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POLICY FORUM

"A Little More than Kin, and Less than Kind": U.S. Immigration Policy on International Medical Graduates

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"IMGs work where there are poor people, people of color and few doctors in proportion to the population."
Kristen Harris [1]

The quote above captures an essential aspect of international medical graduates' (IMG) contributions to American society. Foreign international medical graduates (FIMGs) play important roles in American medicine, but their position, both social and legal, remains tenuous. Despite their high levels of performance and contribution to alleviating the American physician shortage, they seem to be viewed, as Claudius was by Hamlet, as "more than kin, and less than kind" [2]. This piece argues that because of FIMGs' substantial contributions, they should be not only allowed but encouraged to live and work in the United States and recognized as a vital part of the American health care system. The accompanying flow chart illustrates the obstacles commonly encountered by FIMGs in their quest to find a place in the permanent physician workforce in the United States.

IMG Demographics

IMGs are physicians who have graduated from medical schools outside of the U.S. and Canada that lack accreditation by the Liaison Committee on Medical Education (LCME) [3]. IMGs are a heterogeneous group with widely varying cultural, educational, and linguistic backgrounds. Included in this group, but distinct from FIMGs, are USIMGs, who are U.S.-born or naturalized citizens who have obtained their medical education abroad. USIMGs, some of whom are second-generation Americans, tend to be graduates of Caribbean medical schools whose native language is English, are younger, more likely to be male, and more likely to practice in primary care specialties than FIMGs [4]. Though studies indicate that they perform less well than FIMGs on certifying [4], training [5], and specialty board examinations [6], they have less difficulty in entering the workforce in the United States [4].

In 2009, USIMGs and FIMGs accounted for one-fourth of the licensed physicians in the U.S. and 29.2 percent of physicians in residency/fellowship training [7]. The top five countries in which IMGs practicing in the U.S. obtained their medical degrees are India (20.7 percent), the Philippines (8.3 percent), Mexico (5.6 percent), Pakistan (4.9 percent), and the Dominican Republic (3.2 percent) [3]. New York, California, Florida, Texas, and Illinois are favorite destinations for all IMGs in the U.S. [7].

Internal medicine (24.6 percent), pediatrics (8.2 percent), family practice (7.9 percent), psychiatry (5.2 percent) and anesthesiology (4.5 percent) are the top specialty choices for IMGs [7]. About three-quarters (76.9 percent) of IMGs (including those in residency/fellowship training) are mainly engaged in clinical care, with minor representations in medical education (0.7 percent), research (1 percent) and administration (0.7 percent) [7].

Weaving IMGs into the Safety Net

Studies have found that IMGs tend to practice in physician shortage areas characterized by high rates of infant mortality and below-average physician-to-population ratio [8]. They are also believed to take care of more minority patients [9], accept more Medicare and Medicaid patients, and work more hours [10] than U.S. medical graduates (USMGs). In addition, FIMGs have tended to work in primary care medical specialties that are less popular with USMGs, such as internal medicine, pediatrics, psychiatry and ob/gyn [11]. This issue of specialty choice by IMGs is highly controversial: some believe that by choosing such specialties, IMGs correct physician maldistribution [9], while others contend that IMGs do not substantially differ from USMGs in specialty choice [12].

As for the quality of care rendered, in a large retrospective analysis FIMGs performed better than USMGs and USIMGs in, for example, the care of congestive heart failure [13]. In addition, IMGs seem to have greater ability to tolerate stress and higher self-esteem than USMGs and USIMGs [14]. The performance of IMGs on the U.S. Medical Licensing Examination (USMLE) is better than that of USIMGs [15].

The competence of IMGs as physicians and the soundness of their educational backgrounds has long been a contentious issue. This does not mean that IMGs have any fewer or easier requirements than USMGs—in fact, they have more. To qualify for residency training in the United States, IMGs must be certified by the Education Commission for Foreign Medical Graduates [16], which requires that they pass the USMLE Steps 1 and 2, including the Clinical Skills Assessment, within a certain period of time. In addition, they must document that they have studied for 4 years at, graduated from, and received a diploma from a school listed in the *International Medical Education Directory* [17] To obtain a license to practice medicine in the United States, IMGs are required not only to pass the USMLE Step 3, but , in most states, to undergo more residency training than USMGs, e.g. complete 2-3 rather than 1 year [18] (see figure 1).

