COUNCIL ON GRADUATE MEDICAL EDUCATION

Resource Paper

INTERNATIONAL MEDICAL GRADUATES

Immigration Law and Policy and the U.S. Physician Workforce

A COGME Panel Discussion

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Health Resources and Services Administration

The views expressed in this document are solely those of the Council on Graduate Medical Education and do not necessarily represent the views of the Health Resources and Services Administration nor the U.S. Government.

Background

Introduction

Background

The number of International Medical Graduates (IMGs) in the U.S. today is a result of an interplay over the past 50 years of multiple factors. Some of these factors include the exchange visitor program and the accompanying process for obtaining waivers to the requirement for exchange visitors to return home, designations for occupational shortage preferences established during the 1980s, changes in visa regulations inaugurated under the Immigration Act of 1965, and the marked increase in physician demand associated with the passage of Medicare legislation in the early 1970s. As a result, the number of IMGs has risen dramatically, whereas the number of U.S. medical graduates (USMGs) has remained stable, increasing the proportion of IMGs in graduate medical education (GME) and practice.

As explained by the panelists in this resource paper, the entry of IMGs into the physician workforce shares all of the complexity of the U.S. system of temporary and permanent visas and immigration, leading to the various routes of return to and entry into the physician workforce in this and other countries. In sum, however, IMGs play a very direct role in physician distribution and supply as well as the allocation of resources in meeting future health care needs.

COGME Deliberations

Many private and public health policy analysts who consider the current supply of physicians in the U.S. more than adequate view with concern the augmentation of the U.S. physician workforce by IMGs. Reflecting this concern, the Council on Graduate Medical Education (COGME), in its Seventh Report, recommended that Medicare payments to hospitals for IMG residents gradually be reduced to 25% of 1995 levels, to encourage decreasing the number of IMG first-year residents to 110% of U.S. graduates. COGME has subsequently reconsidered this recommendation, and issued new recommendations which are incorporated in the COGME Report on IMGs to be issued in late 1997.

To assist COGME in its consideration of matters related to IMGs, a panel discussion was held March 12, 1996, during a COGME meeting at the Governors House Hotel in Washington, DC. At that meeting, presided by COGME Chair David A. Kindig, COGME members and staff were joined by a panel of experts in the fields of immigration and medical education. The panelists presented and discussed issues involving the following areas:

- The exchange visitor program and the use of waivers
- The complexities of temporary and permanent visas
- The entry of IMGs into GME and the funding of GME
- The impact of IMGs on the U.S. physician workforce

The program was divided into two segments. The first session, Data, Trends, and Physician Education and Workforce Policy, was moderated by Dr. Kindig. The second session, Immigration Law and Policy and Participation in the U.S. Workforce, was moderated by Dr. Sergio Bustamante, chair of COGME's Workgroup on International Medical Graduates.

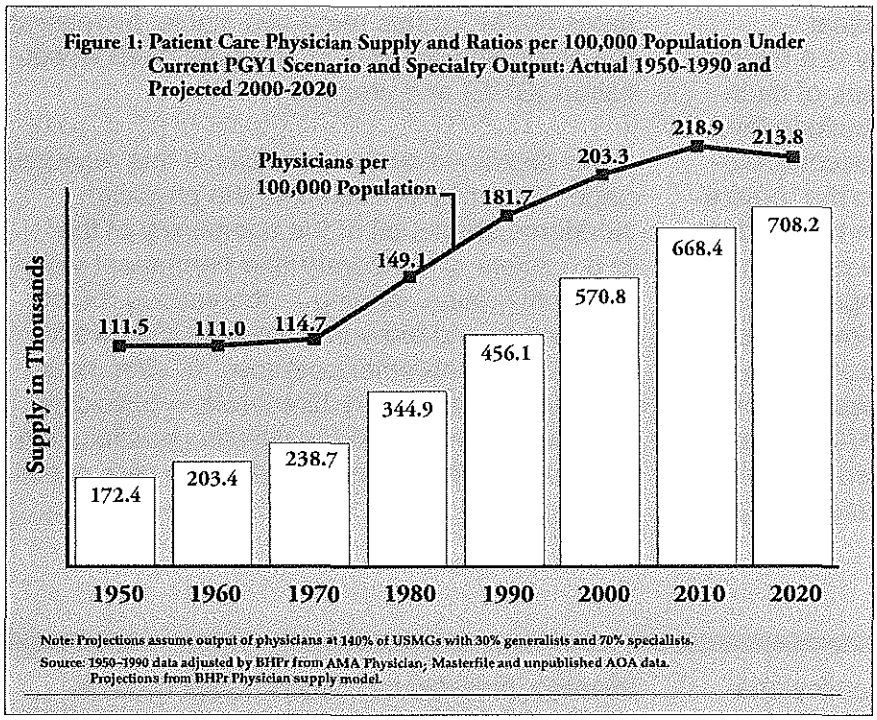

Figure 1: Patient Care Physician Supply and Ratios per 100,000 Population Under Current PGY1 Scenario and Specialty Output: Actual 1950-1990 and Projected 2000-2020

Note: Projections assume output of physicians at 140% of USMGs with 30% generalists and 70% specialists.
Source: 1950-1990 data adjusted by BHPr from AMA Physician; Masterfile and unpublished AOA data.
Projections from BHPr Physician supply model.

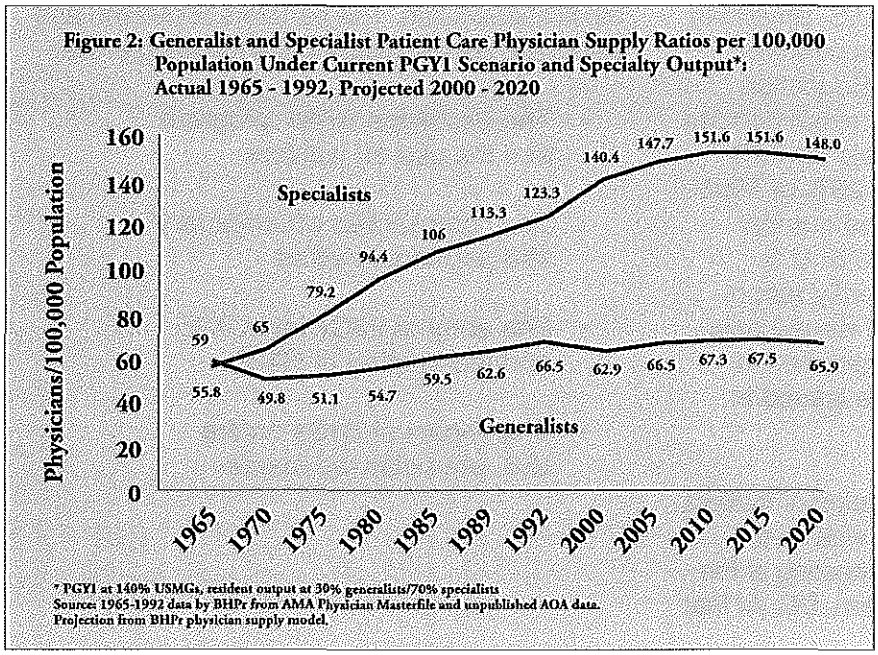

Figure 2: Generalist and Specialist Patient Care Physician Supply Ratios per 100,000 Population Under Current PGY1 Scenario and Specialty Output*: Actual 1965 - 1992, Projected 2000 - 2020

* PGY1 at 140% USMGs, resident output at 30% generalists/70% specialists
Source: 1965-1992 data by BHPr from AMA Physician Masterfile and unpublished AOA data.
Projection from BHPr physician supply model.

COGME believes the discourse of these panel members provides a valuable and substantive contribution to the understanding of these complex issues. Furthermore, it is believed this information should be made available to the public interested in these issues. Thus the proceedings of this panel discussion have been assembled in this report to provide information, education, and insight into the critical role of IMGs in the physician supply in the U.S.

These proceedings and other research dealing with the role that IMGs play in providing health service in the U.S. have contributed to a clarification of these issues by COGME. In its continuing dialogue on this subject, COGME has continued to refine and define these issues, and developed recommendations for reducing residency positions, revising the temporary visa programs but reaffirming the U.S. commitment to international medical education, and improving the U.S. practice environment for USMGs. The new recommendations were issued on June 4, 1997, and will appear in the COGME report on IMGs to be issued in late 1997.

Previous COGME IMG Recommendations

COGME was established to advise the U.S. Congress and the Secretary of Health and Human Services on matters of GME and physician workforce policy, in physician supply and requirements, women in medicine, and GME programs and financing. In addition to IMGs, COGME currently is assessing geographic physician distribution, medical education consortia, minorities in medicine, and physician competencies in managed care.

Several COGME reports have included recommendations relevant to IMGS:

The First Report (July 1988) devoted considerable attention to issues related to IMGs (then called foreign medical graduates or FMGs). Dr. Mullan describes the IMG portions of the report.

The Fourth Report (1994) identified a shortage of generalist physicians, poor geographic distribution of physicians, and potential surplus of physicians in general. It called for moving toward 50% generalist physicians in the physician workforce, and limitation of first-year residency positions to 110% of U.S. medical school graduates in 1993.

The Seventh Report (1995) included a recommendation to reduce Medicare GME payments to 25% of 1995 levels, to encourage hospitals to lower the number of residents

The Eighth Report (Rev 1996) presents a series of statistical analyses that assess the impact of COGMEs earlier recommendations of moving the nations physician workforce toward a GME program consisting of (1) limiting the annual number of first-year training positions to 110% of U.S. medical school graduates and (2) moving toward a better balance of generalists and specialists. These two recommendations constitute the 110:50/50 recommendation. The reader of this Resource Paper will find the rationale behind these proposed changes in earlier COGME reports, particularly the Third Report and the Fourth Report.

The Report to Congress entitled "Process by which International Medical Graduates are Licensed to Practice in the United States," produced by the COGME Medical Licensure Workgroup noted one particular salient finding: processing times were longer for IMGs for initial licensure. Other relevant findings were also noted. The Medical Licensure Workgroup recommended that standardization of licensure policies and processes among States be a goal and that States should share and retain information about credentials of IMGs to facilitate licensure processing and portability.

COGME is pleased to offer this Resource Paper, to provide a greater fund of information in an extremely complex area.

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Opening Remarks

David A. Kindig, M.D., Ph.D.

There are many aspects of data and immigration policy that we need to know more about. This seminar is for COGME membership, in particular the Workgroup on IMGs and for the people who have joined us to discuss issues relating to IMGs in the workforce and in graduate medical education. That is part of our congressional charge from the legislation that sponsors COGME. As early as our First Report, issued in 1988, and continuing with our current Seventh Report, we have been dealing with this issue.

Our latest position recommending the limitation of financial incentives for IMGs in training derives from our supply and requirements perspective. It is a very difficult issue that has implications — social, political, and equity.

The reason for this seminar is to gain a deeper understanding of issues relating to the IMG physician workforce, the residency complement, and immigration. This panel relates to the work of our IMG work group chaired by Dr. Sergio Bustamante, and he and COGME staff, particularly Dr. Stan Bastacky, get a lot of credit for pulling it together.

The first panel is intended to give us some background information and expand on what we know about IMGs in the workforce. This session will be followed by a discussion of issues dealing more generally with immigration policy.

Part I. Data, Trends and Physician Education and Workforce Policy

David A. Kindig, M.D., Ph.D., Moderator

COGME's Role In The IMG Issue

Fitzhugh Mullan, M.D.

The IMG issue is a long-standing one. One of the key elements in COGMEs First Report in 1988 was the findings of a subcommittee that evaluated and heard testimony on IMG issues. The subcommittee came out strongly for competency as a principle, regardless of a person's nationality. It was against differentiation by citizenship status. This was not in terms of payments. In terms of entry into the country, however, the subcommittee was fairly clear that differentiation by citizenship status would be offered, particularly between different categories of IMGs. It felt that educational status was very important and also acknowledged that U.S. graduates ought to be guaranteed positions in the system. These concepts were not integrated into any kind of concrete policy.

The subcommittee supported the creation of a single testing system, and the U.S. Medical Licensure Examination (USMLE) is now in place. Of the various recommendations, the USMLE is the one that has come to fruition. Otherwise, the situation has continued without any major change. Three factors have served to refocus attention on the IMGs in GME: 1) growth in the U.S. physician population; 2) growth in IMGs in GME, contributing

to entry level growth of the physician population; and 3) scrutiny directed to the single most palpable engine of GME funding, Medicare GME.

In the overall physician workforce, IMGs have been an important component for many years. In 1970, 18% of all physicians were IMGs, and in 1992, IMGs represented 23% of the active physician population (Table 1). The IMG component of the U.S. physician workforce has grown significantly, and the size of the U.S. physician workforce has about doubled over these years. The number of IMGs in practice has increased from 57,000 to almost 140,000, with a growing percentage — almost a quarter — of practicing physician IMGs.

Roughly 20% of individuals in training in GME were IMGs in 1980, which dropped to a low of 14% (Fig. 3). Since 1988, the numbers have climbed, and today nearly 25% of residents are graduates of international schools. Currently, the U.S. component of IMGs is around 10%. In previous years it was a good deal higher, representing a greater departure of U.S. medical students to offshore medical schools. The percentage will probably increase as a result of the recent interest in medical education and anecdotal suggestions that more U.S. students are being educated abroad.

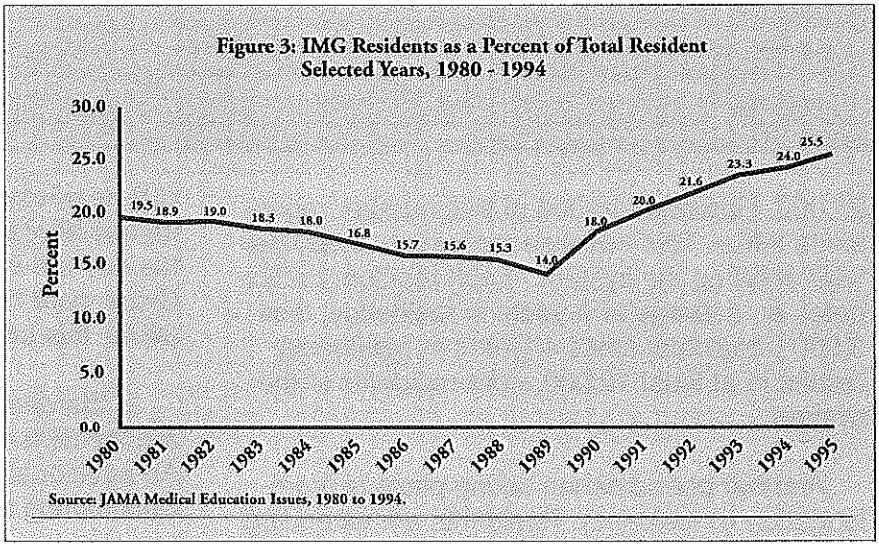
Relatively good data are available on GME during 1988 – 94. Every effort has been made to look retrospectively at the numbers of people in residency by specialty and by geography. The number of first-year IMG residents increased by almost 3,200 over that period (Fig. 4). The total number of first-year residents increased by a little less than 2,700 because of the 485 decrease in the number of USMGs. The U.S. medical student pool is flat and, in fact, shows a slight diminution over this period, indicating that all of the ingress, all of the accessions to GME, all of the increases in terms of people are derived from IMGs.

