system. Under the right conditions, including my own cyclic burn-out and a job offer for my husband, plus a pinch of nurturing, that seed began sprouting into reality. A long-time personal goal began blossoming: I would try something completely new—a new language and new healthcare system.

This is not your typical international locum tenens experience in New Zealand or Australia, or global health experience. The usual challenges of expatriate life apply; for example, tax considerations, salary and costs of living differences, and cultural integration. However, as a health professional, licensing and regulation adds complexity (and bureaucracy) that one only appreciates by doing. These are certainly well-known and worn experiences of IMGs in the United States.

Are you a fully licensed specialist in the United States and thinking about getting licensed in another developed country? If so, here are some tips, based on my early experiences integrating into the Dutch system:

Speak the Language.

The Dutch Ministry of Health, Wellbeing and Sport, responsible for professional recognition procedures for all health professionals, takes a tough love approach: if you are not proficient enough to understand the application and procedures (available in Dutch only), then learn the language first. Language proficiency is essential.

In almost all member states of the European Union (EU), fluency to an advanced level of the official language is the first major step towards professional recognition. The reasoning follows: an effective doctor should be able to communicate clearly and empathically with patients, team members, and more.

Language immersion is ideal but tough to do in the Netherlands. This country boasts the highest English Proficiency Index of all countries globally that do not have English as an official language country-wide.

Determine Your Scope of Practice.

As an American primary care physician, trained as a general internist, my job doesn't exist in the Netherlands. Continuity care in a primary care clinic setting is not typical of a Dutch general internist's scope of practice. Outpatient Internal Medicine clinic functions more like a specialty service. Inpatient service is no different than in the United States.

I had to decide: to become a Dutch primary care physician or *huisarts*, which is a closer scope of practice to my prior work experience, I would likely need to do three-year full-time residency training locally. For Internal Medicine, since I did residency in the United States, at least partial

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professional recognition would obviate repeating residency in full.

Find Out What Documentation You Need.

The professional recognition procedure as a foreign physician in the Netherlands differs depending on where you received your medical diploma. That is, medical graduates from another EU country may more easily obtain professional recognition, although language proficiency is still required. Once you master the official language, you might need an extensive list of required documentation for the licensing application. In my case, I contacted my previous training institutions and employers for notarized letters; I tracked down hundreds of hours of CME certificates; I also submitted original diplomas with my application, along with copies of middle and high school diplomas.

What Tests Will You Take? What Clinical Experience Will You Need?

First, I must pass a physician communication skills exam to prove my Dutch language proficiency. Then, medical knowledge exams follow, which almost precisely parallel the United States Medical Licensing Exams—but are administered almost completely in Dutch. A part is also in English, implicating English language mastery, a challenge for non-English and non-Dutch speaking physicians. To compare, neighboring Belgium, for example, does not have a communication skills exam, but does require proof of advanced Dutch language coursework and administers medical knowledge exams in Dutch, one of Belgium's official languages.

The Netherlands' professional recognition procedure was newly implemented in 2005, emphasizing new examination components, and covering recognition up through medical school graduation. After M.D. recognition, the Dutch Federation

of Medical Specialists, most closely equivalent to the American Medical Specialty Boards, evaluates the equivalency of foreign physicians' medical specialty training. Without equivalency, full-time Internal Medicine specialty training lasts six years, with a duty hour limit of 46 hours/week, including any years of subspecialty training.

Although redoing residency is not necessarily required in the Netherlands, as it is in the United States for IMGs, a *buitenlands gediplomeerde arts* must do at least three months of work under supervision, regardless of non-EU country of origin.²

How Is the Physician Workforce Regulated?

Consider Australia and New Zealand, who popularly import American and Canadian physicians.³ Both countries experienced rural physician shortages, so modified regulations for licensing foreign doctors decades ago. International locum tenens recruitment in the United States consequently became a specialized service aimed at American doctors seeking a relatively quick transition to another English-speaking healthcare system.

But this is not true for all countries. In the Netherlands, the Dutch government regulates the physician workforce. Some residents and young doctors are in fact troubled by difficulty finding long-term positions, especially those in certain subspecialties, in desired locations. To me, this means that the Netherlands is not necessarily wanting for a larger physician workforce, which may mean less incentive to simplify procedures for foreign physicians to become licensed.

Understand the Local Culture of Medicine. What Can You Bring from Your Experience?

Social integration is a foundation of expat life, but integrating into the local culture of medicine offers

a unique immersive experience. Learning about a culture through how its healthcare system functions, how it approaches health and wellness in society, and how each party participates in patient-physician or physician colleague relationships differs in both visible and subtle ways. Consider one small example: in my residency, chief residents led weekday morning reports, presenting one interesting patient case report interactively with interns and residents as a learning activity. Dutch morning report combines working and learning, involving students, residents, and both general internist and specialty attendings. An overnight resident presents patients admitted, distributes them to specialty services, reports on notable overnight coverage events, and everyone is positively welcomed to share opinions on cases discussed. Such is the social and group nature of almost any group meeting I have attended. A teaching session then follows for the remainder of the hour.

Other issues are universal: Physician burnout and suicide are also concerns, although the incidences are lower than in the United States⁴ and the system offers different and arguably more effective supporting infrastructure and policy to help physician trainees and practitioners. Electronic health records are also widely implemented, but with inconsistent interoperability and heavy administrative burdens for clinicians.

So, What Next?

It seems that what my husband once pondered is partially true. I will treat patients again and hopefully will not need to repeat training. But it will take a few years of investment (time, finances, and patience)—this is likely applicable if you plan to continue clinical practice in any EU country.

Aside from the final desired outcome—to see patients independently again—the good news is with full

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professional recognition as a physician in one EU country, it should become easier to be recognized by another member country. That means that after I achieve Dutch licensing as a general internist, I can start working on learning French or German next!

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