gap and dramatically increase the demand for IMGs from other countries and for U.S. IMGs who graduate from medical schools in the Caribbean.

The long-term effects of the narrowing U.S. GME gap on the various types of residency applicants (U.S. M.D. graduates, U.S. D.O. graduates, U.S. IMGs, and non-U.S. IMGs) are uncertain. In recent years, nearly all U.S. M.D. graduates have obtained GME positions. Virtually all D.O. graduates, similarly, match to residency programs accredited by the ACGME or the American Osteopathic Association. IMGs (both U.S. citizens and non-U.S. citizens) have fared less well in the competition, with only about half attaining residency positions. The number of U.S. IMGs has grown considerably, and in 2015, these graduates constituted 42% of all IMGs matched to first-year positions in the National Resident Matching Program Main Match.[5] Although U.S. graduates will be affected by the tightening of the gap, the most intense competition will certainly occur among IMG applicants.

Potential effects on U.S. graduates have many members of the educational community worried, and this concern has been passed on to medical students through authoritative warnings that they may have trouble securing residency positions and that their choice of specialties will be severely curtailed. Congress's unwillingness to legislate more Medicare GME funding is often cited as the reason for the perceived squeeze. The positions actually available and the trends reviewed here do not bear out this interpretation. The primary goal of public GME support, it should be noted, is to produce trained physicians to meet the country's health care needs and not to fulfill the personal preferences of individual graduates for the specialties of their choice. Although the GME gap will narrow slowly, it appears likely that there will be ample positions for all U.S. graduates over the next decade. It would seem difficult to argue that Congress should fund more GME positions in order to create a larger margin for U.S. graduates. Disquiet among medical educators is understandable, but we believe that anxiety among students should not be amplified by well-meaning student advisors or national organizations.

The GME system is proving responsive to the increased output of U.S. medical schools. The country would be best served if academic medicine focused its considerable intellect and energies on the task of transforming GME to respond to our rapidly evolving health care system.

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A Never-Ending Battle

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"Were you in the Army, Navy, Air Force, Marine Corps, or the 'Guard'?" I asked as I admitted my patient, a 78-year-old veteran.

Mr. M. had florid heart failure, the result of multiple myocardial infarctions over years, each one taking a big bite out of his heart's pumping abilities and leaving his lungs and body waterlogged. His aging kidneys had slacked off, too, and despite maximal medical therapy he was now looking at a remaining lifespan of weeks. He was wheelchair-bound and tethered to his oxygen cylinder owing to profound air hunger.

He sketched me a mocking salute. "U.S. Army Cavalry Scout reporting for duty, Ma'am!"

"Have you seen combat?" I asked.

He idly gestured toward the

combat veteran license plate on his scooter wheelchair.

"So what exactly did you do as a scout?"

"Just routine, boring stuff. Nothing fancy," he said dismissively.

"He doesn't like to talk about the war," his wife put in, trying gently to defuse her husband's abruptness.

"Your records show you have chest pain and trouble sleeping. Do you have post-traumatic stress disorder?" I asked.

He shook his head vehemently.

I turned to his wife. "Is he up a lot in the night? Does that bother your sleep?"

"I don't know," she ventured reluctantly. "I sleep in the guest bedroom."

"What about the pain?" I forged on. "Are you taking anything for it?"

"Don't you try and give me none of those narc pills, doc. I want nothing for my pain," Mr. M. said, wincing as a wave of pain washed over him.

Soon after he'd come back from the war, his wife later told me, she woke up one night to find him in the throes of a nightmare, straddling her abdomen as he tried to choke her. Fortunately, she was able to shout and wake him up. Ever since, he refused to sleep in the same room as she did, saying he loved her too much and was afraid that he would harm her. When she suggested that he get help for PTSD, he refused so violently that she never had the nerve to bring it up again.