United States Immigration Policy and FIMGs

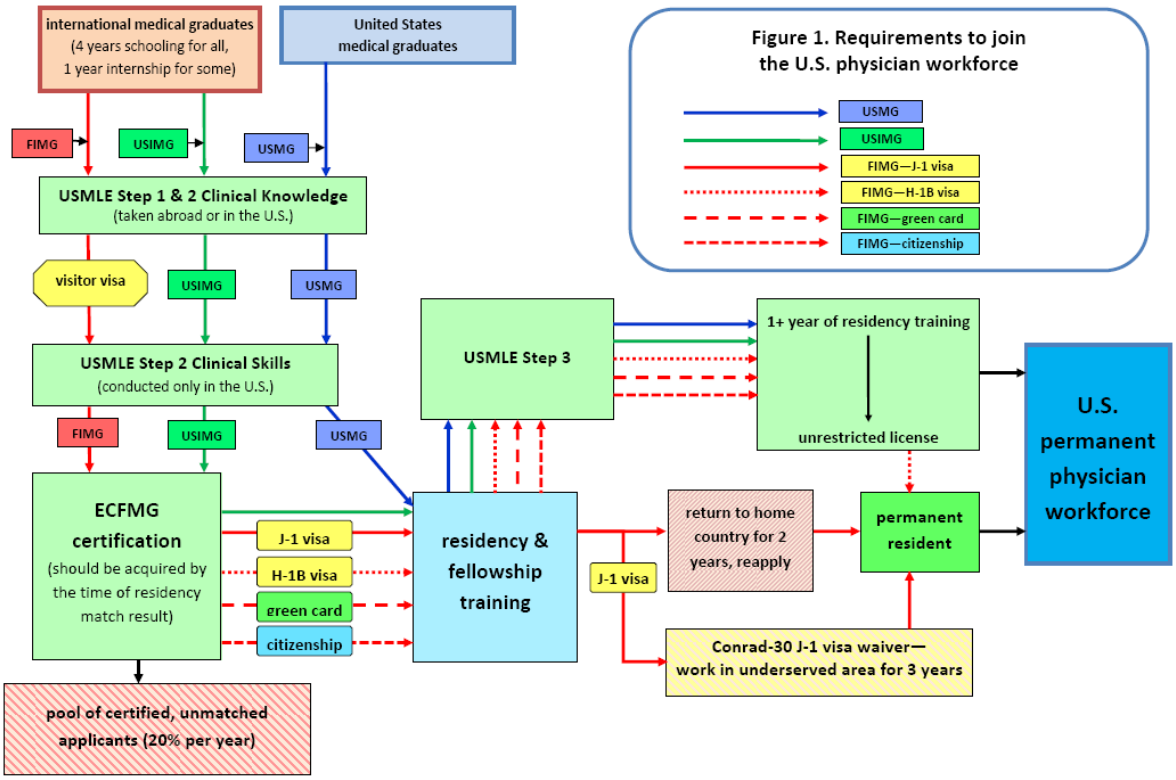
To participate in graduate medical education (GME), in addition to having ECFMG certification, FIMGs are required to obtain a visa from the immigration service. The temporary visas consist of the J-1 exchange visitor (EV) visa and the H-1B visa; the permanent category includes citizenship and permanent resident status. Permanent resident documentation, also known as a “green card” or immigrant visa, is obtained based on a preferential system that classifies an applicant as either family-sponsored

or employer-sponsored. Historically, the J-1 visa has been the dominant mode of temporary entry, and family-preference status the dominant mode of permanent entry for foreign national IMGs [3]. The visa and immigration status of those in graduate medical education programs are shown in table 1.

