



STATEMENT
of the
American Medical Association

to the
U.S. House of Representatives
Committee on the Judiciary Subcommittee on Immigration and Citizenship

Re: Is there a Doctor in the House? The Role of Immigrant Physicians in the US Healthcare System.

February 15, 2022

Division of Legislative Council

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The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House of Representatives Committee on the Judiciary Subcommittee on Immigration and Citizenship as part of the hearing entitled, “Is there a Doctor in the House? The Role of Immigrant Physicians in the US Healthcare System.” The AMA commends the Subcommittee for focusing on the critically important issue of physician immigration and workforce shortages. Prior to the COVID-19 pandemic, the U.S. was already facing a rising shortage of physicians largely due to the growth and aging of the general population and the impending retirement of many physicians.¹ This shortage was dramatically highlighted by the lack of physicians in certain key areas, especially rural and underserved communities, during the COVID-19 pandemic, which forced states to recall retired physicians, expand scope of practice, and temporarily amend out of state licensing laws.² However, none of these adjustments will fill the physician shortage gap long term. As such, additional physicians, in the form of international medical graduates (IMGs), are greatly needed. IMG’s often serve in rural and medically underserved communities, providing care to many of our country’s most at-risk citizens. As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA is committed to ensuring that there is proper access to physicians for all patients and that physicians are well supported in their role as leader of the health care team. If immigration barriers for physicians are reduced, it will help to increase the number of physicians in the U.S. which will lead to healthier communities and ultimately a healthier country as access to much-needed medical care increases.

The cap on Medicare support for graduate medical education must be raised.

As U.S. medical schools have increased enrollment, residency training positions at teaching hospitals have not kept up with the larger pool of applicants, limited by the cap on Medicare support for graduate medical education (GME). As discussed below, workforce experts predict that the U.S. will face a significant physician shortage for both primary care and specialty physicians over the next 13 years if training positions are not expanded. Yet, while new medical schools are opening, and existing medical schools are increasing their enrollment to meet the need for more physicians,

¹ <https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage>.

² <https://www.nashp.org/states-address-provider-shortages-to-meet-the-health-care-demands-of-the-pandemic/>.

federal support for residency positions remains subject to an outdated cap from 1996 that falls dramatically short of the needs of the U.S. population.

When Congress enacted the Balanced Budget Act of 1997 it placed a limit (or cap) on the funding that Medicare would provide for GME.³ This meant that most hospitals would receive direct medical education (DGME) funding and indirect medical education (IME) support only for the number of allopathic and osteopathic full-time equivalent (FTE) residents it had in training in 1996.⁴ As U.S. medical schools have increased enrollment, residency training positions at teaching hospitals have not kept up with the larger pool of applicants, limited by the cap on Medicare support for graduate medical education. According to the Association of American Medical Colleges (AAMC), there has been a 52 percent increase in medical student enrollment since 2002,⁵ but only a 17 percent increase in funded GME slots.⁶ Though, for the first time since 1996, 1,000 new Medicare-supported GME positions were provided in the Consolidated Appropriations Act, 2021,⁷ many more Medicare-supported GME positions are needed to alleviate the physician shortage. **Therefore, it is crucial that we invest in our country's health care infrastructure by providing additional GME slots so that more physicians can be trained, and access to care can be improved.**

Additionally, "Cap-Flexibility," which would allow new and current GME teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), would be helpful to remedy the physician shortage we are currently experiencing.

As the nation faces a pandemic and physician shortages, sustained long-term investments in our physician workforce are necessary to help care for our nation's most vulnerable populations.

The U.S. is currently facing significant and prolonged physician shortages.