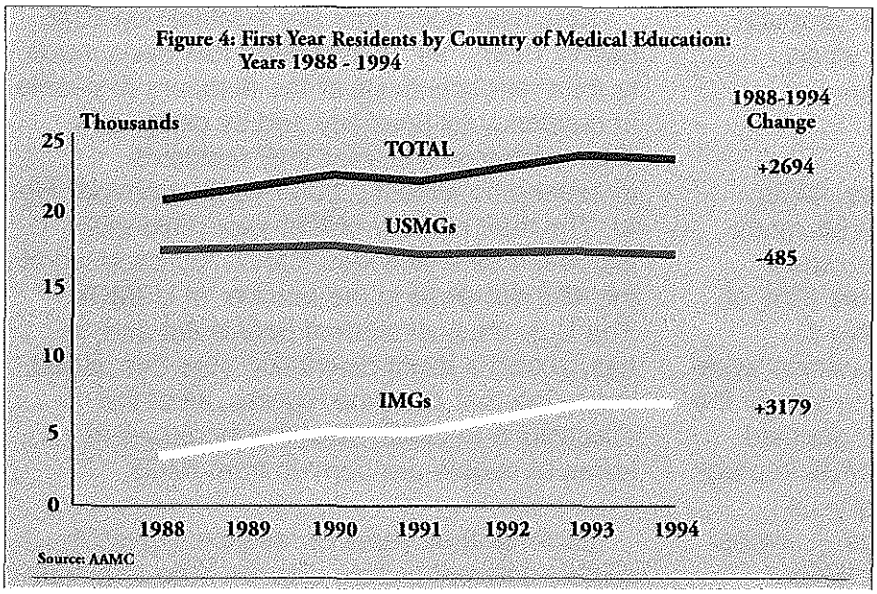
Looking at all years of residency gives a slightly different picture (Fig. 5). The total number of residents in training increased by almost

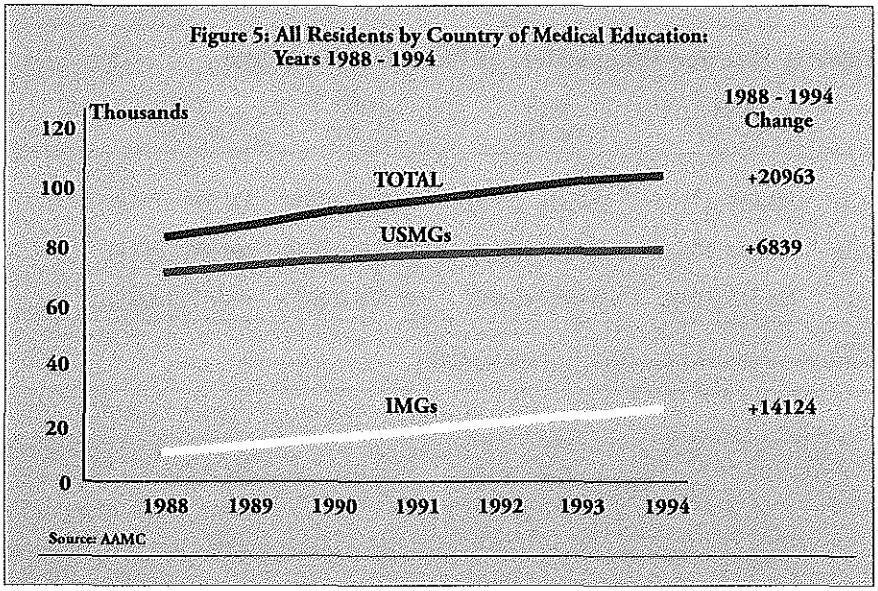
Table 1. Size and Composition of Physician Workforce

Graduate	1970 No. (%)	1980 No. (%)	1991 No. (%)	1992 No. (%)	1994 No. (%)
USMG*	259,240 (81.9)	343,697 (78.9)	460,356 (77.4)	466,599 (77.0)	483,039 (76.4)
IMG	57,217 (18.1)	91,815 (21.1)	134,341 (22.6)	139,086 (23.0)	149,082 (23.6)
Total	316,457 (100.0)	435,512 (100.0)	594,697 (100.0)	605,685 (100.0)	632,121 (100.0)

Source: AMA Physician Masterfile.
*Includes graduates of Canadian schools accredited by the Liaison Committee for Medical Education.







21,000. However, 14,000 of that number represents IMGs. This increase represents 3,000 per year entering the system. Each resident participates an average of 4 years in residency; thus 3,000 [residents] times 4 [years in residency] results in at least 12,000 more residents in the system.

Another phenomenon taking place is a prolongation of residency. Residents are extending their education for additional years, which explains the 7,000 additional USMGs in training while the number entering the system remains stable. IMGs contribute 12,000 additional people in the system. It is estimated that 70 – 80% of IMGs who enter residency eventually enter practice and remain in practice in this country.

The percent over USMGs that the USMG add-on represents in a given year states the figures somewhat more dramatically, but in terms of tracking, it is a useful measure. In 1988, it was 28% more, or 128%. By 1993 it was 148%, reflecting the increasing numbers in each year in the first postgraduate year.

Interestingly, data from 1993 show that the common wisdom about IMGs visa status is not correct (Table 2). In a breakdown of the visa status of IMGs, 10% are native U.S. citizens, and nearly 12% are naturalized U.S. citizens. The latter are individuals trained abroad, presumably born abroad, who have become U.S. citizens. Thirty percent are permanent U.S. residents. These are individuals born and trained abroad who have established a visa status and are in the process of becoming citizens. Green card holders are permanent residents. (Note: this table has been updated.)

In the exchange visitor category are the 35% who have a J visa or an H visa. An additional 11% are not categorized. Considering that 10% are U.S. citizens,

another 12% have been naturalized and are now U.S. citizens, and 30% are permanent residents, over 50% either are citizens or will become citizens. It is unlikely that the permanent resident category is going to be changed or modified in any significant way, and certainly not for medical purposes.

Table 2. Citizenship and Visa Status of IMG Residents

Category	1988 No. (%)	1990 No. (%)	1992 No. (%)	1993 No. (%)	1994 No. (%)	1995 No. (%)
Native U.S. Citizen	3,357 (27.0)	2,817 (18.9)	2,393 (12.5)	2,366 (10.4)	2,053 (8.7)	2,057 (8.2)
Naturalized U.S. Citizen	1,774 (14.3)	2,209 (14.8)	2,622 (13.7)	2,690 (11.8)	2,232 (9.5)	1,973 (7.9)
Permanent U.S. Resident	4,134 (33.3)	4,974 (33.4)	6,192 (32.4)	6,982 (30.7)	6,772 (28.8)	6,985 (28.0)
Exchange Visitor	2,098 (16.9)	3,470 (23.3)	6,009 (31.5)	8,045 (35.4)	9,006 (38.3)	9,183 (36.8)
Other	1,070 (8.6)	1,444 (9.7)	1,868 (9.8)	2,623 (11.5)	3,436 (14.6)	4,784 (19.1)
Total	12,433 (100.0)	14,914 (100.0)	19,084 (100.0)	22,706 (100.0)	24,399 (100.0)	24,982 (100.0)

Source: The Perspective of the Educational Commission for Foreign Medical Graduates (ECFMG) on Graduates of Foreign Medical Schools 1991-1992. Philadelphia: Educational Commission for Foreign Medical Graduates, January. Data from JAMA medical education issues 1989 through 1994.

The exchange visitor category, which is more within reach of policy makers, warrants attention. The H visa situation is out of control, and the J visa situation deserves scrutiny. These categories represent roughly one-third of the people in the system. It is an expansive category, and it has grown rapidly in recent years, reaching 35% in 1993. Significantly, over 50% are really beyond the reach of immigration policy to effect changes. Thus, if there is a desire or a need to manage or control the growth of these categories, changes would be more likely in GME policy than in immigration policy.

There is a great deal at stake beyond just numbers. These policies are national and they affect human beings and their aspirations. The role of the U.S. touches people from many other nations, their aspirations, their family ties. It is not an area to enter into lightly. Todays highly charged environment makes it difficult to consider the issue in exclusion without risking accusations of discrimination.

Nonetheless, the deliberations of COGME, and certainly the writings of myself and others in the Bureau of Health Professions, derive not from any discriminatory basis but rather from the need to manage the workforce and the opportunities that are publicly funded in this country. The U.S. has a tradition of extending opportunity to people from all over the world from whence almost all of us, other than Native Americans, came. We all need to be terribly respectful of this.

The contribution of IMGs to health care of this country is enormous. They provide a quarter of it, and it's very valuable. I have great respect for the work that they have done. That leads me to several caveats about these discussions.

As COGME has raised it, this is not a quality issue. There have been and there will be issues about quality and various efforts to measure different sectors of the educational pool, but that is not the issue we're addressing. It is not an issue either for anyone who is in training or in practice in this country. We're not talking about anything that would discommode or change or diminish opportunities for anybody

who is in the system, either in training or in practice. It is not, in my judgment, principally an immigration issue, but instead about educational funding and opportunities linked to issues of staffing and labor. Inevitably, all residents are a hybrid of student and labor, and clearly we can't avoid the labor issue with regard IMGs, just as we can't avoid it for USMGs. Nonetheless, it is principally an educational issue and an issue, with regard to Medicare dollars, of investment, how we wish to invest large, valuable, hotly contested public U.S. taxpayer-derived dollars. That's how we've arrived at the issue, and that's the context in which I believe it's being discussed.

The COGME proposal is based on the surmise that because we are in a situation of physician surplus and will become more so, both with the continued growth in the physician-to-population ratio and the continued march of managed care, we should curtail the growth of the workforce. Thus, in this market environment, disincentives to draw more IMGs into GME should be created, or at least, incentives that currently exist should be discouraged. Therefore, the proposal in COGMEs Seventh Report is to diminish funding from 100% down to 25% for IMG positions. There two ways in which this can be done.

One way to diminish funding would be by slots; that is, freeze the slots now and phase down the funding of those slots currently occupied by IMGs to 25% of the full funding. The other way would be to do it by individual; that is, run some kind of quality-oriented or lottery-driven competition and fund only certain individuals that would equal 25% of the current numbers funded. Those individuals would be fully funded, and others would not be funded at all.

These two approaches to achieving a 75% reduction were presented for consideration. A 75% reduction would result in a number funded that would equal about 110% of the USMGs, which is the figure that COGME has consistently recommended.

In 1995, Congresswoman Nancy Johnson, a Republication from Connecticut who sits on the House Ways and Means Committee on the Subcommittee on Health, proposed legislation derived from the COGME recommendation. As part of the initial proposal, she suggested the adoption of a differential payment for U.S. citizen graduates with a cut-off established at a different level than COGME recommended. The proposal would, therefore, have favored both USMGs and U.S. native IMGs. Although the legislation did not follow our suggestions, at least it reflected some of the principles behind COGMEs recommendations. The proposal became part of Medicare legislation under consideration this year and is currently pending.

The Pew Health Professions Commission came out with a series of recommendations in December 1995 that proposed cutting U.S. medical school enrollments by approximately 20%. In that report were a series of other proposals that were far less controversial and, from my perspective, made a lot of sense. Most were in concert with COGME, including a severe restriction of funding for IMGs.

In the wake of the Pew Commission report came the Institute of Medicine report, which was much more in concert with COGME thinking. The report focused on the IMG situation as part of the way to control the system. The report pointed out that if GME isn't controlled, cutting back on U.S. undergraduate education in the current environment will cause hospitals to seek residents abroad. Thus, cutting U.S. education without controlling GME in general is counterproductive.

The challenge for us — and for the country — is to calibrate and to deliver. Calibrating means trying to arrive at a more general consensus regarding the right number of physicians

for the country. There are over 17,000 medical school graduates in this country annually. We're training 25,000 a year, some 23,000 or 24,000 of whom will enter into practice. Between the 17,000 trained and 24,000 going into practice, what is the right number?

Once agreement is reached on the right number, or we come closer to a consensus, the next question is how to deliver. In the current situation, the resident is used to fill a lot of holes in the health care system; the IMG resident, in particular, plays a role in inner city hospitals and teaching hospitals. The international graduates have contributed to rural health and inner city health in a substantial way, although the data seem to show that the ultimate practice patterns of IMGs in terms of both geographic location and in terms of specialty were quite close to those of their U.S. counterparts, notwithstanding the fact that certain communities have traditionally been IMG-reliant in a variety of ways.

The delivery notion — how you recalibrate the system to make sure that both the residents and the graduate physicians in it are reasonably distributed in terms of urban and rural areas, in terms of rich and poor populations — remains a problem. We have addressed that problem in a kind of backhanded way by using residents and IMGs in a way that, if we calibrate, we also have to be concerned about how to deliver. There are some very good ways that we can deliver. We need to create educational opportunities for the appropriate number of people and the appropriate types of people, including nurse practitioners, physician assistants, and others who can help in the delivery of health care in both the primary care sector and in the specialty sector.

We need to do much more than we have done, and we can do much more than we have done in linking service to education. The National Health Service Corps (NHSC) is a fabulous model of how people who are eager to get into a profession are willing to undergo a period of service in exchange for educational subsidies. This service is provided under a fairly directed circumstance, which can be exploited and developed and used much more broadly and effectively, including specialty and hospital care. We should increase practice incentives to those communities in which it is difficult to retain health professionals. The capability exists for the U.S. to train and deploy a workforce to take care of its own citizens. While our role in training people from abroad for them to return to their countries is a very important one and should continue, and while the contribution of IMGs to this country has been substantial, failure to deal with problems in the system and continuing to inflate the size of our workforce creates a collision course that we have thus far been able to sweep under the table. With the growing surplus of physicians, the problem must be confronted.

We have the resources to deal with this problem. Every year, thousands of young people in the U.S. are turned away from medical school and, in many cases, from opportunities to be trained as nurse practitioners and physician assistants. We are ready, willing, and eager, to swap education for service. With the right incentives, we can certainly recalibrate in order to do that. It does take political will; in terms of finances, Medicare funds would suffice provided funding is dropped for unneeded slots. Incentives should be put in place to get people where we need them and flatten out the growth in the workforce.

That final note is an editorial. Obviously, I no longer speak for the government nor for COGME, but it's certainly in concert with a lot of the work that COGME has done.

Dimensions Of The International Medical Graduate Presence In The U.S.

Stephen S. Mick, Ph.D.

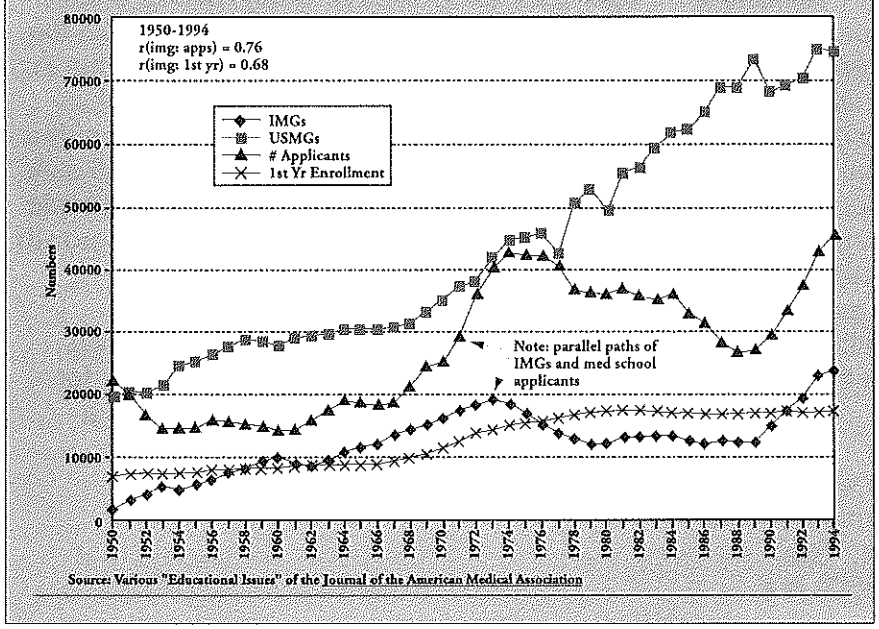
From 1970 through 1992, there was an increase of some 82,000 IMGs, or roughly 143%. The increase in USMGs was about 237,000, or roughly 94%. The rate of growth of IMGs was nearly 50% greater than that of USMGs. Although the actual increase in the number of USMGs was about 2.9, or 3 times greater than that of IMGs, IMGs have unquestionably contributed to the increase in the overall size of the physician workforce. Not counting IMGs, the number of physicians in the U.S. would be approximately 500,000 instead of the current 630,000.