Even if the war they fought is long over, many veterans are perpetual prisoners of an ongoing inner war that rages silently in their heads. Men and women on active duty may be forced to commit actions that directly conflict with their ethical and moral beliefs. Their stoicism and "battle-mind" may serve them well as long as their psychological defenses are intact. At the end of life, however, their previous coping strategies may crumble, especially if they're taking mind-altering medications to relieve pain. Many may even prefer to bear severe pain and avoid pain medications, which make them fuzzy-headed and can unleash war-related nightmares and flashbacks. Thus, I was not surprised that Mr. M. vehemently refused pain medications. Many veterans' war memories are so painful that they never discuss them, even with their loved ones or their doctors.

In the days that followed, Mr. M. and I established a reasonable working relationship. I ran some tests and fine-tuned his medications and started him on IV antibiotics for pneumonia. His little vice was shopping at the hospital gift store, where he enjoyed buying small, whimsical gifts for his family and the staff. He continued to soldier on through his pain, and as his breathing difficulties worsened, his skin took on a grayish hue. He continued to refuse the opioids that might have alleviated both his pain and his air hunger.

The nights were pretty bad for him. He was hyperalert but exhausted, and he often prowled the hospital hallways on his electric scooter all night long.

"Why don't you hold my pager tonight so I can get some sleep?" I joked late one evening as I examined the weeping ulcers in his ankles.

"You got it, V.J.," he said. "It will be just like when I scouted around at night with my army buddies." He smiled for a second and then sobered up. "Doc, it's hard to sleep when you know you're going to wake up in the trenches."

"The trenches?" I echoed, preoccupied by a large ulcer with an angry reddish hue.

"I most remember the cooking smells. On warm nights, the smell of rice used to waft over from the villages. My buddy and I used to wander the fields at night."

"What for?" I probed the ulcer's depths gently to see if I could hit bone.

"Recon," he said. "The scout goes ahead of the platoon to scope out the enemy. Mostly it was pretty quiet. Sometimes we had to fight our way out. One time it was pretty bad."

My ears pricked up, but I knew better than to seem overeager, which would make him shut down.

"This wound needs to be cleaned up," I said. "It's going to sting a bit." I grabbed the wound supplies and got to work. "So what happened? The time you said it got pretty bad — did you run into some hostiles?"

He didn't speak for several minutes, and I continued to work in silence.

"When you see an enemy," he said finally, "it's one thing. When the enemy sees you, that's something entirely different. When you're seen by the enemy, you put your entire platoon at risk. You have to follow the protocol. You have no choice."

I kept my silence.

"V.J., we were almost done with our shift, my buddy and I. Another 30 minutes, we would have been back at camp. My buddy heard a sudden soft noise, and we had to investigate." Mr. M. was staring at the ceiling, his eyes unfocused. "We had our weapons

drawn, ready for combat. Then we saw the woman a few feet away — actually, she looked like a teenager, and she was alone and looked pretty harmless. I signed to my buddy to stand down, and we tried to silently retreat before the girl could sight us. We almost made it, but something must have alerted her, because she looked up and saw us."

Now his words were coming fast and furious.

"We knew what we had to do. I drew the short straw. I made sure that it was swift. It was over before she even knew what was happening. We covered our tracks and returned to camp."

I had stopped débriding the wound, chilled by his words as their meaning sank in.

Finally, Mr. M. looked straight into my eyes and said softly, "The girl was pregnant. I noticed it after . . . you know . . . as I was cleaning my knife. Whenever I close my eyes, I see her face, that split second when she understood what was about to happen. I cannot get it out of my head."

The vault had finally opened, and I knew he had a lot more to say.

I got up quietly and filled two Styrofoam cups with stale hospital coffee. What would I have done if I had been in his shoes, I wondered. I could have let the girl go, but maybe the mission would have been compromised and my entire platoon would have been killed or taken prisoner of war. Or maybe I would have done exactly what Mr. M. did and would now be deep in the throes of moral distress.

As I handed him his coffee, it suddenly dawned on me that my patient was not a war veteran. He was a soldier, very much on active combat duty — just on a different battlefront. And he'll be in combat until he dies.

I sat at his bedside and started sipping my coffee. "I'll stay until your wife gets back from dinner," I said. He nodded.

After several minutes of companionable silence, he asked, "V.J., am I going to hell for killing two innocents?" Without waiting for a response, he continued, "Well, I'm going to find out soon enough."

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