The United States is suffering from a major physician shortage, with forecasts of a widening gap that will continue to grow over the next decade. It is projected that by 2032, there will be a 50 percent growth in the population of those ages 65 and older, compared with only a 3.5 percent growth for those ages 18 or younger.⁸ Partly due to this phenomenon, by 2033 the United States will experience a shortage of between 54,100 and 139,000 physicians. This number includes a projected primary care physician shortage of between 21,400 and 55,200, as well as a shortage of non-primary care specialty physicians of between 33,700 and 86,700.⁹ As such, there is a growing need for a larger physician workforce that the U.S. cannot fill on its own, in part due to the fact that the U.S. physically does not have enough people in the younger generation to care for our aging country. Furthermore, the pandemic has put an incredible strain on our health care system and this crisis has drastically exacerbated physician shortages in many rural and underserved communities across the U.S.

³ <https://www.congress.gov/bill/105th-congress/house-bill/2015>.

⁴ <https://www.ama-assn.org/education/improve-gme/compendium-graduate-medical-education-initiatives>.

⁵ <https://www.aamc.org/news-insights/us-medical-school-enrollment-rises-30>.

⁶ <https://www.ncbi.nlm.nih.gov/books/NBK248024/>.

⁷ <https://www.congress.gov/bill/116th-congress/house-bill/133/text>.

⁸ <https://www.aamc.org/download/472888/data/physicianworkforceissues.pdf>.

⁹ AAMC (2020, June) The Complexities of Supply and Demand: Projections from 2018 to 2033. Retrieved from AAMC: <https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf>.

Health Professional Shortage Areas (HPSAs) are used to identify areas, populations, groups, or facilities within the United States that are experiencing a shortage of health care professionals. According to the latest data released by the Health Resources & Services Administration (HRSA), 88 million people live in primary medical HPSAs in the U.S.¹⁰ The HRSA estimates that an additional 33,887 providers are required to eliminate all current primary care, dental, and mental health HPSAs.¹¹ With the existing and projected physician shortage, and the increased demands that have been placed on physicians during the pandemic, additional support for programs like the Conrad 30 Waiver Program,¹² with an incentive to increase medical school enrollment and place providers in underserved communities, is desperately needed.

If we compare the states where the most H-1B physicians are providing care and the states with some of the highest COVID-19 cases, the stark need for more physicians becomes apparent. For example, as of September 2020, North Dakota had the highest per capita of COVID-19 cases and deaths of any state.¹³ North Dakota also has the highest percentage of H-1B physicians in their workforce.¹⁴

Top States Where H-1B Physicians are Providing Care ⁴⁰	Number of Physician LCAs ⁴¹	States with Increasing COVID-19 Cases ⁴²
New York	1467	2,499 new positive cases per day
Michigan	945	4,109 new positive cases per day
Illinois	826	6,362 new positive cases per day
Ohio	606	3,590 new positive cases per day
Pennsylvania	602	2,235 new positive cases per day
Texas	343	6,886 new positive cases per day
California	309	4,372 new positive cases per day
Indiana	244	3,618 new positive cases per day

Note: Abbreviation: LCA, labor condition application. Total certified physician LCAs by State. Physician LCAs certified in 2016.

Ensuring access to a robust, uninterrupted frontline health care workforce is critically important. As such, the AMA believes that the U.S. should promote an increase of IMGs and that current IMGs should not be hampered by additional unnecessary regulations in the midst of helping the U.S. fight COVID-19.

Even after the public health emergency ends, **the AMA strongly urges Congress to consider the importance of IMGs in providing medical care to U.S. citizens, especially our most at risk**

¹⁰ The U.S. Department of Health & Human Services, Bureau of Health Workforce Health Resources and Services Administration (HRSA), Bureau of Health Workforce, Fourth Quarter of Fiscal Year 2020, Designated HPSA Quarterly Summary. Data as of September 30, 2020. See also, <https://bhw.hrsa.gov/shortage-designation/types>.

¹¹ <https://data.hrsa.gov/topics/health-workforce/shortage-areas>.

¹² <https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program>.