The growth of IMGs and USMGs in U.S. training programs was parallel from 1950 until the early 1970s. In the 1980s, the number of IMGs declined and then stabilized somewhere around 13,000 – 14,000. Meanwhile, USMG resident growth continued. In 1989, for reasons that are perplexing but absolutely critical for the deliberation of COGME or any group interested in health policy, IMGs began an unprecedented spurt of growth. The absolute number of IMG residents now surpasses the highs of the early 1970s.

The number of U.S. medical school applicants and first-year enrollees in U.S. medical schools also followed interesting patterns during that period (Fig. 6). With the exception of the early 1950s, when the GI Bill supported all the people coming back from World War II, there has been an astonishing parallelism between the number of medical school applicants and the number of IMG residents (a correlation coefficient of .76).[1]

The size of the first-year class of U.S. medical schools has remained remarkably stable. The effect of increasing the number of medical schools and the size of medical school classes that occurred in the 1960s and 1970s has flattened. There is a correlation coefficient of .68 between IMGs and first-year enrollment, suggesting that IMGs have not had a suppressing effect on the decision of accepted applicants to enter into medical school.

Figure 6: Number of IMG & USMG Residents, Applicants to U.S. Medical Schools, and First-Year U.S. Medical School Enrollment, 1950-95



During the period of relative inactivity in policy formulation concerning IMGs, there was not much study of the role of IMGs or of the physician workforce in general. Where the number of IMG residents crosses the line of first - year enrollment, there is a correspondence, I believe, in the periods of greatest

1 A correlation coefficient quantifies the strength of the relationship between two variables and can vary from +1 through 0 to -1; +1 indicates a perfect positive relationship, and -1 indicates a perfect negative relationship. Zero indicates no relationship. This finding raise issues about broader, but not well defined, forces that make medicine attractive to U.S. citizens and Native American citizens as well as to IMGs.

agitation, concern, and worry about the IMG presence in America.

The annual rate of change, based on a 3-year average, for IMGs usually increases at a lower rate or decreases at a higher rate than that of the comparable group of USMGs. From the early 1970s until the end of the past decade, there was again a remarkable parallelism, but what is even more remarkable is what happened in 1989 and 1990. The rate of growth for IMG residents exceeded that of USMGs for the first time. This historically atypical relationship underscores that something new and different may contribute to this latest episode in the growth of IMGs.

Since the early 1970s, the IMG phenomenon has been a two-forked one — the foreign national IMG, and the U.S. citizen IMG. From 1972 to 1985, many observers were predicting the eventual disappearance of foreign national IMG residents. The steady increase of the U.S. citizen IMG pool has declined and stabilized. Anecdotally, we are getting word that the offshore schools are up and running again.

There are probably at least four things that propel this situation historically: (1) the foundation of the offshore schools in the Caribbean Islands; (2) the incredibly strong, politically savvy network of parents of U.S. citizen IMGs, especially in New York and New Jersey; (3) the Fifth Pathway Program, which gave preferential treatment to many U.S. IMGs to do a sort of interim-year residency after medical school and before the usual first-year residency, which was geared almost exclusively to the graduates of the Autonomous University of Guadalajara; and (4) the continuation until 1984 of U.S. IMG's ability to take the standard one-day Education Commission for Foreign Medical Graduates (ECFMG) examination, whereas any foreign national IMGs who wanted the J visa had to take the 2-day visa-qualifying examination, which was presumably more difficult.

Both IMGs and USMGs are mostly found in metropolitan areas, but about 23% of the U.S. population lives in nonmetropolitan areas, so neither group could be said to be equally distributed with regard to the general population (Table 3). Even so, it is apparent that IMGs are less likely than USMGs (9.1% versus 12%) at the aggregate level to be in rural counties, and from that it is often concluded that the IMGs are not serving in any disproportionate capacity in rural America.

In most metropolitan areas, there is a reasonably even distribution of both groups. At the very largest metropolitan county size

Table 3. County Size Location: IMGs (ECFMG Certified 1969-82) and U.S. Medical Graduates, December 31, 1987*

County Size	IMG No. (%).		USMG No. (%)		County Size	IMG No. (%).		USMG No. (%)	
Non-Metro					**Metro**				
<10,000	156	(0.3)	681	(0.4)	50,000-499,999	6,714	(13.6)	36,072	(19.2)
10,000-24,999	700	(1.4)	3,865	(2.1)	500,000-999,999	7,085	(14.4)	28,352	(15.1)
25,000-49,999	1,478	(3.0)	7,238	(3.8)	1,000,000-4,999,999	20,881	(42.4)	80,840	(43.0)
≤ 50,000	2,129	(4.3)	10,826	(5.8)	≥ 5,000,000	10,161	(20.6)	20,208	(10.7)
Subtotal	4,463	(9.1)	22,610	(12.0)	Subtotal	44,841	(90.9)	165,472	(88.0)
Total	**IMG. No. (%) 49,304 (100.0)**				**USMG No. (%) 188,082 (100.0)**				

Source: American Medical Association Physician Masterfile and the Educational Commission for Foreign Medical Graduates.

Statistical comparison across the eight county locations: Chi-square = 3967.547, $p < .001$, phi = 0.129

Statistical comparison for aggregate non-metro versus metro location: Chi-square = 340.882, $p < .001$, phi = 0.038

*Omits address unknown

— 5 million or more — the percentage is 20.6 versus 10.7. The denominator in each case is the total number of IMGs in one case, the total number of USMGs in the other. Some argue that IMGs are more likely to be practicing medicine in inner city locales, but that is not obvious from data derived at this level of aggregation. Virtually no studies have looked at which patient populations are or are not served.

A disaggregation of national data into smaller geographic units can be used to assess geographic distribution (Tables 4, 5, 6). In the West North Central, East North Central, and East South Central Divisions, especially the latter, IMGs are more likely to be located in nonmetropolitan counties. In the West South Central region, IMGs are more likely to be in the nonmetropolitan counties of 50,000 population or less. In all cases there are significant associations, but the association is weak. For states that had at least 850 IMGs in the study population, excluding New Jersey which has no rural counties by definition, Florida, Illinois, Texas, Pennsylvania, and Ohio all show greater relative IMG location in nonmetropolitan counties. The largest metropolitan county category — New York, California, Illinois — not surprisingly show the highest IMG concentration. The next largest metropolitan county areas —- Michigan, and Florida — also have large numbers of IMGs.

Looking at the similarity in the distributions of IMGs and USMGs, it could be argued that IMGs are not in major ways different from USMGs and thus are not filling the gaps. Conversely, the existence of these associations and the percentage differences, translated into numbers,

Table 4. States by Census Regions and Divisions

Region/Division	State	Region/Division	State
NORTHEAST		South Atlantic	Delaware
Middle Atlantic	New Jersey		District of Columbia
	New York		Florida
	Pennsylvania		Georgia
			Maryland
New England	Connecticut		North Carolina
	Maine		South Carolina
	Massachusetts		Virginia
	New Hampshire		West Virginia
	Rhode Island		
	Vermont	West South Central	Arkansas
			Louisiana
NORTH CENTRAL			Oklahoma
East North Central	Illinois		Texas
	Indiana	**WEST**	
	Michigan	Mountain	Arizona
	Ohio		Colorado
	Wisconsin		Idaho
			Montana
West North Central	Iowa		Nevada
	Kansas		New Mexico
	Minnesota		Utah
	Missouri		Wyoming
	Nebraska		
	North Dakota	Pacific	Alaska
	South Dakota		California
			Hawaii
SOUTH			Oregon
East South Central	Alabama		Washington
	Kentucky		
	Mississippi	**POSSESSIONS**	Puerto Rico
	Tennessee		Virgin Islands
			Pacific Islands*

*Includes Canton, Caroline, Guam, Marianas, Marshall, Samoa, Wake, Ponape, Truk, and Yap

Table 5. County Location Within U.S. Census Divisions: IMGs (ECFMG Certified 1969-82) and U.S. Medical Graduates, December 31, 1987*

County Size	IMG (%)	USMG (%)
NEW ENGLAND		
Non-Metro		
< 50,000	1.2	3.6
≥50,000	4.5	8.0
Metro		
50,000-999,000	45.7	38.7
1,000,000-4,999,999	48.6	49.7
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	2,600	13,990
IMG vs USMG: Chi-square = 104.443, p < .001, phi = 0.079		
MIDDLE ATLANTIC		
Non-Metro		
< 50,000	1.1	1.8
≥50,000	2.8	3.3
Metro		
50,000-999,999	23.6	23.4
1,000,000-4,999,999	37.4	43.8
≥5,000,000	35.1	27.8
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	14,508	28,666
IMG vs USMG: Chi-square = 303.029, p < .001, phi = 0.084		
EAST NORTH CENTRAL		
Non-Metro		
< 50,000	4.8	5.1
≥50,000	5.5	4.7
Metro		
50,000-999,999	27.6	33.1
1,000,000-4,999,999	31.5	35.4
≥5,000,000	30.6	21.7
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	8,084	22,611
IMG vs USMG: Chi-square = 282.475, p < .001, phi = 0.096		
WEST NORTH CENTRAL		
Non-Metro		
< 50,000	20.5	17.3
≥50,000	3.6	3.3
Metro		
50,000-999,999	28.3	35.9
1,000,000-4,999,999	47.6	43.5
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	1,859	13,254
IMG vs USMG: Chi-square = 42.899, p < .001, phi = 0.053		

County Size	IMG (%)	USMG (%)
EAST SOUTH CENTRAL		
Non-Metro		
< 50,000	20.0	13.0
≥50,000	10.3	10.1
Metro		
50,000-999,999	68.8	75.1
1,000,000-4,999,999	0.9	1.8
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	1,317	10,439
IMG vs USMG: Chi-square = 53.768, p < .001, phi = 0.068		
SOUTH ATLANTIC		
Non-Metro		
< 50,000	5.1	6.1
≥50,000	5.5	7.2
Metro		
50,000-999,999	27.9	39.5
1,000,000-4,999,999	61.5	47.2
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	8,773	36,272
IMG vs USMG: Chi-square = 588.667, p < .001, phi = 0.114		
WEST SOUTH CENTRAL		
Non-Metro		
< 50,000	10.1	8.1
≥50,000	2.3	3.9
Metro		
50,000-999,999	37.1	40.7
1,000,000-4,999,999	50.5	47.3
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	3,976	17,651
IMG vs USMG: Chi-square = 55.126, p < .001, phi = 0.050		
MOUNTAIN		
Non-Metro		
<50,000	9.9	13.0
≥50,000	10.9	9.7
Metro		
50,000-999,999	34.9	34.0
1,000,000-4,999,999	44.2	43.3
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	1,099	10,931
IMG vs USMG: Chi-square = 9.625, p < .05, phi = 0.028		

Table 5 (Continued). County Location Within U.S. Census Divisions: IMGs (ECFMG Certified 1969-82) and U.S. Medical Graduates, December 31, 1987*

County Size	IMG (%)	USMG (%)	County Size	IMG (%)	USMG (%)
PACIFIC			**PACIFIC**		
Non-Metro			**Metro**		
< 50,000	0.9	2.2	50,000-999,999	15.5	19.6
_ 50,000	1.9	4.4	1,000,000-4,999,999	42.8	51.7
			_ 5,000,000	38.9	22.1
			Total IMG/USMG (%.)	100.0	100.0
			Total IMG/USMG (no.)	6,683	33,260
			IMG vs USMG: Chi-square = 906.476, p < .001, phi = 0.151		

Source: American Medical Association Physician Masterfile and the Educational Commission for Foreign Medical Graduates.
*Omits unknown county location.

could lead to the conclusion that those large numbers could mean that IMGs are helping to fill the gap. Part of the debate revolves around what is meant by gap filling. If it is defined as some deviation from expectations measured by a statistical test, one may use the approach I have shown. Or one may simply want to look at the raw numbers or estimates and ask the question, Are there enough doctors, in this instance, IMGs, to make the case that without them an appreciable number of persons would have their access to health services reduced?

In the county category size of 25,000 to about 50,000, there are some interesting numbers. In Florida, 35 IMGs are in those counties versus 39 USMGs. In New York State, there are 49 IMGs and 104 USMGs. In Illinois, there are 94 IMGs and 149 USMGs. In Ohio, there are 85 IMGs versus 215 USMGs. In Texas, there are 137 IMGs versus 344 USMGs. The question remains whether without these IMGs in place, the access problem would be greater. In order to answer to this question, we need to know what these doctors are doing, their specialties, their mode of practice, and the populations they are serving. Is there any reason to expect that USMGs would replace the IMGs if somehow the IMGs were removed, either by some sort of fiat or through the gradual reduction of IMGs by gradual reduction through GME? The ultimate question is, Would there be a concomitant movement of USMGs into these places?

From 1980 to 1994, there has been an increase in the proportion of IMGs as a total all of residents in internal medicine, moving to about 53% of all residents in 1994. There has also been a mild decline and then a sharp increase in IMGs in psychiatry. Internal medicine, pediatrics, and family medicine represent an overall percentage of IMGs well in excess of USMGs training in the so-called primary care specialties. There are 12,571 IMGs, or 53% in these specialties in the most recent training year for which data are available, versus 24,000, or 24.6% of USMGs in the specialties.

Although there are a lot of IMGs in internal medicine, it is not clear whether they're all going to subspecialize. For the period 1987 – 94, I calculated a total number of medical graduates in each group who are either in internal medicine or one of the internal medicine subspecialties. I then took the number in the subspecialties as the numerator and the total in both internal medicine and subspecialties as the denominator, and calculated the percentage. The overall IMG/USMG residents have been

Table 6: County Location: States (> 850 IMGs), IMGs (ECFMG Certified 1969-82), and U.S. Medical Graduates, December 31, 1987*

County Size	IMG (%)	USMG (%)
NEW YORK		
Non-Metro		
< 50,000	0.6	0.9
≥50,000	2.8	3.7
Metro		
50,000-999,999	14.6	18.1
1,000,000-4,999,999	21.5	20.7
≥5,000,000	60.5	56.6
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	8,421	14,050
IMG vs USMG: Chi-square = 68.496, p < .001, phi = 0.055		
CALIFORNIA		
Non-Metro		
< 50,000	0.6	0.9
≥50,000	1.2	1.9
Metro		
50,000-999,999	12.7	13.1
1,000,000-4,999,999	42.7	54.2
≥5,000,000	42.8	29.8
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	6,065	24,577
IMG vs USMG: Chi-square = 398.495, p < .001, phi = 0.114		
FLORIDA		
Non-Metro		
< 50,000	2.3	1.0
≥50,000	4.0	3.5
Metro		
50,000-999,999	33.5	54.2
1,000,000-4,999,999	60.2	41.4
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	3,925	8,081
IMG vs USMG: Chi-square = 470.696, p < .001, phi = 0.198		
ILLINOIS		
Non-Metro		
< 50,000	4.2	3.4
≥50,000	5.2	3.3
Metro		
50,000-999,999	15.8	23.2
1,000,000-4,999,999	2.1	3.2
≥5,000,000	72.7	66.8
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	3,398	7,360
IMG vs USMG: Chi-square = 109.484, p < .001, phi = 0.101		

