February 15, 2022

The Honorable Zoe Lofgren
Chair
Subcommittee on Immigration & Citizenship
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Tom McClintock
Ranking Member
Subcommittee on Immigration & Citizenship
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairwoman Lofgren, Ranking Member McClintock, and Members of the Subcommittee on Immigration and Citizenship:

My name is Jeffrey A. Singer. I am a Senior Fellow in Health Policy Studies at the Cato Institute. I am also a medical doctor specializing in general surgery and have been practicing that specialty in Phoenix, Arizona for over 35 years. I would like to thank the Subcommittee on Immigration and Citizenship for convening a hearing on Tuesday, February 15, 2022, titled "Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System." I appreciate this opportunity to provide my perspective, as a health care practitioner and policy analyst, to assist this committee in its assessment of existing policies that obstruct well-trained immigrant physicians, eager to deliver health care services to Americans, from doing so.

The COVID-19 pandemic brought more clearly into focus this nation's growing need for more health care practitioners. Governors implemented emergency measures aimed at alleviating the shortage by admitting health care practitioners licensed in other states to render care to the states' residents. In some cases, such as with New Jersey, the governor permitted physicians trained, licensed, and experienced in other countries to render care, under supervision, to the state's residents.[i] As the crisis recedes, most emergency measures have come to an end and the regulatory regime regarding healthcare practitioners has returned to the status quo ante.

Even without the pandemic, the United States already needed more physicians. The United States ranks behind most developed countries for physicians per capita.[ii] The shortage of health care practitioners broadly—and the physician shortage more specifically—can be mitigated to some degree if more international medical graduates and licensed and experienced practitioners in other countries would be able to come to the United States and become part of our nation's physician workforce. There are two separate problems that stand in the way: (1) state licensing laws make it difficult for foreign physicians to obtain licenses; and (2) complicated and restrictive immigration regulations make it difficult for foreign-born and educated physicians to work in states independent of state licensing requirements. I will address both issues here.

A cumbersome approval process begun in the late 1950s places daunting obstacles in the way of International Medical Graduates (IMGs) who want to practice in the U.S., keeping tight reins on the already short supply of doctors.[iii] The process is overseen by the Educational Commission for Foreign Medical Graduates (ECFMG), a non-profit organization established in 1956 to "evaluate the readiness" of IMGs to enter graduate medical education programs (residencies and fellowships) in this country.[iv] (Graduates of Canadian medical schools are not considered IMGs.) The American Medical Association and the American Hospital Association soon recognized the ECFMG as the

standard for evaluating IMGs entering the U.S. healthcare system and serving patients in hospitals. The ECFMG obtained responsibility for visa sponsorship of Exchange Visitor physicians (J-1 visas).

Graduates of medical schools outside of the U.S. and Canada must become certified by the ECFMG before they can enter U.S. graduate medical programs. This means they must receive their diplomas from an ECFMG-approved medical school, pass Steps 1 and 2 of the three-step U.S. Medical Licensing Examination (USMLE), complete a graduate medical education program, and then pass Step 3 of the USMLE. State licensing requirements vary regarding IMGs.[v] Some require more years of graduate medical education training than they require from graduates of U.S. and Canadian medical schools before they grant them a license. Most issue licenses to graduates of U.S. and Canadian medical schools after the applicants have passed Step 2 of the USMLE and several don't require these licensees to pass Step 3 to maintain their license.

IMGs who received their diplomas a while ago, however, and have been practicing medicine outside of the U.S.—often for many years—must go through the same process as a fresh medical school graduate. This means they must pass the ECFMG certification—including taking and passing all three steps of the USMLE—and go through a residency training program **all over again.** Then they must apply for state medical licenses. Many very experienced foreign-trained doctors take positions in ancillary medical fields, such as nurse, lab technician, and radiology technician instead of starting all over again. Some enter residency programs in a specialty completely different than the one they are practicing, to be able to work as a doctor in this country. And some, sadly, even work in industries or fields in which their years of training and experience go unutilized.

The Canadian provinces, Australia, and most European Union countries have a provisional licensing system whereby experienced foreign doctors are allowed to practice under the supervision of a licensed domestic physician for a designated period. When the supervisory period is complete, and contingent on passing the same exams required of domestic physicians, they are granted an unconditional license. In many cases they are required to practice for a certain period in an underserved area.[vi]

America's patients would benefit greatly if state lawmakers reformed licensing laws to make it easier for IMGs who complete an accredited U.S. graduate medical program to obtain a license to practice within the state. They would also benefit if state lawmakers would create provisional licensing programs for licensed and experienced physicians who were trained and practice in other countries. Governor Phil Murphy of New Jersey patterned a public health emergency measure on the provisional license model.