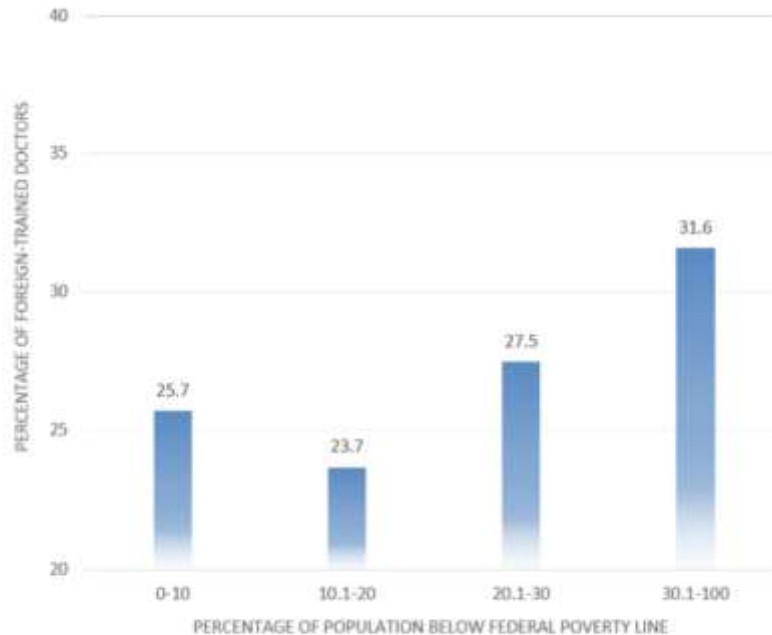
¹³ The U.S. Department of Health & Human Services, Bureau of Health Workforce Health Resources and Services Administration (HRSA), Bureau of Health Workforce, Fourth Quarter of Fiscal Year 2020, Designated HPSA Quarterly Summary. Data as of September 30, 2020.

¹⁴ JAMA Network, Peter A. Kahn, MPH, ThM, et al., Distribution of Physicians With H-1B Visas By State and Sponsoring Employer, June 6, 2017. <https://jamanetwork.com/journals/jama/fullarticle/2620160?resultClick=1>.

citizens in rural and medically underserved communities across this country who rely on H-1B physicians to provide much needed primary and specialty health care services.

The 2019 State Physician Workforce Data Report found that nationally, almost 25 percent of active physicians providing care in the U.S. are IMGs. Likewise, more than 20 million people live in areas of the U.S. where foreign-trained physicians account for at least half of all physicians.¹⁵

Foreign-trained Doctors Serving U.S. Population by Poverty Level¹⁶



Source: American Immigration Council analysis of data from the American Medical Association, U.S. Healthcare Resources and Services Administration, 2010 U.S. Census, and 2006-2010 American Community Survey.

The escalating physician shortage over the last 20 years, coupled with the COVID-19 pandemic, should serve as an alarm that the U.S. needs to increase its number of physicians to ensure we can care for patients in both the short- and long-term. **The AMA firmly believes that as we continue to face a mounting physician shortage in the U.S., Congress should be promoting and easing the way for IMGs in our workforce.**

J-1 and H-1B physicians are valuable assets to the U.S. medical system.

In 2017, nearly 30 percent of medical residents in the U.S. were IMGs, with about half working as physicians in the U.S. on non-immigrant visas, such as J-1s.¹⁷ These non-U.S. citizen IMGs play a vital role in caring for some of the most vulnerable populations in the U.S. For example, foreign-trained physicians are more likely than U.S.-trained physicians to practice in lower income and

¹⁵https://www.americanimmigrationcouncil.org/sites/default/files/research/foreigntrained_doctors_are_critical_to_serving_many_us_communities.pdf.

¹⁶https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf.