County Size	IMG (%)	USMG (%)
TEXAS		
Non-Metro		
< 50,000	8.0	5.5
≥ 50,000	1.0	1.2
Metro		
50,000-999,999	32.6	30.7
1,000,000-4,999,999	58.4	62.6
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	2,862	11,084
IMG vs USMG: Chi-square = 34.888, p < .001, phi = 0.050		
PENNSYLVANIA		
Non-Metro		
< 50,000	4.1	3.9
≥50,000	6.5	4.1
Metro		
50,000-999,999	28.4	25.4
1,000,000-4,999,999	61.0	66.6
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	2,580	10,064
IMG vs USMG: Chi-square = 42.458, p < .001, phi = 0.058		
OHIO		
Non-Metro		
< 50,000	4.2	3.4
≥50,000	7.5	5.5
Metro		
50,000-999,999	39.6	32.0
1,000,000-4,999,999	48.8	59.2
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	2,120	6,779
IMG vs USMG: Chi-square = 72.111, p < .001, phi = 0.090		
MICHIGAN		
Non-Metro		
< 50,000	4.5	6.9
≥50,000	3.1	5.0
Metro		
50,000-999,999	26.0	43.7
1,000,000-4,999,999	66.4	44.4
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	2,028	5,310
IMG vs USMG: Chi-square = 285.003, p < .001, phi = 0.197		

Table 6 (Continued): County Location: States (> 850 IMGs), IMGs (ECFMG Certified 1969-82), and U.S. Medical Graduates, December 31, 1987*

County Size	IMG (%)	USMG (%)
MARYLAND		
Non-Metro		
< 50,000	0.6	1.5
≥50,000	1.5	1.6
Metro		
50,000-999,999	3.9	2.1
1,000,000-4,999,999	94.1	94.9
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	1,709	5,916
IMG vs USMG: Chi-square = 26.037, p < .001, phi = 0.058		
MASSACHUSETTS		
Non-Metro		
< 50,000	0.1	0.1
≥50,000	1.0	2.1
Metro		
50,000-999,999	25.3	19.4
1,000,000-4,999,999	73.6	78.3
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	1,311	7,490
IMG vs USMG: Chi-square = 30.116, p < .001, phi = 0.058		

County Size	IMG (%)	USMG (%)
CONNECTICUT		
Non-Metro		
< 50,000	0.0	0.0
≥50,000	4.2	4.9
Metro		
50,000-999,999	62.2	61.7
1,000,000-4,999,999	33.5	33.5
≥5,000,000	0.0	21.7
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	898	3,244
IMG vs USMG: Chi-square = 0.647, NS, phi = 0.013		
VIRGINIA		
Non-Metro		
< 50,000	9.8	11.2
≥50,000	4.4	4.3
Metro		
50,000-999,999	26.4	36.2
1,000,000-4,999,999	59.5	48.3
≥5,000,000	0.0	0.0
Total IMG/USMG (%.)	100.0	100.0
Total IMG/USMG (no.)	891	4,892
IMG vs USMG: Chi-square = 41.014, p < .001, phi = 0.084		

Source: American Medical Association Physician Masterfile and the Educational Commission for Foreign Medical Graduates.
*Omits New Jersey, which had no non-metropolitan counties, and address unknown.

fairly parallel over this period. If there's any pattern at all, it is that USMGs, not IMGs, appear to have a greater tendency to subspecialize since 1991. Thus, these data are evidence that IMGs, for whatever reason, may be responding to market signals and demand for primary care physicians and may be gap filling to some extent by selecting one of the three traditional primary care specialties as a mode of entry into the system. This is a very shaky analysis, however.

In an assessment of IMG participation in the U.S. physician workforce, at year end 1987, IMGs were more likely to be in solo practice and proportionately less likely to be in group practice. The group practice variable needs to be refined. It can only be assumed that it includes those working in managed care organizations, although as we know, nothing prohibits a doctor in solo practice from taking on contracts from managed care groups. Still, the contribution of IMGs to managed care is not clear. The greater percentage of IMGs in government hospitals grouped at all levels and in the Veterans' Administration, suggests that IMGs are gap filling to some extent in this area. In some geographic, specialty, and employment settings, there is a portrait of some gap filling when the data are refined or, in some cases, viewed as a national aggregation.

Is this gap filling a major reason why IMGs are in the U.S.? Based on what I have presented to you and all my reading of the literature and about 23 years worth of study on the question, I have to say that I don't believe so. Although this may be a partial explanation, there is not enough gap filling as defined here to be able to explain the presence of approximately 130,000 IMGs in the U.S.; a close look at the distributions reveals similarities as well as differences. While the differences are real, I do not believe they are sufficient to explain the entire phenomenon. Although IMGs often begin by filling gaps, as they become socialized into U.S. medicine, they become mainstream players. They're following the pattern of any immigrant group.

Policy efforts over the past 50 years have had virtually no impact on the increase in the supply of IMGs in the U.S. These efforts have mostly been in the realm of changes in visa law and changes in the testing of the preparedness of IMGs to undertake practice in U.S. hospitals. For example, Public Law 94-484 put into place a qualifying examination, a stiffer examination developed and administered by the ECFMG. Many thought at the time that this would stop IMGs from coming to the U.S. However, there was already a sharp downward movement well under way that started early enough to eliminate the possibility of an anticipatory effect to account for the decline. This kind of puzzle makes it difficult to analyze the impact of various policy changes on IMGs.

Since the inception of the examination system in 1958, there has been consistency and uniformity in the pass rates of IMGs on the various generations of ECFMG examinations. The Clinical Skills Assessment (CSA), which may be implemented this year and which, as I understand it, may be offered only in the U. S., might have an impact.

The growth of managed care, at least the health maintenance organization component of it, is strongly correlated with the growth of the number of USMGs. It has not been correlated with the growth in the number of IMGs, at least from 1971 to 1989. One important force in the growth of managed care has been the growth of the physician supply, in addition to circumstances related to growth in costs and efforts by public and private payers to control these costs. The Pew report and Institute of Medicine report, some of the COGME reports, and the Bureau of Health Professions documents all reflect concern that the spread of managed care and its efficient use of physicians and physician substitutes will result in less need for physicians. Accordingly, it is only logical to reduce the overall physician complement, either through reductions in U.S. medical schools, in medical school enrollments, in IMGs, or a combination of all of these approaches.

Another approach may be to reduce the number of physicians, which will reduce growth in managed care, perhaps not immediately, but almost surely eventually. Health plans are able to reduce costs by being able to hire or contract with a physician workforce subdued by its large numbers. Any medical sociologist who has studied professional dominance or any medical economist who looks at the shape of markets, even in perfect markets, knows that under conditions of scarcity, the profession can control itself. The opposite is the case when a surplus exists.

Cutbacks in IMGs in U.S. residency programs and their enrollments are a double-edged issue. We have not come up with a policy approach that will deal with the fallout of cutbacks to the IMG workforce. There is a long history of underservice and maldistribution of physicians in this country, and it's hard to imagine that any cutback on the physician workforce will improve this problem. I am uncomfortable with the belief that removing IMGs is a good thing for the Nation. With a smaller workforce, we are trying to move toward filling the gaps that do exist. It will take a strong hand from both the public and private sectors to do it, but I urge caution in formulating any recommendations for cutbacks in the IMG workforce.

Role Of International Medical Graduates In Graduate Medical Education: A New York Perspective

Patricia J. Wang, Esq.

The Greater New York Hospital Association represents 78 not - for - profit hospitals, both voluntary and public, in the New York City area, in addition to a similar number of nursing homes. Our membership is primarily teaching and public hospitals. My comments focus on the New York City members because of the constancy of the data that we have, although these descriptions apply to our other members. Virtually all of our New York City hospital members are teaching hospitals, and virtually all receive Medicare disproportionate share hospital adjustments. These are payments from the Medicare program for hospitals that serve large number of indigent patients.

The overlap between teaching hospitals and the provision of care to the medically indigent in New York City is very great. In 1996, about 85% of Medicare indirect medical expenditure payments in the city were projected to go to hospitals that also receive disproportionate share hospital payments, and over 99% of Medicare disproportionate share hospital payments were projected to go to hospitals that receive indirect medical expenditure payments. This is reflective of the fact that about 23% of New York City's population in 1995 received health coverage through the Medicaid program and another 21.5% were uninsured (Table 6). Hospitals and other providers in New York City deliver care to about 2.3 million persons who are either insured by Medicaid or uninsured.

Consequently, the payer mix for New York City's hospitals looked like this in 1993: Looking at the discharge data for all New York City hospitals, the Medicaid share at 38.2% is quite high. It is higher, of course, in the public sector but, nonetheless, quite high in the voluntary sector (Table 7). This suggests that we have something approaching one tier of care in New York City; poor patients do not go exclusively through the public hospital system but instead are spread throughout the system.

In 1994, New York City members were training 11,750 physician residents or 78% of New York

Table 6. Selected Demographic Characteristics

NEW YORK CITY	
1994 Population	7,333,000
1995 Medicaid Non-Elderly Population (22.8%)	1,676,000
1995 Estimated Uninsured Population (21.5%)	1,576,000

Source: U.S. Department of Commerce, Bureau of the Census; NYS Department of Social Services; 1995 Current Population Survey

Table 7. 1993 Public Sector Payer Shares

	Discharges			Days		
Hospitals	% Medicare	% Medicaid	% Public	% Medicare	% Medicaid	% Public
New York City All	27.1%	38.2%	65.3%	37.3%	37.9%	75.2%
NYC Voluntary	30.7	31.7	62.4	42.4	30.6	73.0
NYC Public	12.6	64.4	77.0	19.4	63.5	82.9
New York State	33.1%	25.8%	58.9%	43.9%	27.9%	1.8%

Source: Institutional Cost Reports

State's total complement of slightly over 15,000 residents. Of these, 49% were graduates of international medical schools. The number of IMGs in New York State increased by more than 60% from 1988 to 1993, although their presence as a percentage of the total number of residents increased to a lesser degree, from about 34% of the total in 1988 to about 45.5% in 1993. Some of the specialties in which IMGs were most heavily represented as a percentage of total residents included geriatrics (88%), nephrology (87%), hematology and oncology (83%), family practice (68%), internal medicine (67%), pediatrics (67%), infectious diseases (67%), and psychiatry (55%). The uncompensated care burden for the city's hospitals corresponds to what might be expected given the demographics of the payer share. In the city, uncompensated care was 6.5% of gross charges at $1.3 billion (Table 8).

The distribution of IMGs throughout New York City area residency programs, including suburban members, is roughly equally divided between the voluntary teaching and public hospital sectors. It is lower at academic medical centers but still significant at 27% overall. For all programs, voluntary hospitals and public hospitals are roughly comparable at 65% and 69%, respectively.

The Whitcomb standard is an important attempt to develop a taxonomy to define IMG - dependent hospitals that might qualify for attention by way of replacement or transition mechanisms in the event that GME reimbursement for IMGs was refused. It requires a hospital to be a principal teaching hospital, that is, to have at least three of six core residency programs, two of which are IMG - dependent, to have at least a 20% share of Medicaid and no - pay patients, and to have a 50% or greater reliance on IMGs in the PGY 1 level in at least two of the programs.

Interestingly, Dr. Whitcomb found that 40% of the IMG-dependent programs he identified were not located at disproportionate share hospitals (DSH), a phenomenon that invites further examination for possible relationships with manpower shortages, etc. This is not the situation in New York, where there is an obvious confluence between IMG presence and the DSH status. Aside from the fact that the presence of IMGs in a city such as New York is thoroughly in keeping with the intensely international character of the population, IMGs play a vital role in delivering care to the medically indigent.

We tried to look at IMG dependence from this and another perspective. Rather than applying a threshold definition of a teaching hospital and then looking for IMG dependence, we asked what the characteristics were of hospitals that trained large numbers of IMGs.

Twenty-two New York City hospitals met the Whitcomb standard, including 17 voluntary and 5 public. The Medicaid share of discharges in this group is significantly higher than that in the overall New York City teaching hospital group. Medicare shares did not vary tremendously (Table 9).

Some hospitals did not meet the Whitcomb standard simply because they did not offer three of six core residency programs; that is, they failed to meet Whitcomb's definition of a principal teaching hospital. We evaluated

Table 8. 1993 Uncompensated Care Burden

	Uncompensated Care	Uncompensated Care as a % of Gross Charges
New York City	$1.3 billion	6.5%
New York State	$1.7 billion	4.9%

Source: Institutional Cost Reports

Table 9. Discharges and Days by Payor for Selected Hospital Groups, 1993

Hospital Group	Number of Hospitals	Distribution of Discharges: Medicaid Share	Medicare Share	Total Other	Public Share	Distribution of Days: Medicaid Share	Medicare Share	Total Other	Public Share
All NYC Teaching Hospitals									
Total	56	39.4%	25.6%	35.0%	65.0%	39.3%	35.6%	25.1%	74.9%
Voluntary	44	32.7%	29.1%	38.2%	61.8%	31.7%	40.7%	27.6%	72.4%
Public*	12	64.4%	12.6%	23.0%	77.0%	63.5%	19.4%	17.1%	82.9%
Hospitals meeting the Whitcomb Standard									
Total	22	48.6%	23.1%	28.3%	71.7%	45.9%	33.3%	20.8%	79.2%
Voluntary	17	44.0%	26.4%	29.6%	70.4%	39.7%	38.5%	21.8%	78.2%
Public	5	65.6%	10.8%	23.6%	76.4%	65.8%	16.7%	17.5%	82.5%
NYC Hospitals with 80% or more IMG's In Internal Medicine									
Total	32	45.6%	25.0%	29.4%	70.6%	43.0%	36.2%	20.8%	79.2%
Voluntary	25	39.7%	28.7%	31.6%	68.4%	36.0%	41.8%	22.2%	77.8%
Public	7	65.7%	12.3%	22.0%	78.0%	64.6%	19.0%	16.4%	83.6%
NYC Hospitals with 50% or more IMG's Overall									
Total	35	47.3%	23.7%	29.0%	71.0%	45.0%	34.5%	20.6%	79.4%
Voluntary	25	40.2%	28.2%	31.7%	68.3%	36.5%	41.0%	22.5%	77.5%
Public	10	65.9%	12.1%	22.1%	77.9%	64.6%	19.2%	16.2%	83.8%

* Includes University Hospital of Brooklyn

Notes: 1. Discharges and days excluding newborns.
2. Hospital Units defined by New York State Operating Certificates for counting purposes.

Source: Institutional Cost Reports.

these and other hospitals based on two additional scenarios: (1) 80% of greater IMG presence in first-year internal medicine programs, regardless of other programs or the number of other programs offered, and (2) hospitals with 50% or more IMGs overall through all program years and through all programs. Thirty-two hospitals had an 80% or greater IMG presence in the first internal medicine residency year. Voluntary hospitals increased by eight, and the number of public hospitals increased by two. Assessment of the characteristics of the voluntary hospital increase revealed that five of the newly added institutions have a special designation under New York State law that entitles them to receive additional uncompensated care funds because they serve underserved areas and provide a disproportionate amount or uncompensated care. In addition, two city public hospitals were added. Thus, the facilities that are added by broadening the definition appear to be hospitals that have characteristics of serving the medically indigent.

The role played by IMGs in a variety of settings, particularly in institutions that deliver care to the poor, is an important one to maintain. However, when defining what kind of policy the Government should formulate, identification of vulnerable hospitals according to the breadth of their teaching programs and then their dependence on IMGs appears too narrow. If what we are really interested in is the role IMGs play in delivering service to the uninsured and to the underserved, perhaps we should look at the institutions that deliver care to those populations, including health centers, and then examine how such institutions actually use IMGs. I'm not sure that the notion of an "IMG dependent hospital" is one that makes a lot of real-world sense to the communities that would be affected by any reductions in GME funding for IMGs. So I would suggest that better understanding of how medically indigent populations are served might be fostered by flipping the equation and, first, locating the institutions and the providers who deliver care to those populations, and then seeing how IMGs are used.

Because of the particular characteristics of hospitals in New York City that rely on IMGs, the various recommendations that have been made to reduce GME funding for IMGs have caused great consternation. Proposals of that nature strike straight at the heart of these hospitals, the programs they sponsor, and the populations they serve.

