plex, and solutions will be country-specific. Recognizing that a practical approach is required, the Breast Health Global Initiative is developing guidelines for breast care that are "evidence-based, economically feasible, and culturally appropriate."[5] Certainly, early detection must be a primary goal worldwide: given that we cannot effectively treat metastatic breast cancer in the United States, there is little hope that we'll do so in developing countries.

As more countries modernize, more women will enter an increasingly sedentary workforce, delay childbearing, exert control over their reproductive lives, live longer, and eat a more Westernized diet. Their breast-cancer rates will no doubt increase. It is crucial that women's awareness of their risk and their expectations of their government and the medical community regarding detection and treatment increase at a similar rate.

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1. Curado MP, Edwards B, Shin HR, et al., eds. Cancer incidence in five continents. Vol. IX. Lyon, France: International Agency for Research on Cancer, 2007. (IARC scientific publications no. 160.) (Accessed December 27, 2007, at http://www-dep.iarc.fr/.)
2. Cui X, Dai Q, Tseng M, Shu X-O, Gao Y-T, Zheng W. Dietary patterns and breast cancer risk in the Shanghai Breast Cancer Study. Cancer Epidemiol Biomarkers Prev 2007;16:1443-8.
3. World Cancer Research Fund, American Institute for Cancer Research. Food, nutrition, physical activity, and the prevention of cancer: a global perspective. Washington, DC: American Institute for Cancer Research, 2007.
4. Thomas DB, Gao DL, Ray RM, et al. Randomized trial of breast self-examination in Shanghai: final results. J Natl Cancer Inst 2002;94:1445-7.
5. Anderson BO, Shyyan R, Eniu A, et al. Breast cancer in limited-resource countries: an overview of the Breast Health Global Initiative 2005 guidelines. Breast J 2006;12:Suppl 1:S3-S15.

A Bridge to Nowhere — The Troubled Trek of Foreign Medical Graduates

Ranjana Srivastava, F.R.A.C.P.

It is a typical day in my Melbourne clinic, with missing files, scans gone astray, and patients overwhelmed by their diagnoses. Though a mountain of dictation remains, the day's end appears promisingly close . . . but for a scheduled tutorial. Biting into lukewarm leftovers, I am sorely tempted to cancel it. After all, I reason, it is volunteer work, squeezed in among other pressing commitments. The students will surely understand and perhaps even be grateful for the reprieve on a balmy summer evening.

Maybe the time has come to give up the tutorials, I muse. I have taught since I was a resident. Now, busy workdays added to new motherhood fill my plate; many days, the planning and patience required for the tutorial seem beyond my reach. Soon my musings turn to resentment, resentment to self-righteous justification. Surely, it is someone else's turn to assume the mantle. The hospital is filled with doctors — someone must have spare time. Seizing on this thought, I reach for the phone. But before I finish dialing, I receive a page: "Doctor, don't worry if you are late. We will wait."

My conscience pricks me. I rush through the dictation and climb the stairs to meet my students, silently rehearsing my farewell speech.

Six expectant, eager faces greet me.

"I'm sorry I'm late."

"That's OK! We thought we would have to miss the tutorial altogether, so we are lucky!" There is a nodding of heads, shuffling of chairs and books as the students get into position.

"What a beautiful day!" I enthuse.

"To us, all the days seem the same," a glum voice says.

"What's new?" I ask.

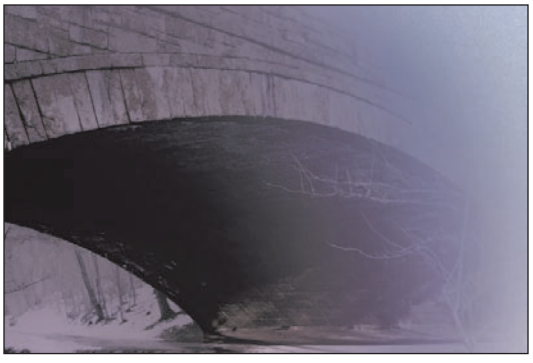
"No one got a spot for next month's exam."

"Oh, I am sorry to hear that. What happened?" I already know the answer.