¹⁷<https://www.americanprogress.org/article/immigrant-doctors-can-help-lower-physician-shortages-rural-america/>.

disadvantaged communities.¹⁸ As such, it is important to support and create pathways for these physicians to be able to continue to remain in the U.S. and care for their patients. **Therefore, foreign trained physicians and medical residents should be prioritized during the visa process to enable the U.S. to, in the short-term, more effectively fight COVID-19 and, in the long-term, ensure the physician shortages in our rural and underserved communities are remedied.**

J-1 physicians

A prospective exchange visitor must be sponsored by a U.S. Department of State (DOS) designated program sponsor to be admitted to the United States in the “J” nonimmigrant category or to participate in an exchange visitor program. The DOS-designated sponsor, which for all J-1 physicians is the Educational Commission for Foreign Medical Graduates (ECFMG), will issue the prospective J-1 physician a Form DS-2019, Certificate of Eligibility for Exchange Visitor (J-1) Status. The DS-2019 permits a prospective exchange visitor to apply for a J-1 nonimmigrant visa at a U.S. embassy or consulate abroad, or seek admission as a J-1 nonimmigrant at a port of entry.

Due to this process, J-1 physicians are already a carefully monitored cohort. Since ECFMG sponsors all J-1 physicians, it coordinates closely with U.S. teaching hospitals and with the U.S. DOS throughout each academic year to ensure that J-1 physicians comply with all federal requirements. Additionally, under the current process, J-1 physicians are required to apply to ECFMG to extend their visa sponsorship on an annual basis.

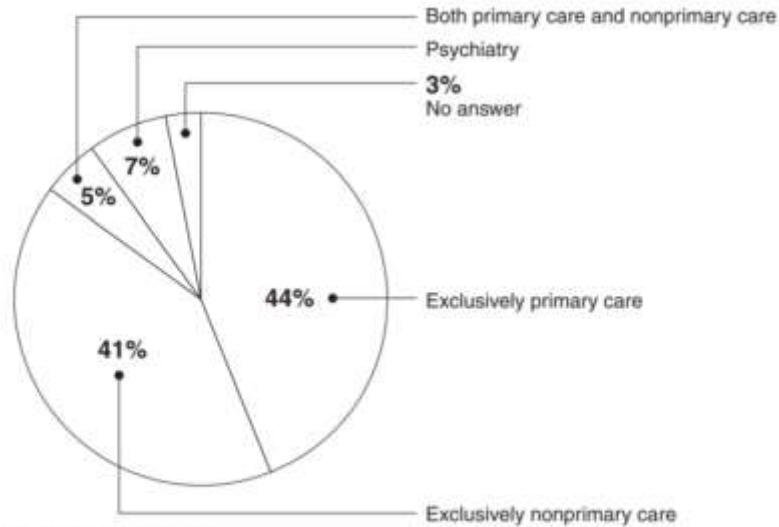
Currently, there are more than 12,000 physicians from 130 countries engaged in residency or fellowship training in J-1 status at approximately 750 teaching hospitals in 51 U.S. states and provinces. J-1 physicians not only serve as vital members of health care teams at the institutions where they train, but also lend a diversity of thought and experience that is invaluable to U.S. health care. As such, over the past 10 years, more than 10,000 J-1 IMGs have worked in underserved communities.¹⁹ Moreover, according to a 2005 Government Accountability Office report, 44 percent of J-1 physicians provided primary care services in underserved communities across this country.

Specialties Practiced by Physicians for Whom States Requested J-1 Visa Waivers, Fiscal Year 2005²⁰

¹⁸ https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf.

¹⁹ <https://www.kunr.org/post/visa-program-enables-foreign-doctors-work-underserved-communities#stream/0>.

²⁰ <https://www.govinfo.gov/content/pkg/GAOREPORTS-GAO-06-773T/pdf/GAOREPORTS-GAO-06-773T.pdf>.



Source: GAO survey of states, 2005.

Note: Percentages are based on 956 waivers requested by 52 states in fiscal year 2005. Puerto Rico and the U.S. Virgin Islands did not request waivers that year. Psychiatry is reported as a separate medical specialty because some states' J-1 visa waiver programs have requirements for psychiatrists that differ from those for other physicians.