The congressional proposal to reduce IMG funding would have cost these hospitals about $1 billion over 7 years, which would have been a completely unaffordable as well as an inequitable situation. The bottom-line margins of hospitals in New York City and New York State are consistently slightly negative every year. Even when public hospital performance is extracted from total hospital performance, the fiscal situation is consistent. The mild surplus that was experienced by the voluntary hospital sector, $80 million across all institutions, would have been more than eaten up by 1 year of the Congressional proposal to reduce the direct medical education (DME) component of funding for IMGs to 25%.

The number of hospitals that would require alternative strategies in the event that GME payments were cut is greater than currently imagined. Approaches regarding replacement personnel should include several considerations. One consideration is the permanence of the funding needs. The Institute of Medicine report clearly recognized this issue. Ultimately, of course, universal coverage is the answer. Pending that, there is a permanent need for personnel to deliver the services now delivered by IMGs in underserved areas, and the need is not going to go away, particularly when an IMG as well as the Medicare funding for that IMG are lost.

Many studies have shown that there is a potentially greater level of funding that is required in replacement funding for cut residents. The Greater New York Hospital Association performed its own study a couple of years ago and found that additional personnel would be needed to replace residents at higher salary requirements.

There are also issues that money alone might not solve. Even if resident replacement funds were given to hospitals, current problems in recruiting personnel to difficult neighborhoods will not disappear.

There are also issues of quality and workforce pipeline. Teaching programs have brought quality to the hospitals that sponsor them; replacement personnel strategies would have to be specifically designed to maintain that quality. With respect to the workforce pipeline, anecdotally, program directors and CEOs in many hospitals that rely on IMGs say that their teaching programs produce physicians who continue to serve those communities, either in community health centers or in continuing roles at the hospital. This simply points to the need to include the issues of geographic maldistribution of physicians with any discussion of reducing IMG funding.

I would suggest a separate evaluation of the contributions of IMGs as residents and as physicians in the workforce in underserved areas. They are valuable in both respects, but there are different nuances and perhaps different solutions. It is extremely important that organizations such as yours order the priorities when developing recommendations in this area.

The only proposal that has been really picked up and made inroads anywhere is the proposal to cut payments. That just underscores the importance of making sure that all of your priorities receive due consideration and that this not be the only one that moves forward. Of course, in the meantime it is also very important to continue the debate about issues raised with respect to the physician workforce and whether the IMG policy and the reduction

of IMGs is at all the right way to get there. Regardless, certainly the reduction of GME funding for IMGs is an issue that causes tremendous concern to hospitals such as those in New York City. Because such an approach would cripple institutions in various neighborhoods and would target funding cuts to particular geographic areas of the country, those of us in New York City will continue vehemently to disagree with it.

Comments And Discussion

Dr. Kindig: Your data and observations are incredibly important. COGME has been considering this not in the context of 1990 numbers but rather of 2010 numbers when there will be, if we do nothing, a 30 – 35% increase in physicians, IMGs and USMGs together. Would your cautionary concerns about intervention be less in that context?

Dr. Mick: I'm not for just completely open- ended funding of both undergraduate and GME. What I am for is a much more closely interdigitated discussion, policy that links graduate medical education with undergraduate medical education, and a more realistic view of the activity of market forces in this debate. There is an absence of consideration of market forces in almost all our discussions inside and outside of COGME other than the increase of managed care, and managed care won't increase with cutbacks.

Dr. Haspel: COGME was actually responding in a market when we made our last set of recommendations. In a market in which there are excess physicians (if I was a payer, e.g., Medicare), then it would be reasonable to say I need "X" number of doctors. In the market environment I would therefore create incentives for production (increase GME funding) if I needed more or different types of doctors. Likewise, if there was a glut, I would create disincentives for the payment of GME. COGME thought that, within the options that were available, the use of the payment system as a means to leverage down the number of physicians being produced was an appropriate response to the market on the part of the Federal Government (Medicare).

It seems pretty clear to me when the expansion in GME numbers took place. I was a CEO running two hospitals. I looked at the elasticity in the market place for GME payment. I had some payers resisting additional payment for GME. The only payer that actually showed flexibility and allowed growth easily was Medicare, and the only part of Medicare payment that was actually elastic was GME. Capital was being carved back, and the updates were being reduced, so the only part that was left was GME. I don't think that was lost on any of us. We found fairly rational purposes for increasing the physician workforce until recently. We thought we were making ourselves better able to deliver service to patients in the hospital and in the communities we serve.

Clearly, increasing Medicare GME funding payment had a bottom-line benefit, and anybody who looked at prospective payment system margins of hospitals in the late 1980s saw the difference between those who were receiving disproportionate share hospital payments and GME payments. It seemed clear to me that in New York they were just smarter than the rest of the country in leveraging those dollars. I would like to believe that the population in New York is being better served in 1996 than in 1989, but I have seen nothing that would suggest to me that we have reduced the number of health profession shortage areas

in New York State in a substantial way nor any evidence that the health status of the patients is substantially different. In fact, New York is at the top of the Nation in terms of numbers of physicians per 100,000 and that would be antithetical to what a market would be doing simply on the basis of distribution and demand. I think there is a problem here; the financing system is, in fact, the source of the problem, and it threatens to overwhelm us, not necessarily in 1996, but as you go forward into the 21st century.

Ms. Wang: Your observations about the Medicare payment system are accurate. However, I think there is a difference between approaches that limit Medicare GME payments on some sort of equitable basis and those that focus cuts at particular types of residents, such as IMGs. We can all have a debate about what would happen if Medicare were to roll back to an earlier glorious day when the number of physicians in training was the right number, whatever year that is. When you say, let's just roll back the payment for the IMGs, you limit the number of people in the room who really have an interest in this issue to very few, and that's a problem.

Dr. Kindig: For those who haven't followed COGME carefully, the recommendation was based on the assumption that U.S. output was fixed, at least for now, because we certainly didn't have any policy handles, nor does the government, on domestic output. So if you want to shrink and you can't do that, you're forced into the GME position. That could change, and other formulations can perhaps be discussed.

Dr. Mullan: COGME's initial position, which was a position that was embodied in the Health Security Act, was not IMG dependent. It was to limit the number of physicians and manage it through a national commission. The representatives of New York fought that recommendation as well, and it didn't contain an IMG element. This round of COGME recommendations is based on the given conditions that there will not be that kind of regulatory approach. All you have to work with are incentives and disincentives and, as has been well pointed out by Dr. Haspel, Medicare GME is a huge incentive.

The growth in the number of residents of New York between the late 1980s and the current time has been fairly constant. The IMG figures have gone up appreciably over those years.

Ms. Wang: I can't tell you the exact numbers. I can tell you that the percentage increase as a total is smaller than the number increase. It is possible that the IMG component has gone up faster, but I don't actually know.

Dr. Mullan: The U.S. figures have been flat, and all of the increase has been in IMGs, and it's been quite appreciable. The second factor in New York that I believe is a particular stimulus is that with your all-payer system, a resident in New York State pulls down about $200,000 a year to the institution each year. Is that correct?

Ms. Wang: This is a much confused issue in terms of the way that our non-Medicare all-payer systems work. There's a component of case payment rates that are set for all payers — Medicaid, Blue Cross, commercial — that is identified as GME. It does not fluctuate with the number of residents or the interns and residents per bed in a particular institution but rather is part of the operating component. It is identified as GME, but it does not change based on the resident complement and costs in 1981 trended forward with no adjustment for the number of residents or for interns and residents per bed.

Dr. Knouss: There are actually two factors that play a role: (1) immigration law and how immigration law is formulated, and (2)

changes in GME financing that account in large part for the small but significant changes that occurred in this curve in 1985 – 87 with respect to foreign national IMGs. In 1965 and 1970 there were complex changes in immigration law that altered how aliens entered the U. S. At the same time, there was a large increase in the number of USMGs that were filling graduate training slots, and it took some time for the system to adjust. At that point IMGs were being squeezed out of GME.

In 1976, with enactment of Public Law 94 - 484, a significant change revolved around the H visas, which are another kind of temporary visa. Someone entering the U. S. as a temporary visa holder, an H visa holder, was no longer able to participate in GME. This legislation had an enormous impact on the entry of foreign national IMGs into graduate training programs. That law was reversed in 1989, coinciding with an exact reversal of the entry of foreign national IMGs into GME slots. A huge increase recurred in 1989 and is continuing now in 1995 – 96 and doubling annually.

The temporary worker H visa holder can stay in this country for an initial 3 years and an additional 3 years. It is regulated under immigration reform, but it is under a totally different provision of the Immigration Act, and it's having an enormous impact at present. Changes in that legislation have been resisted, but it is going to be one of the keys to trying to come to grips with this particular problem.

Dr. Brucker: My question is, what really is going on in New York City? Certainly in Philadelphia we're going to take 10,000 of 16,000 acute beds out of circulation in the next 3 years. We'll have 6,000 left. It's pretty hard to develop specialty programs that are so hospital dependent with so few patients. In other words, just from a training perspective, people are very concerned about how many patients you need to do a good job. Secondly, there's a lot of concern in a very competitive Philadelphia now about whether residents should work harder and for less because everybody else in the hospital is doing the same thing and carrying two or three different loads. There's no doubt that the need for GME in the system, the service component of it, is rapidly disappearing and we're not ready to go ahead and shift that into the outpatient setting.

In New York City, where you have a fair amount of managed care penetration, particularly in the past year with organizations such as Oxford and U.S. Healthcare, what has been the impact on hospital census issues such as open beds, and is some of the loss that we see up there because the hospital industry hasn't responded to the changes and adjusted and downsized and are still dependent on educational funding?

Ms. Wang: Hospitals in New York City are still at about 75 – 78% occupancy. That is down from prior times. Actually, it's probably slightly higher than that . Traditionally, as you know, we've run 85 – 88% occupancy. The level is down but still way above national averages. A good number of hospitals have closed beds and have made internal changes. The city administration has plans to change the configuration of the New York City Health and Hospitals Corporation, which is composed of 11 municipal hospitals, perhaps resulting in the closure of many of those facilities. Thus many institutions are consolidating and investigating consolidation into systems. I don't think it's happening quite as rapidly as in Philadelphia at this point. However, we are certainly on the cusp of something very big. Our State regulatory system is set to expire at the end of June.

The managed care penetration of organizations such as Oxford and U.S. Healthcare is very significant. When you look at the percentage of commercial payers in these hospitals

though, while significant, it's still not a huge bite out of the hospitals. There is no question some hospitals have increased percentages of managed care discharges, but many of the institutions are so heavily Medicaid oriented that at this point the managed care world for them is really Medicaid managed care.

It's a complicated question. There's a lot of downsizing going on and a lot more consolidation to come. It differs from institution to institution and has an impact on this picture.

Dr. Bustamante: It appears from the first two presentations that the numbers of IMGs are taken as a problem. In fact, the origin of the problem is the number of positions created in excess of the USMGs. Why is it that we can present the problem, either here or in the Institute of Medicine report or the Pew report, as the IMG increase without discussing the actual origin of the problem, which is the creation of jobs for physicians above the number of USMGs in the market to fill those jobs? In our public relations, we need to have some kind of an understanding that the public should not perceive this as a foreign threat but as a problem locally produced within the U.S. that needs to be solved within the U.S.

Dr. Kindig: Obviously, you need to help us in COGME with getting that across because, in fact, our policy says that. It is our policy that financial incentives should decrease the number of positions. Maybe it does not come across that way, in which case we ought to join you in saying it better.

Dr. Bustamante: As a Director of Pediatric Medical Education in my new position in New Jersey and as an observer from previous lives, I can tell that no program director is going to be hiring IMGs in preference over USMGs. Why then target these funding issues in creating a misconception, a misperception? Why not just leave it to program directors to hire the USMGs plus 10%, 15%, 20%, as necessary, and downsize the number of slots without targeting IMGs, which I think is unnecessary and creates a bad perception.

Dr. Bigby: These three presentations have been very helpful. The numbers are useful and can be very convincing. I would agree with some of the other comments that have been made regarding the separation of the issues of how many residents we need from the IMG issue and service to the underserved. The system of having in-hospital care for the disenfranchised of New York City discharged by a group of people who change every 3 – 5 years doesn't make sense to me as being the best solution for taking care of a poor, minority population, whether it be in New York or Philadelphia or Boston. Could we begin a discussion by saying there may be some impact in Medicare GME policy changes but this is an opportunity to ask, "Is this the way to take care of this group of people?" We were talking about in-hospital care. What about the whole spectrum, the continuum of care, and is that type of care being delivered to these people?

None of the information presented talks to the issue of the type of care or the quality of care. I'm not raising that issue because of the IMG issue but rather because I question if it is really an acceptable standard to be in the hospital cared for by people who rotate through the system on a 3 – 5 year basis? I don't think so, and it seems like this is an opportunity to separate that issue.

Dr. Bustamante: There has been an issue that connects the geographic distribution, minority representation, and IMGs. In the late 1960s and 1970s and maybe early 1980s, there was either a real or perceived notion that there was a shortage of physicians in the U.S. and many IMGs came to the rescue at no cost to the U.S. We came already prepared to practice medicine. We got distributed in many areas,

but I am talking particularly about the 2,000 mile region of the southern border of the U.S., where there are a number of IMGs who came through in those times when there was a perceived shortage and that within a few years will be ready to retire. Now, who is going to substitute for them, I don't know, but this is an issue that perhaps could be resolved by studying the composition or the origin of physicians that are working in those areas, particularly the southern border of the U.S.

Part II. Immigration Law and Policy and Participation in the U.S. Workforce

Sergio A. Bustamante, M.D., Moderator

As a member of COGME, I have had the privilege to work with David Kindig in developing both the concept and the need for an international medical graduate group. In this second panel on IMGs, we hope to explore the immigration law and policy that have an impact on IMGS and the participation of IMGs in the physician workforce. These are very important issues, and I hope to elicit a lot of public participation.

Immigration Legislation: An Overview

Sophia Cox

The J-1 visa category is designed to further international exchange, and J-1 exchange visitors are basically viewed as goodwill ambassadors for their home country. The J-1 category was created in the late 1940s as a result of the U.S. Information and Educational Exchange Act, which is also known as the Smith-Mundt Act. Basically, the U.S. undertook a new foreign policy initiative with the idea to strengthen international relations and further mutual understanding by establishing educational and cultural exchanges. Medical trainees were included in this group, and they were expected to go home upon completing the objective of their program. In 1976, the Health Professions Educational Assistance Act was passed, imposing a number of restrictions on the immigration of alien physicians, including new credentialing procedures, improved mechanisms for ensuring that the trainees returned home, and separate authorizations for clinical and nonclinical activity.

There were several factors driving the change in this policy. First, Congress was concerned that the increasing numbers of alien physicians were possibly undercutting job opportunities for U.S. physicians, especially since the physicians appeared to practice in disproportionately high numbers in metropolitan areas. Second, there was a public concern with the quality of the health care provided by the doctors who had obtained their training outside the U.S. Finally, the immigration of alien physicians to the U.S. was perceived to be causing a brain drain from developing countries. For many years the only way for an IMG to come to the U.S. to participate in graduate training or residency was the J-1 visa. It wasn't until very recently that the H-1B category was permitted in some limited circumstances.

Under the J category, the alien has to be sponsored by the ECFMG. There are some options that would allow the doctor to bypass this requirement. One of these options is for doctors of national or international renown who entered under an H-1B visa to provide direct patient care for up to 6 years. These doctors were exempt from the patient care restriction that otherwise would apply. The O-1 category, which was implemented as a result of the Immigration Act of 1990, allows the employment of a nonimmigrant physician of extraordinary ability in the sciences; conceivably, a doctor who is of extraordinary ability would be allowed to practice medicine for the duration of the event.

Since the Immigration Act of 1990, doctors can, under certain circumstances, practice medicine with an H-1B visa. The J-2 dependents can be granted employment authorization, allowing them to practice medicine so long as they meet the licensure requirements of that particular State. This is a circumstance in which the immigration requirements on one side and the requirements of the particular State in question may be slightly different.