However, despite any reforms that state lawmakers might enact, federal immigration laws remain an obstacle for their smooth implementation.

For example, under present law, IMGs who obtained a J-1 visa must return to their country after completing their graduate medical training in the U.S. and may not apply to return to the U.S. for 2 years.[vii] It is unfortunate that these well-trained physicians cannot stay in the country they've called "home" for several years and deliver care to its residents. Under the Conrad 30 J-1 Visa Waiver program, IMGs who complete their postgraduate training and receive a job offer in a medically underserved area in the U.S. may obtain a waiver of the requirement to return home. However, each state is granted just 30 Conrad waivers, and different state regulations affect the usage of these spots. In some states the 30 waivers are rapidly exhausted, while in others they are underutilized.

Furthermore, the physician who works under a Conrad waiver must seek employer sponsorship of an H-1B visa. The H-1B visa program has a cap of 85,000 visas issued per year. Then, in most cases, the physician needs to request that their employer obtain an extension of the H-1B status as well as petition for the physician to receive a green card. This is often easier said than done, because the employer has no guarantee that the physician will stay on after fulfilling the requirements of the Conrad waiver and therefore has no incentive to cooperate.

IMGs who've trained in the U.S. may also obtain a Physician National Interest Waiver (NIW). After again obtaining a letter of need from a state, the NIW allows physicians to apply directly for a green card after serving 5 years in a medically underserved area without the need for an employer-sponsor. But state requirements vary considerably. During that 5-year window the IMG must obtain an H-1B visa through the H-1B lottery and, after that, a green card—both of which are capped.

Meanwhile, experienced and licensed physicians in other countries—some of whom may even be on the faculty of foreign medical schools—must win H-1B visas through the lottery to work in the U.S. and, eventually, obtain a green card under the green card caps if they hope to stay here permanently. The low employer-sponsored green card cap was last updated in 1990, and special limits on immigrants based on birthplace are causing physicians from India and China to face extremely long waits. Many India-born physicians will die waiting for a green card.[viii]

While Congress has no constitutional authority to intervene in state licensing matters, Congress can facilitate state lawmakers who seek to reform state licensing requirements for IMGs and foreign physicians by removing immigration law barriers that impede the effectiveness of state licensing reform.

One way to do this would be to remove the requirement that J-1 visa holders must return to their country of origin for at least two years after they complete their postgraduate training. They should be allowed to apply directly for a green card that would take effect once the J-1 visa expires. At a minimum, Congress should adopt this reform for any physician who works for three years in a medically underserved area without involving state governments.

Congress can—and should—also eliminate the cap on H-1B visas or create an extra allotment of H-1B visas designated for foreign healthcare professionals who now must compete for H-1B visas with other applicants in highly-skilled fields. Likewise, the cap on green cards should be eliminated or an extra allotment created for foreign healthcare professionals. Congress should also guarantee green cards to the family of any healthcare worker if the worker dies while still in a temporary status—a tragedy that is a regular occurrence in the United States.[ix]

These past two years have exposed many weaknesses in our healthcare system. State and federal emergency measures were implemented as workarounds but, unfortunately, were mostly temporary. Congress should not wait for the next pandemic before it addresses these weaknesses. An obvious place to start is by addressing the healthcare work force available to a population that continues to grow and age.

Reforming immigration laws that stand in the way of people from other countries who want to provide health care services to Americans is a good place to start.

Respectfully submitted,

Jeffrey A. Singer, MD, FACS
Senior Fellow
Department of Health Policy Studies
Cato Institute

---

[i] https://www.phillyvoice.com/new-jersey-coronavirus-emergency-medical-license-foreign-doctors-covid-19/
[ii] https://www.kff.org/health-costs/press-release/the-u-s-has-fewer-physicians-and-hospital-beds-per-capita-than-italy-and-other-countries-overwhelmed-by-covid-19/#:~:text=Compared%20to%20Italy%20and%20Spain,Spain%20%E2%80%93%20but%20more%20licensed%20nurses.
[iii] https://www.ama-assn.org/education/international-medical-education/practicing-medicine-us-international-medical-graduate
[iv] https://www.ecfmg.org/about/history.html
[v] https://www.fsmb.org/step-3/state-licensure/
[vi] https://www.royalcollege.ca/rcsite/credentials-exams/assessment-international-medical-graduates-e see also https://scholarlycommons.law.wlu.edu/wlulr-online/vol76/iss2/1/ and http://www.harvard-jlpp.com/wp-content/uploads/sites/21/2019/02/Larkin-Final.pdf
[vii] 8 U.S. Code § 1182(e)
[viii] https://www.cato.org/blog/employment-based-green-card-backlog-hits-12-million-2020
[ix] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780929