The Institute of International Education estimates that during the 2018 academic year, international students alone had a positive economic impact of \$44.7 billion from tuition and fees, food, clothing, travel, textbooks, and other spending. If these students and exchange visitors choose another country over the United States due to overly burdensome immigration laws, then the reduced demand could result in a decrease in enrollment of U.S. medical schools, therefore, negatively impacting school programs in terms of forgone tuition and other fees, jobs in communities surrounding schools, and the U.S. economy.

The number of J-1 physicians participating in U.S. training programs has grown 62 percent over the past decade, illustrating that these physicians have become an essential part of the U.S. health care system, education system, and economy. These residents come from over 130 different countries, attend 1,200 different medical schools, and are selected through a competitive process to join U.S. residency and fellowship programs through the National Resident Matching Program. As such, J-1 physicians bring valuable cultural and intellectual diversity to their U.S. training programs.

However, residency training requires a minimum of three years of training and as many as seven years for surgical specialties. As such, physicians experience numerous immigration hurdles that they must overcome just during their medical education and residency. If programs cannot count on J-1 physicians for uninterrupted training and patient care, they may choose to invest in other, less qualified candidates. This will likely mean that fewer J-1 physicians will apply to U.S. medical schools and residencies knowing that they are unlikely to be matched due to administrative burdens. As such, medical school and residency programs could become less competitive which will likely diminish the overall quality of the U.S. physician workforce. However, if smoother pathways are created for IMGs the positive impacts on U.S. health care will be great, particularly in rural and urban medically underserved areas of the country where J-1 physicians represent a much higher percentage of the trainee and practicing physician workforce.

H-1B physicians

The H-1B visa program was established by Congress to provide an avenue for employers to hire a skilled foreign worker in a specialty occupation. In general, if there are no available U.S. workers to fill a position, then a firm's labor need goes unmet without substantial investment in worker recruitment and training. Accordingly, importing needed workers allows companies to innovate and grow, creating more work opportunities and higher-paying jobs for U.S. workers. As such, the H-1B nonimmigrant visa program allows U.S. employers to temporarily employ foreign workers in specialty occupations. A "specialty occupation" is defined by statute as an occupation that requires the theoretical and practical application of a body of "highly specialized knowledge," and a bachelor's or higher degree in the specific specialty, or its equivalent, as a minimum for entry into the occupation in the U.S.²¹

Since all physicians are required to complete education and training that far exceed an undergraduate degree, there can be no doubt that physicians meet the education requirement. Moreover, since physicians undergo anywhere between three and seven years of residency to expand their knowledge of a specific area of medicine the "highly specialized knowledge" requirement described by statute has also been met. As such, H-1B physicians clearly deserve the "specialty occupation" designation and are critical to filling a gap in our workforce that the U.S. cannot fill on its own.

H-1B physicians fulfill a vital and irreplaceable role. In some specialties, such as geriatric medicine and nephrology, IMGs make up approximately 50 percent of active physicians.²² In other areas IMGs make up about 30 percent of active physicians including in more specialized areas of medicine such as infectious disease, internal medicine, and endocrinology.²³ Thus, H-1B physicians already are required to, and do, meet a very high threshold, and fulfill a need that the U.S. cannot fill on its own.

Immigration barriers

J-1 physicians were surveyed by ECFMG in late 2019 and asked to describe challenges to their well-being. Responses were received from 7,817 physicians and showed that fluctuating immigration laws contribute to a unique set of stressors for this cohort. Further, 63 percent of male respondents reported that visa and immigration concerns were among the top issues impacting their wellness.²⁴ This is not surprising given the massive fluctuation in immigration laws over the past few years and the significant increase in wait time associated with many immigration forms. For example, overall U.S. Citizenship and Immigration Services (USCIS) average processing times have increased by 46 percent over the past two fiscal years and 91 percent since fiscal year 2014.²⁵ As such, a number of administrative changes could help to increase the number of physicians in the U.S. and decrease the stress that IMGs face when applying for visas and green cards. For example, physician J-1 visas could be granted premium processing rights or some other form of expedited processing. With the delays that were caused by COVID-19 and the difficulties that some consulates are facing, a number of J-1 physicians over the past two years have come close to, or completely missed, their residency

²¹ See 8 U.S.C 1101(a)(15)(H)(i)(b), 1184(i).