In terms of waivers, all IMGs who came to the U.S. with J-1 visas to receive GME or training are subject to what is known as the 2-year home country physical presence requirement. This requires doctors to be in their country of nationality or last permanent residence abroad for 2 years in the aggregate before they can apply for status under the H or L temporary working categories or before they can apply for permanent residence, otherwise known as the green card. They can be granted a waiver, which would allow them to then enter the country in a temporary classification or apply for permanent residence. Otherwise, they have to stay home for 2 years to fulfill the requirement.

Doctors are advised of their obligation at the time that they commence the program. The form that is used to initiate the paperwork is the IAP-66. They sign that form, thereby acknowledging their obligation to go home. Under Section 212(e) of the Act, a waiver can be granted by the Immigration and Naturalization Service (INS) only if there is a favorable recommendation from the Director of the U.S. Information Agency (USIA), which administers the J-1 program. There are different ways that a waiver can be obtained, but the route pursued will depend largely on the reason why the doctor is subject to this requirement.

Some of the basic waiver channels include exceptional hardship to the applicant's U.S. citizen or permanent residence spouse or children; persecution on account of race, religion, or national origin; a no objection statement that is issued by the applicant's home country; an interested government agency that has requested the waiver because the applicant's work would benefit the public interest; or a State department of public health request based on the applicant's agreement to work in a medically underserved area. State health department waivers have certain conditions that are attached to them.

Once the waiver of the 2-year requirement has been granted, any subsequent J-1 or J-2 program participation, extension, or renewal can possibly resubject the IMG to the 2-year requirement. This is because the applicant essentially acquires or reaquires the obligations of that exchange program, which can include the 2-year requirement, depending on the nature of the new or reinstated or extended program and the source of funding.

In the case of doctors, the waiver channels are a bit more limited. One reason is the restrictions in the law and the other is the process itself and the fact that a favorable waiver recommendation is required from USIA. The most common routes are through interested government agencies. Under the law, any interested Government agency can ask USIA

to submit a waiver recommendation to INS. The law does not mandate that the agency submit the waiver request. If they choose not to do so, for whatever reason, that's entirely up to the discretion of the agency.

Several agencies can be involved, such as the Veterans' Administration (VA) for doctors working in VA or affiliated hospitals, and the Appalachian Regional Commission for doctors working in rural areas. The Department of Housing and Urban Development recently got involved in recommending waivers. The Department of Health and Human Services focuses more on research that has a strong international health component. Physicians may qualify if their work fulfills this criterion.

The organization that seeks to have the IMG's services approaches the government agency. Each agency has its own internal procedures, criteria, and requirements for deciding whether it's going to go to bat for the hospital or for the organization. If the criteria have been satisfied, the interested government agency will submit a request for a recommendation to USIA, which then looks at this request and consults with the program sponsor to get their views. If the program sponsor consents, they look at the foreign relations and foreign policy aspects of the case. From there, they decide whether to make the recommendation to INS.

Once the favorable recommendation is made, unless there's something absolutely egregious in the applicant's case file, the waiver is usually granted. As a result of the Technical Corrections Act of 1994, another waiver route has become possible based on a request by a State department of public health. Prior to this change in the law, the term interested government agency was limited strictly to a Federal agency. This change in the law expanded the legal definition to include a State health department. Prior to the law, the health department would have to seek the assistance of an intermediary agency, such as the Department of Agriculture, for doctors working in these rural areas. They would have to direct the request to the Department of Agriculture which, in turn, would have to submit the request for a waiver recommendation directly to USIA. This bill was sponsored by Senator Conrad of North Dakota, who wanted to make sure that people in medically underserved areas could get the health care that they so desperately needed. It allows the State health department to assess its needs and go straight to USIA without having to go through an interested Federal agency.

These waivers have special conditions attached to them. It is a pilot program and applies only to those doctors who entered the U.S. in J status before June 1, 1996, or who acquire such status. It can take a doctor up to 7 years to finish the program. It is acceptable for the completion date to extend beyond June 1, 1996, as long as the status was acquired before then. (Note: Since this writing, the program has been extended to June 1, 2002.)

Twenty waivers are allowed per State per year. A 3-year employment contract is also required. Waivers are also given for exceptional hardship and persecution, but these waivers are more difficult to obtain. State waivers require physicians to provide a no objection statement indicating that the individual's training is not required in that country.

To apply for permanent residence, the alien has to qualify under a specific category. The category that the person qualifies under will depend on the relationship between the petitioner, the person who's filing the papers and requesting the benefit, and the beneficiary. Immediate relatives include the spouse, children under 21, or the parent of the U.S. citizen. There is no numerical limitation on the amount of visas that can be issued under this category. The family-based category includes unmarried

sons and daughters of U.S. citizens who are over 21 years of age.

The spouse and unmarried sons and daughters of lawful permanent residents are divided into two categories: (1) spouses and children under 21 of permanent residents, and (2) spouses and unmarried children over 21 of permanent residents. There is also a category for married sons and daughters of U.S. citizens and, finally, brothers and sisters of U.S. citizens.

The process of applying for family-based immigration involves filing a petition. The date of receipt of this petition by INS is the priority date and is used to determine visa availability. A visa number must be available. A distinction is made if an IMG happens to be immigrating through a family member; the exclusion provision does not apply because this is someone who is not primarily coming to the U.S. to practice medicine. The basis for immigration here is the family member, not the profession, so the exclusion ground does not apply.

Visa Classifications

John W. Brown

The H classification is a temporary classification that is valid for 6 years. Prior to the passage of the Immigration Act of 1990, the only way an IMG could come into the U.S. to perform services in the medical profession was to teach or conduct research. After the passage of this act, the door was wide open for the foreign medical graduate to use the H-1B classification for clinical care as well as teaching. The act had some restrictions regarding the performance of these clinical services, including the requirements that the physician have a degree, pass the Federation Licensing Examination or its equivalent (the USMLE or the national board examinations), and speak English.

Approximately 11/2 years ago the service published a proposed rule attempting to force all medical residents to go into the J-1 program. We backed off from that. It didn't attract a lot of positive attention. So now medical residents can come in under the H-1B classification as well as J-1. I don't know how many residents are taking H-1B classification. With the H-1B classification, hospitals must promise the Department of Labor that the physician will work under certain conditions subject to civil penalties. There are also return transportation provisions that don't exist under the J.

The odd thing about temporary and permanent status is that individuals with temporary status only have to work for the petitioning employer for the length of time that they're here, whereas those with permanent do not. With permanent status, however, a U.S. employee must file a petition for the alien to come here. Once they're here, they're under no obligation to work for the petitioner. Normally, they're expected to show up, but if they can show good cause for why they're not working there a year later, 6 months later, sometimes a month later, its okay with the INS.

Most physicians enter the country under the third preference classification, which has a provision that you can waive the labor certification requirement based on national interest. Many physicians have argued successfully that the shortage of physicians in a particular area is of national interest. INS grants the waiver. In June 1996, we proposed a rule suggesting tightening of the use of the national interest waiver. A final rule is in the works.

Joyce E. Jones

For waiver of J-1 classification, the Department of Health and Human Services (DHHS) has endorsed the Mutual Cultural Exchange Act set up with the United States Information Agency (USIA). This act was created for the purpose of exchange, so the program would not be used as a stepping stone to immigration. In theory, any Federal agency can go to USIA and request a waiver of a J-1 classification if they find it (1) in the interest of their department and (2) in the national interest.

At DHHS, we use national-international level of interest, taking into consideration the intent of the program. Its an old term, brain drain, but it still exists. Although the issue arises of serving a local need, it is very difficult to justify, particularly to underdeveloped countries, that our need is greater than theirs when they have sent doctors here for the exclusive purpose of exchange. The Department of DHHS reviews waiver requests for research, primarily biomedical, for exceptionally qualified and trained researchers. Any other Federal agency can do that, and in the past, this activity has been almost exclusively reserved for research positions. Foreign researchers have been used by the Departments of Agriculture and Defense and the National Science Foundation. The Appalachian Regional Commission and Veterans' Administration were the only other agencies that have used foreign physicians for either service or research and then only under controlled situations. About 2 years ago, that situation changed, fueling, in part, the controversy going on now with the J-1 classification.

Other Federal agencies, such as the Departments of Housing and Urban Development and Agriculture, at the request and instigation of Congress, began to request waivers for medical doctors. This raised concerns because there really wasn't an organized, uniform process for requesting waivers for medical doctors. This activity was not the expertise of those agencies, but they got into it and once in, it's very difficult to get out.

Traditionally, DHHS Secretaries have supported the way the program was run, feeling that it should be research oriented. The cultural exchange part of it should be taken very seriously. Now that has changed, and there are massive numbers of waivers. We probably request anywhere from 100 to 200 a year for research spots, and those are very well established positions. Within 2 years the number of applications that actually go to USIA has doubled, mostly coming from the Departments of Agriculture, and Housing and Urban Development on the basis of providing services to medically underserved and Health Professional Shortage Areas (HPSAs).

In August 1995, the Secretary sent a letter to the agencies that were participating in the waiver program asking them to examine their policies in the hope of coming up with a more uniform approach. In the meantime, legislation has been put into public law allowing each State to request up to 20 waivers per year per State to work in a DHHS- designated HPSA or Medically Underserved Area (MUA). As of today, USIA told me that there are two States that have determined they do not want to go along with this procedure. The first year was pretty slow, although now the pace is picking up, with more States participating in the program.

The differences in the agencies and in the way they are processing waivers have to do with the teeth in the regulation. It carries with it a penalty. If the physician moves from the area

in which the waiver has been granted, the J-1 could be revoked. The regulation includes a requirement for a 3-year stay. Some agencies that are giving waivers now may only have a 2-year stay requirement in the shortage areas.

Several problems have arisen. Shortage areas shift before the waiver is actually granted. One scenario is that, for instance, there is a needy group in Mississippi that enters the program. What follows is a lot of immigration lawyer and physician recruitment activity generating interest. Mississippi is given a spot and, just as they're about to be finalized, somebody else comes along with a better offer in Tennessee. According to USIA, this scenario seems to be increasing. Another one of the recommendations that we'd like to see taken up is to establish a better way for States to control how many doctors are coming into their state and how to keep them for at least the 3-year commitment. There is really not much any of the Federal agencies can do to enforce this if doctors don't stay.

Role Of The Educational Commission For Foreign Medical Graduates

Nancy E. Gary, M.D., and Marie Shafron

The Educational Commission for Foreign Medical Graduates (ECFMG) was founded by several organizations — the American Medical Association, the Federation of State Medical Boards, the Association of American Medical Colleges, and the American Hospital Association — in recognition and fulfillment of their public responsibilities for the quality of health care delivered by the health profession education system. Consequently, ECFMG is neither an advocate for nor an adversary of graduates of foreign medical schools. It assesses and evaluates information provided by such graduates through a series of examinations and verification of medical education credentials to ensure that they are ready to enter accredited programs of GME in this country.

Contrary to an earlier statement by another panelist, ECFMG did not institute the Clinical Skills Assessment (CSA) in 1995 as an added qualification for ECFMG certification. As stated in our information booklet, the CSA will be implemented no sooner than mid-1996. We are still in the process of refining the logistics of implementation. It will initially be offered at a single site in Philadelphia. International sites may be used later, but we've got to get it up and running first at one place.

Our major program is the certification of graduates of foreign medical schools for entry into GME programs. We also are a sponsor of exchange visitor physicians and offer fellowships for basic science faculty of foreign medical schools and for international medical scholars. We are participating in the new electronic residency application service developed by the Association of American Medical Colleges. Our basic program is ECFMG certification, however, which involves evaluation and assessment of the readiness of graduates of foreign medical schools who wish to enter GME. It provides assurances to program directors as well as to the people in the U.S. that these physicians have met certain minimum requirements to enter GME. The rationale for this program is that medical education varies tremendously throughout the world with respect to content, quality, and duration of the curriculum. There is no standard to determine equivalency of medical education among foreign medical schools.

Those who take the examination are self - selected individuals from over 1,000

medical schools in about 120 countries. The elements of our certification program include an assessment of medical science knowledge, an assessment of English language proficiency, and a validation of medical education credentials.

The examination requirements for ECFMG certification consist of the USMLE, Steps 1 and 2, as well as the ECFMG English test or the alternative Test of English as a Foreign Language. Steps 1 and 2 are administered by ECFMG in approximately 70 test centers internationally on the same day that Steps 1 and 2 are administered by the National Board of Medical Examiners to students and graduates of medical schools accredited by the Liaison Committee for Medical Education. In 1 year, approximately 80,000 examinations have been administered to approximately 50,000 individuals.

The pass rates in 1995 were about 45%, both in the June and the September Step 1 administrations. For Step 2, it was 42.5% in March and 49% in August, averaging out to about 45% again. The ECFMG English test has a higher pass rate of about 60%.

Validation of the medical education requirement is an equally important component in the certification process. Applicants must document the completion of all of the educational requirements to practice medicine in the country where they obtained their medical education. A national of the country must also have a full and unrestricted license from that country. He or she must have had at least 4 credit years (academic years for which credit has been given toward completion of the medical curriculum). The medical school must be listed in the World Directory of Medical Schools at the time of graduation, which is a publication of the World Health Organization. Most important, the medical education credentials must be verified by ECFMG with the institution that issued them. We receive approximately 30,000 submissions of credentials each year.

The credentials that graduates must submit are those prescribed by the country at the time of their graduation. The verification process includes sending these credentials to the originating institution with a multilingual verification form to facilitate communication with the officials of the medical school. A copy of the credentials is accompanied by a photograph of the individual and information about any other unique requirements that may be imposed on this process by the school or the foreign country.

If the credentials are valid, a recognized officer of the institution must sign the form, affix the school seal, and return the form directly to ECFMG. If the credentials are not valid, the institution is asked for an explanation. Upon receipt, the forms are checked to ensure the authenticity of the signatures, the title, and the seals. If any differences are noted, then there is further communication with the medical school.

There are exceptions to the process. It's possible that someone may not be able to obtain the routine documents or we may not be able to obtain the verification directly from the institution. There is a process in place to handle such exceptions, all of which must be reviewed by a standing committee of the ECFMG Board of Trustees, which makes recommendations to the full board to approve or disapprove the exceptions. The exceptions may relate to an individual or a class of individuals. They may be country or medical school specific. The resolutions require communication with an extensive international network the ECFMG has developed over the years, reliance on 40 years of established expertise, procurement of alternative documentation that provides appropriate assurances, and development of protocols in each of the

circumstances that may be either time limited or indefinite.

The duration of response from medical schools can vary anywhere from 3 weeks to a year. Factors include the reorganization and demise of some institutions, volume and duration of the ECFMG processing time, time required by medical schools to handle processing, as well as the speed of international mail. Processing of exceptions takes time, and of course, added pressures are created, depending on where the individual is within the educational continuum. Because these are self-selected individuals, they represent all years of graduation from medical school.

Once the graduate has passed the examination requirements and the medical school education credentials have been validated, a Standard ECFMG Certificate is issued. Over the past several years, the number of certificates issued has increased. In the middle to late 1980s, we provided about 4,500 Standard ECFMG Certificates. In 1995, about 9,500 Standard ECFMG Certificates were issued. About 60% had addresses in the U.S., some of which may be drop-off or mailing addresses, and the recipients are not actually living in this country.

We are making prospective changes to the certification program. Currently, the examination requirements for ECFMG certification are USMLE Step 1 and Step 2, and the ECFMG English test. As mentioned above, the CSA, which includes an assessment of spoken English, will be added to the certification requirements some time after mid-1996. The CSA will be administered in Philadelphia to those individuals who have prequalified by passing both Step 1 and Step 2 and the ECFMG English test. With the introduction of the CSA, we will also make a change to the medical credential requirement. Individuals will be expected to meet our medical credential requirement at the time they complete all of the requirements and have obtained the medical doctor or the terminal degree from the medical school. The ECFMG will no longer require for certification that graduates of foreign medical schools complete postgraduate education in countries where it is a requirement for licensure. Instead, a clinical skills assessment will be administered to these individuals. Of course, we will continue to verify medical education documentation.