Table 1. Citizenship status of participants in GME programs [19]

Immigration Status	**All GME participants**	**IMG portion of column 1 category**
Native-born citizens	66.1%	7.6%
Naturalized citizens	8.1%	37.7%
Permanent residents	7.3%	67.6%
Non-immigrant H- and J-visa holders	8.9%	96.7%
Other (B-1, B-2, F-1, refugees, unknown citizenship, etc.)	9.6%	65%

The J-1 visa is for residency training, and it is sponsored by the ECFMG (see figure 1). For a graduating resident on a J-1 visa to continue to work in the U.S. after completing training, the following steps need to be taken.



Conrad-30 waivers. J-1s are waived under certain circumstances, such as when the applicant's skills are needed, the visa holder anticipates persecution in his home country, or the applicant's U.S.-citizen spouse will experience exceptional hardship if the applicant returns to his or her home country [20]. The Conrad-30 waiver program allows each state's Department of Health to sponsor up to 30 (initially 20)

international medical graduates each year for waivers of the requirement that they reside in their home countries for 2 years after their visas expire before applying to change their immigration status.

Those approved for Conrad-30 waivers are required to serve in rural or urban federally designated health professional shortage areas or medically underserved areas [21, 22]. The 1,000 waivers issued in 2010 is a tremendous increase from the 70 issued in 1990 [23], attesting to the extent to which many communities across the United States continue to face severe difficulties in attracting U.S. physicians to meet their health care needs [22] and to which IMG residents on J-1 visas contribute to the alleviation of those difficulties.

According to the U.S. Government Accountability Office [23], the J-1 visa waiver has become the major means of placing physicians in rural and other health professional shortage areas. Ninety percent of J-1 physicians complete their employment term, and 28 percent of them continue to practice in the same area up to 4 years later [3].

H-1B visa. The H-1B visa is for temporary workers in specialty occupations holding professional-level degrees, including graduates of foreign medical schools. Unlike the J-1 visa, the H-1B visa does not have a 2-year home residence requirement; it allows a foreign national to remain in the United States for professional-level employment for up to 6 years, and it does not prohibit "immigrant intent." H-1B visas require the prospective employer to attest to the Department of Labor that the candidate will be paid the same salary that is paid to a citizen [24] and the candidate to pass USMLE Step 3. Physicians who complete 6 years of employment on H-1B visas usually seek permanent resident status.

Immigrant visa (green card). IMGs may qualify for an immigrant visa (also known as a green card), which permits foreign citizens to remain permanently in the United States if they are immediate relatives of a U.S. citizen or lawful permanent resident, employees of a sponsoring employer or prospective employer, or "diversity immigrants" chosen by lottery.

Effects of Immigration Policies on IMGs

There has been considerable ambivalence, inconsistency, and arbitrariness in U.S. immigration policies towards FIMGs. A few little known and potentially serious obstacles that immigration policy presents for IMGs will be discussed and their implications for the U.S. health care system will be considered. A brief discussion of remedies to address these problems will conclude the paper.

Treatment of J-1 visa holders. J-1 visas have one of the most exacting sets of requirements. The United States Citizenship and Immigration Service (USCIS) prohibits J-1 visa holders from having current or possible future "immigrant intent," and they are subject to suspicion on that front. In this regard one major policy-related issue for IMGs, which is little-known outside of the IMG community and some

training programs, is USCIS's preventing IMGs on J-1 visas from reentering the U.S. after visiting their home countries.

This policy is randomly enforced, however, creating considerable uncertainty for IMGs, as well as distraction from learning and enormous stress and worry. One program alone saw one of its residents on a J-1 visa and the family of another resident on a J-1 visa unable to return from their home countries after their visas were rejected by U.S. consulates. They were able to reenter the U.S. much later, only after frantic activity on the part of elected officials in the U.S. In the process, both patient care and residency training for the residents were interrupted, not to mention the extreme degree of personal anxiety the forced separation from their families caused. Incidents such as these are not infrequent among IMGs on J-1 visas.