²² <https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-who-are-international-medical-graduates-imgs-specialty-2017>.

²³ *Id.*

²⁴ <https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-10-26-Duration-of-Status-Comment-Letter-FINAL.pdf>.

²⁵ AILA Policy Brief: USCIS Processing Delays Have Reached Crisis Levels Under the Trump Administration, January 30, 2019, <https://www.aila.org/infonet/aila-policy-brief-uscis-processing-delays>.

start date, putting their training spot in jeopardy. Additionally, Congress could work with DHS to institute a process by which physicians already in the U.S. in valid visa status would receive expedited processing when seeking a change of status through USCIS to either begin a U.S. residency or assume a position in an underserved area of the U.S. Furthermore, at the end of training, supplementary avenues could be presented to residents that would make it easier to avoid the two-year home country return requirement. That way, U.S. trained physicians can stay and practice in the U.S. where they are greatly needed and where considerable time and resources have been put into their training.

Moreover, currently, IMGs with an H-1B status are restricted in terms of the facilities in which they are permitted to work. Also, any work outside the strict limits of the H-1B petition is a violation of the physician's H-1B status. In situations where an employer needs an IMG who possesses H-1B status to work at additional locations, the employer is required to file an amended petition, which is a time-consuming and costly process for the employer. In the current public health emergency, when many IMG physicians are severely restricted in their work locations and in the type of care they can provide (under the terms of their H-1B petitions), some nonimmigrant status physicians have seen their normal worksites closed or have been furloughed. As a result, some IMGs have been unable to work at a time when their services are greatly needed throughout the U.S. Allowing IMG physicians to serve at multiple locations and facilities will provide greater access to health care for millions of Americans. As such, **it would be greatly beneficial to permit IMG physicians currently practicing in the U.S. with an active license and an approved immigrant petition, to apply and quickly receive authorization, to work at multiple locations and facilities with a broader range of medical services for the duration of the COVID-19 pandemic.**

Finally, it would be immensely helpful if physicians who served five years in an underserved community would either be granted an EB-1 status or green cards that are specifically designated for physicians. This would help to decrease the physician green card backlog, incentivize IMGs to remain in the U.S. and serve in underserved communities, and would help to ensure stability in the workforce for those IMG physicians who are already working in the U.S. The AMA has other immigration ideas that could help to streamline the immigration process for physicians and would be happy to work further with the Subcommittee in this area.

Legislation that could help to alleviate the current and impeding physician shortage.

The AMA has been a strong [supporter](https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-5-27-Letter-to-House-re-Support-for-Conrad-State-30-and-Physician-Access-Reauth-Act.pdf)²⁶ of the Conrad 30 program, and H.R. 3541/S. 1810, the "Conrad State 30 and Physician Access Reauthorization Act," for more than a decade.²⁷ Currently, resident physicians from other countries working in the U.S. on J-1 visas are required to return to their home country after their residency has ended for two years before they can apply for another visa or a green card. Established in 1994 by former Senator Kent Conrad (D-ND) and reauthorized numerous times by Congress since its inception, the Conrad 30 program allows these physicians to remain in the U.S. without having to return to their home country if they agree to practice in an underserved area for three years. The "30" refers to the number of physicians per state that can participate in the program. As such, Conrad 30 is a valuable program that ensures that physicians, who are often educated and trained in the U.S., can continue to provide care for their U.S. patients.

²⁶ <https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-5-27-Letter-to-House-re-Support-for-Conrad-State-30-and-Physician-Access-Reauth-Act.pdf>.