"There were too many people and too few spots." Disappointment and resignation hang in the air.

My students are foreign-trained doctors taking a "bridging" course to earn medical credentials in

Australia. Their training, in almost all cases completed in a non-Western country, is not recognized here, so they must pass exams and undertake retraining to enter the system. Every year, hundreds of foreign graduates in Australia slog through thousands of practice questions ranging from internal medicine to gynecology. They must not only relearn the theory, which many of them first studied decades ago, but also master the social and behavioral nuances of being a doctor in the West. Some must do so while supporting themselves by driving taxis or picking fruit; others rely on meager personal savings or small government handouts. They are driven by the dream of becoming doctors again, but the reality can be a nightmare.



We begin with Yakov in the doctor's role. Yakov is a 40-year-old orthopedic surgeon from Russia. His wife works as a secretary while looking after their two children. He discovered very early the impossibility of breaking into the tightly controlled orthopedic training program, but it took him a long time to overcome his reservations and fears to enroll in the bridging course with the aim of becoming a family practitioner. Finally, he did it for his children, wishing to set them a good example.

I play the part of a young man with classic coronary risk factors who presents to the ER with myocardial infarction. I make the case as uncomplicated as possible, mindful of Yakov's background in surgery. Unfortunately, he starts poorly and botches the encounter, as his colleagues nervously avert their eyes from his apparent lack of knowledge and seemingly uncaring attitude. Sweat trickles down Yakov's forehead. Even as I strain to find something constructive to say, my confounded words escape: "I don't think you even tried."

Another student shakes his head. "But we just studied it this morning!"

It has taken just 8 minutes for Yakov's shaming to be complete. His eyes flash defiantly, "*This* is why I am here all day. Because I *need* to learn!" He buries his head in a well-thumbed *Oxford Handbook of Medicine*. I walk through the history and management of myocardial infarction, but I know I've lost Yakov. What meaning should such terms as angioplasty, abciximab, and door-to-balloon time have for this surgeon who always summoned a medical consultant at any whiff of chest pain? I kick myself, but it is too late.

Next is Abbas, an Iraqi thoracic physician, who has spent the past 3 years working as a personal care assistant in a nursing home. One day, a nurse caught him reading a patient's chart. He quickly divulged his background but begged her to keep it a secret lest he lose the sole livelihood for his family of five. After months of her encouragement, he came to see me. With deep longing in his eyes, he said, "There is nothing wrong with being a carer, but all I have ever wanted was to be a doctor." He wept when I offered to let him to join my tutorial group. "Just to pretend to be a doctor again will be so nice," he exclaimed.

I ask Abbas to demonstrate a knee joint examination. To my surprise, his years of isolation have not affected his capacity for being thorough and pleasant. I commend him on his performance. The others throw in their appreciation, and his face momentarily lights up. Then his modesty returns. "I have a long way to go. The examiners will not be as kind."

Little do I know that his circumstances will force him to put off his journey. After being absent for weeks, he e-mails me to apologize — he cannot afford to cut back on his 60-hour week to attend tutorials. He tells me that the 2 hours he spent with the other doctors were some of the happiest in his recent life, and he asks me to wish the others luck. Abbas would have been an asset to patients. He has never returned my calls.

We race onward, reviewing various clinical scenarios. I play the emphysematous woman and the drug-seeking adolescent, the dying cancer patient and the school-avoiding teen. I try to praise reasonably and criticize constructively. Between the role-play scenes, there is random conversation. Have I ever met a successful foreign medical graduate who put his life back in order? (In fact I have — for instance, a physician who left

20 years of factory work behind to become a successful family practice doctor.) Which ward is friendliest to foreign doctors? Which branches of medicine are both accessible to foreigners and lucrative? But we rarely follow these probing questions to meaningful conclusions, mindful of the tutorial's precious academic purpose.