In addition to the certification program, ECFMG is a designated sponsor of exchange visitors. Primarily, we sponsor exchange visitor physicians in GME, defined by Federal regulations as residency and fellowship programs. There is a maximum 7-year duration of stay for individuals with this J-1 visa. They must, in addition to other requirements, have received adequate prior education, have passed the National Board of Medical Examiners, Parts I and II or the equivalent, and be proficient in English. These requirements may be equated to the requirements that we have for ECFMG certification.

In addition, ECFMG sponsors foreign national physicians in observation, consultation, teaching, and research programs which may be either with no patient contact or patient contact incidental to the observation, consultation, teaching, or research. These individuals may stay for a maximum of 3 years.

The number of exchange visitors was high in 1976 and 1977, then declined for a few years, only to gradually increase in the early 1980s. Regardless of the length of sponsorship, an application is required each year that they're in the U.S. as a sponsored visitor. The application requires several documents, including hospital contracts.

The number of individuals obtaining a J-1 visa peaked in 1993 – 94 and then began

to decline in 1994 – 95. We believe this is a result of increased use of the H-1B visa. It may represent individuals who are getting 212E waivers and who are no longer continuing as exchange visitors but obtaining other visas. Of the 23,000 IMG resident physicians on duty as of August 1, 1994, about 9,000 were exchange visitors.

Since the responsibility of ECFMG is the evaluation of the quality of the preparation and credentialing of graduates of foreign medical schools for entry into the U.S. GME system, we have some concerns about the H-1B visa entrant. If graduates do not hold a State license and an ECFMG certificate, who is validating their credentials? We are concerned that individuals may be entering the country under the definition of being license eligible rather than licensed. In that case, who validates whether they have taken the examination, whether they have graduated from medical school, and whether their documents are accurate and true?

U.S. Immigration Policy Reforms

Susan Martin, Ph.D.

Foreign medical graduates and their entry through the immigration system is an issue that overlaps the mandates of COGME and the U.S. Commission on Immigration Reform. I hope that this can be the start of a working relationship on these issues. You have the medical expertise, and we have the immigration expertise. Putting that together, we could certainly do a better job on these issues than either group working separately.

The U.S. Commission on Immigration Reform is a bipartisan commission mandated by Congress in the Immigration Act of 1990. Our chair is appointed by the President. We are waiting for the appointment of a new chair after the death of our former chair, Barbara Jordan. The other eight members are appointed by the House and Senate majority and minority leadership. Many of the senior staff are on detail from the executive branch agencies, so we work very closely with them.

The Commission was formed largely because immigration policy is something that attracts high - level public and policy attention about once a generation. In the 1980s and 1990, two major pieces of legislation were passed — the first time major legislation was passed since 1965 — that dealt with issues of both illegal immigration and legal admissions. Congress, not wanting to wait another 30 years or more before looking at the impact of those legislative changes, formed the Commission as a way of giving them up-to-date information about both the intended and the unintended consequences of immigration change. Interim reports are issued, and the final report is due to Congress at the end of fiscal year 1997.

The overall stance that the Commission has taken so far on immigration policy, which I believe is reflected in the bills that are pending before Congress, is that legal immigration, properly regulated, is in the national interest of the U.S., even at relatively substantial levels of immigration in the range of 600,0000 to 700,000 per year. Current immigration is now at about 700,000 legal immigrants. Through most of the 1980s, it was in the range of about 550,000 to 600,000. At those levels, properly regulated immigration can serve our overall national interests.

Illegal immigration, however, is a problem for the country because it is an

abrogation of the rule of law and thereby places a premium on the entry of people who have violated our law in order to get in. More important, however, it's a problem from the immigration point of view because it holds the potential for seriously undermining the commitment to legal immigration. The American public tends to not understand the distinctions between the two types of immigration, and the perception that our immigration system is out of control makes it very difficult to have a generous, humanitarian-based immigration policy in terms of legal admissions.

Of the current 700,000 to 800,000 legal immigrants per year, about 475,000 come to this country on the basis of a family sponsor, or family membership in the U.S. About 100,000 people are now coming on the basis of some type of an employment offer, about 90,000 being skilled professionals and 10,000 being unskilled workers. About 50,000 to 55,000 come each year in what we call the Diversity Program, which are special visas issued through a lottery that go to people from countries that have not been contributing large numbers of immigrants over the past year in order to have some redistribution of the sources of immigration into the U.S.. They have basic education skills, but other than that, the lottery is based on a random selection of people who send in a postcard.

There are about 125,000 refugee and other humanitarian entries per year. These individuals range from people coming from extremely highly educated backgrounds in the former Soviet Union, Eastern Europe, and other countries, to people without any skills or education at all who come from preliterate societies like the highlands of Laos. There is a very wide range of refugees, but a fair number of the people who have over the last 20 years entered as refugees were physicians in their home countries. They are part of the group of refugees for which exceptions need to be made because the circumstances in their home countries pose difficulties in getting documentation or information about their experiences.

In addition, there is illegal immigration. There are about 4.5 to 5 million illegal immigrants in this country who have become long-term residents. Added to that number are about 100,000 new net long-term entrants each year. These numbers do not include people who are commuters or come for short periods, work for several months, and then return to their home countries. That number may be in the 1 to 1.5 million range each year.

About half of the illegal immigrants who come into the country, the unauthorized entries, cross the southern border between the ports of entry. They enter surreptitiously without ever having contact with the Immigration Service. The other half of the illegal immigrants are authorized entries. They come on legal visitors permits on visas, and then at the end of their stay, they either overstay their visa and remain illegally in the country or they violate the terms of the visa and take employment here and enter the job market. There is a fairly large number of people who have been admitted as legal temporary residents and then become permanent parts of our population through this route.

Another major type of immigration into the U.S. is through the nonimmigrant route. That is by far the largest type of migration into this country and probably the least studied, least understood, and certainly, the least documented. The Commerce Department estimates that, including all types of international visitors, tourists, business travelers, students, and workers, this category numbers about 45 million per year. It's a tremendous economic value to the U.S. After the health segment of the economy, the second largest part of the economy is actually international tourism. One of our largest net additions to our gross national product is through foreign tourism. It's a tremendous

value to us but also requires monitoring, in light of the potential problem in terms of the overstay, although those that overstay are an extremely small part of a 45 million group.

In addition to tourists, there's a smaller number of people admitted for longer periods, usually with J and H visas. There are a variety of other visas, as well. Each year we provide visas for about 250,000 foreign students through the F visa. There are about 200,000 coming in under the J visa, of which a small number are foreign medical graduates. A much larger number are coming to study or to participate in other types of cultural exchange or training programs.

We also have several hundred thousand temporary workers who come in either through the H visa or through an alphabet soup of other visas that include the O, P, Q, R, and T N visas. There are 44 different separate nonimmigrant visa categories, which makes it extremely difficult to keep track of this system of immigration or to know its full impact.

The Commissions first report, "Restoring Credibility," dealt with what we considered to be the first priority for immigration reform — controlling illegal immigration. We needed better border management and a better system for enforcement of labor laws and immigration laws at the work site to allow employers to verify whether a worker is legally authorized to be in this country and to work here. We also need an approved capability to remove illegal aliens who have remained in this country and managed to avert border controls and work site enforcement efforts. We need a better way to move people during emergencies, as with Cuba and Haiti, for example, where we have people directly arriving on our shores and no way to handle those movements.

Both of the bills introduced by Senator Alan Simpson and Congresswoman Lamar Smith have provisions that would increase the capability for curbing illegal immigration into this country. The most controversial parts of those bills are provisions to pilot test a computerized system by which employers can verify the authorization of both citizens and aliens who work in this country using the social security number as the principal method of verifying eligibility. So far, those provisions have survived in the House and Senate Judiciary Committee, but it is likely that they will be hotly debated on the floor of both the Senate and the House.

Our second report was on legal immigration, the permanent immigration system, where numbers were not considered the issue. The issue really is how we regulate our immigration system. The system can sustain fairly sizable numbers of people coming in each year as long as we have our priorities straight and are admitting the people that we feel are most important to admit. Here we've made a number of recommendations which again are reflected more or less in the legislation. First, we've recommended that family-based immigration be shifted so that we would take numbers that are currently used for admitting extended family members and adult children and brothers and sisters and transfer them into speedier admission of nuclear families, spouses, and minor children. The reason is that — and this is an issue that would come up more in terms of the family members than foreign medical graduates — there is now a list of 1.1 million spouses and minor children who are awaiting entry into the U.S. Many of them are in the country illegally, some with a tolerated status. Others are outside of the country unable to even visit with their spouses in the U.S. This backlog grew very large as a result of the legalization of about 3 million illegal aliens in 1987 – 88, but only illegal aliens in the U.S. obtained legal status. The spouses and minor children did not, and therefore, they have now had to apply through the regular system. We have

recommended that we process these applicants very quickly, even if it means that the numbers are taken from those currently used for adult brothers and sisters and adult children, because the nuclear family has a higher priority for our immigration system.

In terms of the skill-based immigration system, we have recommended that visa categories be continued for highly skilled workers and professionals but that the categories for unskilled workers be eliminated. There are far too many unskilled workers in our own society, and in the context of welfare reform, many of them will be entering the labor market. We must ensure unskilled workers are not facing competition from foreign workers any more so than is absolutely necessary.

In terms of skilled workers, we believe that the priorities for admission should be somewhat commensurate with the skill level. Those who have advanced degrees or who are highly skilled professionals pose many advantages and relatively few disadvantages for the U.S. economy. The tests for admitting those individuals should be as streamlined as possible. American professionals, we believe, thrive on competition from other highly skilled professionals with experience and advanced degrees. It now takes 2 years to get certification for the entry on a permanent basis of a skilled professional. We would like to see that go down to a few weeks rather than a couple of years, and in exchange for a tedious bureaucratic labor certification process, we would like to see employers pay a fee that's about equivalent to the dollar amount that they spend now on labor certification. On average, we understand there's about a $7,000 – 10,000 cost for labor certification. We prefer that this money, instead of going to immigration attorneys and advertising for nonexistent positions, go into a training fund to increase the skills of American workers and be used as the method of determining need.

The Commission is currently in the process of reviewing the nonimmigrant system. There are a number of areas that require reform, many of which touch on the foreign medical graduate issue. First, there should be a much more simplified system for nonimmigrant admissions. People with similar reasons now enter this country under numerous different visa categories; thus a medical resident can enter either under the J category or the H-1B category. One is for cultural exchange; the other is for temporary work. I'm not sure why either is really appropriate to this category of entry; neither quite explains the rationale. We would like to have categories that are simpler, more discrete in terms of their usage, and more understandable to average people.

We need to ensure that we have the basic protections required for the U.S. workforce, commensurate with the skill levels. If an individual is entering this country because he or she has unique skills needed by an American employer, that process should be fairly simple and easy and as economical to the employer as possible. Conversely, when we're bringing in hundreds of people at a time in a basic journeyman professional capacity with relatively few requirements for additional expertise or skills or experience, at that point we have to really ask, "Who might be displaced by the entry of those individuals?" I'm not sure foreign medical graduates fit this particular area, but in the health professions, probably the largest growing H-1B category is for physical and occupational therapists with certifications.

Another area of consideration is the transition from one nonimmigrant visa to another. This involves primarily students who have temporary work visas who obtain permanent status. What are the circumstances under which we want to see people remain in the U.S.? What are the circumstances under which it would make more sense for a return to be either encouraged or required?

Personal Perspective Of An International Medical Graduate

AppaRao Mukkamala, M.D.

We are not guilty as charged. I bring to you greetings from 129,00 IMGs presently in the U.S. who pursued their undergraduate education outside of the shores of this country at no cost to the taxpayers of this country. I bring to you greetings from 23,500 IMGs who are presently enrolled in graduate medical programs in the U.S. Of these, 4,000 IMGs who are American citizens send their greetings to you. I bring to you greetings from 8,200 IMGs who are permanent residents, legally obliged to stay permanently in this country, receiving their postgraduate education in this great land of opportunity. I bring to you greetings from 8,900 IMGs who are exchange visitors who received their undergraduate education outside this country and are currently here and plan to go back to their country of origin unless INS offers them a waiver because they're needed here.

As you can see, IMGs are not a homogeneous group. They are U.S. citizens, immigrants, refugees, and exchange visitors. These IMGs received their undergraduate education in a foreign land at no cost to the taxpayers of this country.

Physician workforce is clearly a key factor in several issues facing medicine today. What is not clear is what should be done about it. I believe, and most of my colleagues believe, that the quantity dimension of the workforce is one of the fundamental factors in a free market system and is better left alone to find its own equilibrium through the normal workings of supply and demand. Anything that is done to interfere with it will only make matters worse in the long run. It may look appealing in the short run. This is not the first time that a panel of this size has been convened in this country. In the 1980s, the old imperative dictated that by 1995 there would be so many physicians that they would be driving taxi cabs. I don't see that happening. I don't see very many doctors standing in the welfare lines.

There is no consensus among researchers as to the quantitative and qualitative aspects of the workforce needed in the future to serve the American public in the best possible way. Of the 23,500 IMGs who are currently enrolled in GME programs, approximately 50% are either citizens or permanent residents who hold immigrant status. They made this adopted home their permanent home. Put in other words, approximately 3,000 IMGs who are entering the GME programs every year are either immigrants or permanent residents and citizens. They need to be accommodated in GME programs. We'll have to add this number to the 17,500 U.S. medical students that graduate every year, making it imperative that we need approximately 21,000 entry level positions to accommodate our own citizens who are graduates of medical schools in this country and citizens who have gone outside our shores to get medical education because they could not fulfill their wish of becoming a doctor in this country. We have to add to this the physicians that may want to enter into GME programs to be retrained. This puts a question on the magic number of 110%. Where it came from, I do not understand and neither do most of my colleagues.

Exchange visitors are in a totally different situation. They are here for advanced training in this great country and plan to return to their homes unless an opportunity is offered to them because they're needed in underserved areas.

Please remember that IMGs have come to this great land of opportunity based on need. American citizens have gone abroad to become doctors because they could not make their

dreams come true in this country. We could not accommodate them in our American schools. These IMGs practice in locations that are not really attractive to U.S. medical graduates — public hospitals, rural areas, indigent areas, and public health centers. It is very often the poor, the indigent, and the uninsured that are dependent on IMGs for their care. The IMGs and minority physicians bear a disproportionate share of the financial burden of caring for this population.

The whole issue of workforce and physician supply and GME funding needs further thorough study by a private sector task force before jumping to solutions. There are four distinctly different yet related issues that need to be addressed: (1) physician workforce needs, quantitative and qualitative; (2) GME funding, how it affects the Medicare budget, and what it would cost to substitute the residents with other workforces; (3) immigration and naturalization policy; and (4) the maldistribution of physicians.

As many of you are aware, there is at least 100% variance between the number of physicians that are practicing in the most affluent areas compared to undeserved areas. In the present system of GME, educational competence is inseparable from the patient care complement, regardless of the original policy. Let me dramatize for you a typical event that occurs any given day at every hospital in this country. At 2:00 a.m. an ambulance pulls up to the emergency room carrying a patient with a gunshot wound or a patient severely injured in an auto accident. The chances are that the patient will be seen, evaluated, and treated by a group of residents working in the emergency room, the emergency department, surgery, and the critical care unit. The chances are at least one-fourth of these residents will be IMGs. These graduates are paid by the hospital, which in turn receives funding from Medicare, representing approximately 30% of the total cost, the remainder being paid for by nongovernmental sources. Can anyone separate the patient care component in this clinical situation from the educational component? I believe not.