²⁷ The AMA has been a strong supporter of the Conrad 30 program in previous congressional sessions (2019, 2017, 2015, 2013, 2012).

Despite the success of the Conrad 30 Waiver program, additional improvements are needed to make the policy function even better. As a result, Congress should expeditiously pass H.R. 3541/S. 1810, “the Conrad State 30 and Physician Access Reauthorization Act.” If enacted, this legislation would enhance the underlying stability of the program by reauthorizing the Conrad 30 waiver policy for an additional three years. The bill also makes targeted improvements by requiring greater transparency in employment contract terms, outlining a process for providing up to 45 waivers per state, and protecting spouses and children of physicians who participate in the program. Most importantly, the legislation provides physicians who practice in underserved areas or at Department of Veteran’s Affairs facilities for five years priority access within the green card system, thereby helping to address the current physician green card backlog.

IMGs are an important part of our U.S. health care teams and serve on medical front lines across the country. Consequently, the ability to recapture 15,000 unused employment-based physician immigrant visas from prior fiscal years would further enable our U.S. physicians to have the support they need and our U.S. patients to access the care they deserve during this unprecedented public health crisis.²⁸ As such, the AMA [supports](#)²⁹ H.R. 2255/S. 1024, the “Healthcare Workforce Resilience Act.” This legislation would recapture 15,000 unused employment-based physician immigrant visas and 25,000 unused employment-based professional nurse immigrant visas from prior fiscal years as a way to bolster our U.S. physician workforce and ensure U.S. patients retain access to the care they deserve during this unprecedented public health crisis.

To further protect patient access to care, the AMA urges Congress to invest in additional Medicare-funded GME positions. Physicians are a vital part of our health care infrastructure, and it is critical that we train more in order to meet the needs of our diverse and growing nation, ensure patient access to care, and prepare for the next public health crisis. As such, the AMA [supports](#)³⁰ H.R. 2256/S. 834, the “Resident Physician Shortage Reduction Act.” This bill would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share of these positions would be given to hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas, hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps.

In addition, the AMA strongly supports H.R. 4014/S. 2094, “the Physician Shortage GME Cap Flex Act,” bipartisan legislation that helps address the national physician workforce shortage by providing teaching hospitals with an additional five years to set their Medicare GME cap if they establish residency training programs in primary care or specialties that are facing shortages. As the nation continues to grapple with the opioid crisis, AMA also supports H.R. 3441, “the Substance Use Disorder Workforce Act”/S. 1438, the Opioid Workforce Act,” which provides 1,000 additional Medicare supported GME positions in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine.

²⁸ Much of our advocacy work related to H-1B visa holders has been with the Administration. On March 31, 2021, the AMA sent the U.S. Department of Homeland Security a [letter](#) identifying several regulations relating to immigration that we urged the Biden Administration to review and revoke, modify, or supersede.

²⁹ [https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-7-Letter-to-House-re-Healthcare-Workforce-Resilience-Act-\(1\).pdf](https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-7-Letter-to-House-re-Healthcare-Workforce-Resilience-Act-(1).pdf).

³⁰ <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-3-24-House-GMAC-Sign-on-Resident-Physician-Shortage-Reduction-Act-of-2021-FINAL.pdf>.

Conclusion

The U.S. health care workforce relies upon physicians from other countries to provide high-quality and accessible patient care.³¹ The physician workforce shortage is well documented, and the pandemic has only served to magnify these workforce issues and other structural problems. The AMA thanks the Subcommittee for this hearing and for the careful consideration of solutions to improve the physician shortage in this country. We look forward to working with the Subcommittee and Congress to seek bipartisan policy solutions that will ensure that patients are provided the best care and that immigration barriers are addressed to resolve the physician workforce shortage and preserve patient access to care.

³¹ https://www.supremecourt.gov/DocketPDF/17/17-965/40128/20180327105855912_17-965%20Amicus%20Br.%20Proclamation.pdf.