I have observed over the years that most foreign doctors receive little encouragement, advice, or collegiality from a medical hierarchy engrossed in its own needs. The professional lives of foreign doctors exist mainly in their imagination, as they face an unpredictable future. Even if they manage to secure steady mentoring and jump the hurdle of costly and competitive exams, many must move to rural areas to nurture a career. This often involves uprooting a family that may just have found its feet in a new country. Those who get jobs in metropolitan centers often find themselves in a silent second tier of staff members, whose needs are different, diverse, and largely unmet. Personal lives suffer, as their families face prolonged periods of financial constraints. Most graduates report having left a comfortable lifestyle in their home countries, despite the social or political upheaval that prompted them to leave. Here, the conditions are reversed, but the resulting reality may be equally unpleasant. Family relationships become testy, fueling doubt about the decision to migrate. The sacrifices sometimes seem too great, the end too murky.

The foreign doctors I teach are uniformly respectful, diligent, interested, and interesting. Armed with uncommon wisdom born of their arduous journeys, they trade me life lessons for my lessons in Western medicine. So why is it that when one group finishes, I'm always hesitant about taking on another?

After many groups, I am beginning to see why: their needs are much larger than I had ever imagined or feel equipped to handle. I can expound on peptic ulcer disease or the staging of breast cancer, but I feel helpless when I stumble onto the legion of unexplored personal issues. When a doctor 20 years my senior is driven to tears of exasperation over the ailments of a mock patient, I feel like crying, too, out of frustration with a system that can barely see to adequate medical retraining, let alone psychological assistance. When the group, hungry for help, protests at a truncated tutorial, I am dismayed, even irritated by the needs I cannot fulfill. And I can never confidently deliver a tutorial, knowing that even a casual comment may uncover a secret that is beyond my capacity to address effectively.

The colleagues of a Muslim doctor indicate that she is being harassed by her husband for wanting to step out into Western society. My circuitous attempts to engage her fail miserably. A Chinese doctor feels discriminated against because of his strong accent and is contemplating returning to the factory where he worked unpaid hours but was left alone. The father of another is dying; she can spend her money either flying overseas to see him or saving up for her exam. Beneath their affable smiles lies a private world of doubt, resignation, and impossible choices. They wear their medical degrees like ill-fitting overcoats — too awkward to parade but too warm to discard. Every week I console myself that perhaps if I just help them get through the exam, the other pieces will gather into place.

The last time I expressed my unease, a colleague retorted that foreign doctors ought to stay in their home countries to serve their own people. Ironically, he and I are both migrants; we were simply fortunate that a previous generation undertook the hard work of assimilating into a new society. Certainly, millions of people lack basic health care and resource allocation is a just concern, but just as our parents ensured our eventual success, these doctors seek opportunity and stability, partly for themselves but largely for their offspring. Who can begrudge them this most fundamental of life's quests?

When foreign graduates ultimately qualify as physicians, they go on to serve ably, often working in areas of great need. Indeed, the medical systems of many Western countries rely on immigrant doctors to function. It is reasonable to expect foreign medical graduates to comply with local practice standards, but it is incumbent on us to deliver the support and infrastructure they require in the process. Governments may espouse principles and pledge funding to facilitate assimilation, but it is ordinary doctors in the course of everyday work who will guarantee the endeavor's success. We pride ourselves on our compassion for patients; it

is high time we offered the same to our dislocated colleagues.

Finally, the tutorial is over. I think of my original resolve to call it a day.

"Can we please not do the next one on Monday?" a voice pleads softly. "I really don't like missing these sessions."

"Sure," I reply, about to tell them they can work it out with the next tutor. "Thank you," says the relieved voice.

"She has to go the airport to pick up her baby," someone else feels compelled to add.

It takes me a few seconds to register the comment.

"How long has it been since you saw your baby?"

"Two years. My mother has been caring for her since her birth while I try to get the exam."

I am staggered by her resilience before I realize that everyone else in the group probably has a story to match, if I dared to ask.

I think of my own baby, whom I saw only this morning and feel the urge to return to. I think of my annoyance this afternoon at having to fit in this tutorial. I think of all the doctors I have taught, many of whom still await their chance to be doctors again. I swallow hard, unable to raise my guilty eyes.

"Can you do Friday?"

"Absolutely," they respond eagerly.

"See you then."

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Dr. Srivastava is a medical oncologist and internist in Melbourne, Australia.