In the GME program, IMGs are filling the slots left unfilled by USMGs. Approximately 10 – 15 years ago, these openings were in primary care, internal medicine, pediatrics, psychiatry, and obstetrics and gynecology. In 1995, the openings are in anesthesiology because two-thirds of the slots, I believe, were unfilled at the first shot. IMGs take the slots not occupied by USMGs. They are not displacing anyone from his or her position.

I'm not a statistician, I'm not a policy maker, I'm no expert on immigration issues, but I am an IMG. I repeat that we are not guilty as charged. We have not contributed to the excess of physicians that is perceived at present. We have filled a void created by lack of physicians in this country.

Market forces, not interference and manipulation, should determine the answers to the workforce issue. We need a minimum of 120% first-year residency slots available to accommodate U.S. citizens and immigrants. We cannot discriminate against our own citizens by paying differently for the same service because one has received undergraduate medical education elsewhere. IMGs should not be used as solutions to the problems of a confused health care system. By reducing the number of physicians, the American public will be left with a smaller pool of doctors, which will have a more serious impact on the problems of distribution.

The health care system in America should be devoted to providing the best possible care to its citizens. Resources should not be squandered in assuring that adequate income and employment for physicians will exist

in the years to come. Residency programs should accept participants from the available pool of applicants based on merit and qualifications only. Physicians should also be able to advance in a free market system by merit and qualifications alone. To arbitrarily indicate that the number of IMGs must be reduced because they're causing an oversupply of physicians is very un-American and anti-free market. There is no evidence that undergraduate medical education pursued by IMGs is inferior to that provided to USMGs.

Questions And Comments

Dr. Bustamante: I hope that we can work toward a credible immigration law in the U.S. that is regarded internationally on par with other countries that have been successful in inviting physicians to train in their midst and then return to their home countries to practice improved medicine. Germany, Canada, and Sweden are good examples. There is a lot that we can do to work toward the solutions. There will be no total solutions, but each one of the solutions will help in the final product.

Dr. Knouss: I'd like to ask a question about the current legislation that's going through Congress because it's my impression that it is going to really ratchet down tremendously, if passed in either the Senate or House form, the number of immigrant visas that are awarded. It's going to constrain preference categories and, most important, it's going to impose some new conditions on employers for hiring people here on temporary visas. Could you explain a bit about that because I think in the next month or two we should see some very significant changes.

Dr. Martin: The legislation focuses more on constraining visa categories than on imposing an immediate drop in immigration numbers. The reason is that in both bills there is a commitment to shift visas from extended to nuclear family members, based on the rationale that the categories allowed to enter the country under family-sponsored immigration will be spouses and minor children of U.S. citizens, parents of U.S. citizens, and spouses and minor children of legal immigrants. No longer admitted would be adult children of U.S. citizens or legal immigrants or brothers and sisters of adult U.S. citizens.

For the short term, those numbers would be transferred because of the backlog in clearances for spouses and minor children of legal immigrants. Once those backlogs are cleared, immigration would drop because the demand in the nuclear family categories is quite a lot lower on a year-to-year basis. The extended family members are counted when we're not legalizing millions of people. It would result in tremendous dislocation for some of the families expecting their adult children or their adult siblings to be coming into the country, so it is a major shift in policy. Whether it will have as much of an immediate effect as it sounds is somewhat questionable right now because there are more than 1.5 million brothers and sisters on the waiting list. On average, the separation took place about 15 years ago because it was necessary to have applied 15 years ago in order to enter the country today as a brother or sister of a U.S. citizen. It actually means that the wait is even longer because a legal immigrant coming here would have to wait 5 years to become a citizen, then could petition for a sibling who can enter the country 12 – 15 years later.

For example, if an immigrant comes from the Philippines and applies today as a

brother or sister of a U.S. citizen, he or she will be admissible in 44 years. There are going to be some shifts, partly because our system really doesn't work right now.

The House bill keeps the employment-based system virtually unchanged. It alters the ceiling from 140,000 to 135,000 and eliminates unskilled workers, so actually 135,000 is a higher number for skilled workers than current law. The Simpson Bill did lower the ceiling on skill-based immigration from 140,000 to 90,000, but 90,000 is the current number of skilled workers coming into the country, so it was setting the ceiling at the current level. It would not have allowed as much growth as might have occurred under the current law. Senator Simpson has announced that he will pull back those employment base proposals because of the opposition of corporations to those changes, and he has also said that he will not move to have changes made in the labor testing or labor certification for the skill-based areas. Right now it's not clear whether that would be seen in the bills.

Dr. Kindig: Where are we in terms of either consolidation of the Federal authority under the DHHS or moving totally to a State-based system [in the administration of the J-1 waiver policy]?

Ms. Jones: It is under review. There have been a few meetings in which the White House Domestic Policy Council is involved. We have spoken to all of the other agencies involved, and there has been at least one meeting where we're trying to move toward State control, but as it is right now, nothing has changed. The Departments of Health and Human Services, Agriculture, and Housing and Urban Development, and the Veterans' Administration, and Appalachian Resources Commission are continuing their programs as in the past. Whether there will be any change is impossible to know right now.

Dr. Bustamante: Improving our credibility in immigration laws is very important. All those waivers and the intricate ways they're applied may need to be simplified in order for the U.S. and the international scene to improve our credibility.

Public Comments

Dr. Ahmad: The comments and the diversity of opinions about this issue are very interesting, as are the different areas and subjects covered. I have two points to make.

The IMG issue can be divided into two factions: those IMGs who are here on a J-1 visa, those who are, and hopefully, will go back to their countries. The latter are different from the IMGs who are citizens, either USIMGs or foreign-born IMGs. The issue of the J-1 visa really depends either on the INS or the State Department and the Department of International Relations in determining how much we want to train physicians from other countries to go back to their countries and to help them transfer knowledge from here to there.

My concern in the COGME report is about those physicians who are U.S. citizens, green card holders, or the U.S. citizens who have gone abroad for education. I hope we remember that those are U.S. citizens as much as anybody else, and it is not right to say to them under any guise that we will either cut their funding by 35% or cut residents by 35%. I've been here for 27 years. I have been

president of a chamber of commerce, and president of a school board, and I serve the Nation in many capacities. I pay my income taxes and my social security taxes, and I've met all the obligations that I have as an American citizen. Then you tell me, "you are a good citizen, you do everything we want you to do, pay your taxes, but we will not pay for your medical education." It is downright un-American. It's illegal. It's immoral.

You can stop immigration, stop the people on the border, but as a citizen, when I apply for my medical education, to say that I can not test on a legal basis with anybody of equal competence and education just because I went to a foreign medical school and to cut my funding is not right. You can do that, but then tell me I don't have to pay taxes. When thinking about cutting the funding for the IMGs, I want you to think twice. For people like us who've been here, who were born here, who've done everything, as American citizens, as American as — maybe not apple pie but cherry pie — we need the same rights and privileges as anybody else. That report will exclude us from going into GME.

Dr. Haspel: You must be thinking of a different report. I don't think we ever said in any COGME reports that we were excluding anybody from entering GME. The only recommendations in the Seventh Report that dealt with IMGs dealt with funding, and that is not cut off for IMGs. In fact, it presumed that a number ultimately 10% greater than the output of the U.S. system would, in fact, enter GME slots and would be paid for by Medicare. Nothing prohibits institutions from taking IMGs without making the Medicare system pay for them. In fact, for many years before the Federal government got in the game, institutions were paying for GME. Many citizens trained in the U.S. actually got GME with small stipends or no stipends. So I don't think this is anything un-American whatsoever. I don't think it's even focused on that.

From an equity perspective, if your son or daughter wants to go to a U.S. medical school, you ought to have some certainty that at the end of the pipeline of his or her training, GME training is available in this country, and that is the higher order. It's not un-American at all. It's an effort to preserve the rights of Americans to seek and receive education in the U.S. if they qualify to get that training. We're all from different nationalities. We all came from immigrant populations. So I guess I understand the concern, but I don't really think that's what we said, and I want to make sure that we at least have clarified that issue.

Dr. Rodriquez: I represent the Inter-American College of Physicians and Surgeons. I would like to make a comment in reference to IMGs. Obviously, we haven't talked here about the real problem with the IMGs. They come in different sizes, shapes, colors, and speak different languages. Obviously, we have the problem of the visa. These are IMGs like those that have spoken here and the invisible ones, such as those that come from Canada or from Eastern Europe that nobody mentions, like the professor in my medical school who came from Italy where Americans graduate but have the opportunity to intermingle and look like everyone around and they all speak funny like we do.

At any rate, I would like to see COGME try to concentrate on what we can fix and not what is wrong because we have a lot of things wrong here in this country, mainly in health issues. GME is part of the problem of health care today. Why in New York State and Massachusetts do medical education programs get $200,000 a year per resident and in Texas or Tennessee they get only $40,000 or $50,000? It is because they don't have a Senator Kennedy or a Moynihan that can push in the big pile of money. These are public numbers that we all know.

Health has never been fully marketed in this country. We talk about all the issues of free market, but there has never been a free market in health. Since I came to this country 35 years ago, when we passed Medicare and created this big pile of money, every time a physician sees a patient with a green card or with a Medicare card, they order more than they should and the patient goes to the doctor even to get an aspirin because, if they go to the doctor, they get the free consultation and the aspirin is free, paid by Medicare.

When I came to this country, we had the best communication — I should say the best telephone system in the world. Then Congress got hold of AT&T. Now when you break your phone, you don't know who to call. I think that the best thing that COGME could do is to tell Congress to get out of the health care business, and I'm sure that we'll resolve a lot of problems.

Dr. Jayasankar: I'm an orthopedic surgeon from Boston. I'm an IMG. I'm not formally representing any group or all of the IMGs, except informally, and I want to present a slightly different viewpoint.

There was a time when I came here in the 1960s when health care was very different. There was a blank check. We needed more physicians. We were actively recruiting from all over the world. Things have changed, and now we're looking at what happened and how to control it. So the perspective is very different from the point of view of the politicians and people such as the group here trying to organize and plan things. The data that have been collected on which to base proposed solutions are very good.

I heard one of the talks yesterday at the American Medical Association meeting. They have very thoughtful minds, but they can't agree on the data or how to interpret them. These are very serious students of this aspect of medical care in terms of the physician workforce. Two of the speakers, one of whom was the chairperson, Dr. Kennedy, had a different viewpoint and different numbers to present than some of the other members. So the data, at best, are arguable. They're not uniform. The interpretation is certainly very different and the inferences drawn by very capable students are quite different. In fact, the recommendations seem to be extremely different, almost diametrically opposed. Given that, I might reinforce some of the caution that was mentioned by some earlier speakers that we not jump into solutions that may be more dangerous than the disease. We want to be cautious in interpreting the data because some of the data that were projected 10 years ago don't seem to be accurate.

The next question is, if there is a problem based on the data, if we accept that there is a problem, should we propose a solution and, if so, how? The part that occurs to most of us, especially when we look at it scientifically as many of us are devoted to do in some sciences, is that we should plan it, and organize it, and do it. That was the talk among many of the elite intelligentsia at the beginning of the century. We've had some very major experiments of central planning, and they did not work out as planned.

My concern is that in planning all this, you should not reduce the pool of talent available, to be chosen for either undergraduate or graduate medical education, because the ultimate loser will be the American public. If that is what we're concerned about — and rightly I think we should be if medical education and physician supply and workforce face that — then I think we should not reduce the number of IMGs. It's not only the quantity, it's the quality that's important. We should not artificially restrict the pool by making these recommendations to restrict one group or the other.

Dr. Winn: I'm the Executive Vice President of the Federation of State Medical Boards. I'm not really here to make a public comment, but the discussions this afternoon were very interesting. I have a question for Mr. Brown and Ms. Cox from INS. This concerns the issuance of H-1B visas to physicians. The legislation, as I understood it, required physicians who wanted an H-1B visa to have successfully passed an examination acceptable to licensure in this country, which was determined by the Secretary to be Federation Licensing Examination, National Boards, or the USMLE.

Unfortunately, though, there apparently were a number of H-1B visas issued to physicians who did not qualify. We have identified a sizable number of physicians who are engaged in residency training programs who have not passed any examination to qualify for such entry, any portion of the Federation Licensing Examination, or any portion of USMLE. My question really is how can we address this quality issue? Can those physicians be recalled and the H-1B visa be reissued after determination that they had in fact passed an examination or at least be required to conclude their training at the end of the specified period (i.e., the end of the graduate year) and reapply through ECFMG (which our preference would be) to become ECFMG certified before continuing any further training?

Mr. Brown: We would be more than happy to look at those cases we apparently approved in error if you could provide us with any information concerning those individuals. In H-1B there's a petition that has to be filed for the aliens so the service reviews every case — the field office — has been instructed to make sure that applicants have licensure, that they meet all the State requirements, and that they pass the Federation Licensing Examination or the equivalent. The cases are reviewed by human beings. I can't sit here and say that we don't make mistakes. I'm sure we do. But if there is a trend, we would be more than happy to get the information.

Another problem we run into is that a new service center started doing business petitions again, the one down in Texas. There are four service centers. We think there might be some problems down there. Hopefully, they're related to one issue. But seriously, if you could get the information to me, I will be more than happy to look at it.

Dr. Sumaya: This issue is going to last awhile, and one has to bring much scrutiny and critical thinking into the issue. What is going to be the effect of market forces as we see the decrease in hospital beds, particularly of our large public hospital system? How will that affect residency slot numbers, and also what impact will that have on IMGs in a number of residency positions? I think it's something we need to monitor and study very carefully.

Another issue is what is happening to programs like the J-1 visa? We at the Health Resources and Services Administration are sponsoring a study with the Appalachian Regional grouping, looking at tracking systems for them to see where they are going, whether they are staying, what impact they are having in these underserved communities, and to what extent of time. These are just two small points that I think we need to study more to determine what is happening and the impact of various changing health care environments.

To Professor Mick, I presume that the data that were presented represent more of the prevalence type approach, and I would hope there are cohort studies that we're following through a longer period, trying to get to this complicated issue. That may be an area that we also need to explore.

Dr. Bustamante: The Bureau is commissioning a study on where IMGs come from and where they go. It's very important to fill this gap because studies as serious as that published by Miller et al. are still relying on data generated in the late 1970s and obviously are not relevant to the mid-1990s.

Dr. Kindig: In closing, I'd like to thank our guests from both panels who have provided us with an enormous education. I'd also again like to thank the COGME staff, Enrique Fernandez, Larry Clare, and particularly Stan Bastacky, for helping to put this program together. This is an education seminar to help COGME, its membership, and its work group, get a better handle on the issue. Last year we were only looking at the little IMG resident piece of it, and we need to put this in a broader context. This information is going to help us as our workgroup continues to do studies.

In addition to that ongoing work, whatever studies we can come out with, along with perhaps some revised policy considerations down the road, it is also clear to me that we have a communication issue about what we've done. It's a very difficult issue. It's like when we worked only on the primary care issue. If you're for primary care, you're often against specialists. That becomes the implication. Of course, that isn't the case. It's the same kind of thing here. The implication that anything we would consider would be directed to U.S. citizens who have been trained abroad is unthinkable, and we've never talked about that. Actually, I decided sitting here to offer Sergio [Bustamante], Why don't you and I try to co-author a piece that at least explains what we did in a way that hopefully communicates that and puts it in some other context? We need to communicate clearly what we're doing on these things. This is going to put our work forward and, hopefully, the work of others.

Abbreviations

CSA: Clinical Skills Assessment

COGME: Council on Graduate Medical Education

DHHS: Department of Health and Human Services

ECFMG: Educational Commission for Foreign Medical Graduates

GME: graduate medical education

INS: Immigration and Naturalization Service

IMG: International medical graduates

NHSC: National Health Service Corps

USIA: U.S. Information Agency

USMG: U.S. medical graduate

USMLE: U.S. Medical Licensure Examination

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