Denial of visas for the Step 2 Clinical Skills exam. The second issue concerns the experience of foreign medical students seeking visas to enter the U.S. to take the Clinical Skills (Step 2 CS) exam. Obtaining ECFMG certification is a drawn-out and expensive process that requires FIMGs to pass USMLE Step 1 and Step 2 CK (Clinical Knowledge) examinations in their native country and travel to the US to take the Step 2 CS (Clinical Skills) examination, which is administered at only a handful of centers in the U.S. After passing the Step 1 and Step 2 CK exams, however, some applicants find that their applications for visas to take the CS exam are rejected (unpublished data). The effort and resources they put into passing the first two steps is thus wasted.

Brain drain. Concerned about possible deleterious effects of physician emigration on IMGs' home nations, also called "brain drain," policy makers have been advocating that the United States depend on itself to address the physician shortage [25]. Such a stance is paternalistic, and immigration is not necessarily incompatible with one's responsibility to the home country and its needs. While an emigrating physician might deprive his or her home country of the knowledge and skills of a medical professional, he or she may contribute to the native economy in other, perhaps more important, ways, such as sending money home, taking much-needed skills back, and building hospitals.

To try to address its physician shortage, the United States has embarked on an expansion of its internal educational capabilities by 30 percent by adding new medical schools and expanding the class sizes of existing schools [26]. However, this expansion will not fix the shortage unless it is coupled with a correlative expansion in GME slots (and since, as the number of USMGs increases, the number of FIMGs in GME decreases [27], so it appears that this will prevent IMGs from being able to become licensed in the U.S.). The primary source of GME funding—from the Centers for Medicare and Medicaid Services—is frozen at 1997 levels [28] and is threatened with significant reductions due to the current budget crisis. Meanwhile, the demand for physician services will increase enormously with the addition of 32 million currently uninsured people who will become insured under the recent health care reforms and aging baby boomers' need for medical services.

Therefore, due to the inherent impossibility of expanding both USMG slots and GME slots quickly enough to enable an entirely domestic solution to the physician shortage, serious consideration should be given to a role for IMGs.

Remedies

1. *Address the inconsistencies*. To prevent disruption of patient care, IMGs on temporary visas should be allowed the freedom to travel out of the country and return unfettered.
2. *Address unemployed IMGs.* To avoid putting examinees through the expensive USMLE process fruitlessly, the ECFMG should limit the number of examinees based on GME slots in a given year and ensure that all the candidates who pass USMLE Step 2 CK get visas to enter the U.S.
3. *Fund more GME.* If the number of GME slots were determined by the needs of the system, the physician shortage could more realistically be addressed.
4. *Redesign immigration visa categories* by permitting dual intent for people on temporary visas or doing away with temporary visas altogether. A new visa type similar to category O (a temporary visa for "aliens of extraordinary ability") should be created for physicians to allow flexibility during the various phases of their training and careers.
5. *Plan for the long term.* If the current physician shortage is not addressed by the measures suggested, one might consider the following long-range solutions.
    a) *Undertake active recruitment of foreign physicians.* This is a radical idea that would allow IMGs with postgraduate degrees from certain English-speaking countries to enter the U.S. and start practicing right away. (The requirement is that any foreign physician, no matter how senior, who wishes to obtain a license to practice medicine in the United States must complete a residency program here.) Active recruitment was used by the United Kingdom to recruit a large number of senior physicians from India and South Africa to run its national health service [29, 30]. However, one must keep in mind that it is unethical for the recruiter to rescind these physicians' employment when the native physician supply improves.
    b) *Develop a truly global medical education system* in which the United States' undergraduate and graduate medical education standards shape medical education abroad. This would allow professionals to move back and forth between the United States and their countries of origin as people are able to move within countries and Euro-zone countries. Recently, the ACGME accredited Singapore's GME [31], and many U.S. medical schools have established satellite campuses abroad [32]. The ECFMG will require international accreditation of foreign medical schools starting in 2023 [16].

In conclusion, high-performing doctors willing to work to alleviate the shortage of medical care in the United States should not be barred from doing so because of their foreign medical education. Allowing and encouraging international medical graduates to work in the U.S. will benefit those who need care here, the IMGs themselves, and the global economy.

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