IS THERE A DOCTOR IN THE HOUSE? THE ROLE OF IMMIGRANT PHYSICIANS IN THE U.S. HEALTHCARE SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON IMMIGRATION AND CITIZENSHIP

OF THE

COMMITTEE ON THE JUDICIARY
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APPENDIX

IS THERE A DOCTOR IN THE HOUSE? THE ROLE OF IMMIGRANT PHYSICIANS IN THE U.S. HEALTHCARE SYSTEM

Tuesday, February 15, 2022

HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON IMMIGRATION AND CITIZENSHIP

COMMITTEE ON THE JUDICIARY
Washington, DC

The Subcommittee met, pursuant to call, at 2:00 p.m., via Zoom, Hon. Zoe Lofgren [Chair of the Subcommittee] presiding.

Present: Representatives Lofgren, Nadler, Jayapal, Correa, Garcia, Jackson Lee, Scanlon, McClintock, Buck, Biggs, Tiffany, and Spartz.

Staff Present: John Doty, Senior Advisor and Deputy Staff Director; David Greengrass, Senior Counsel; Moh Sharma, Director of Member Services and Outreach & Policy Advisor; Cierra Fontenot, Chief Clerk; Merrick Nelson, Digital Director; Joshua Breisblatt, Deputy Chief Counsel; Anthony Valdez, Professional Staff Member/Legislative Aide; Julie Rheinstrom, Counsel; Andrea Loving, Minority Chief Counsel for Immigration; Kyle Smithwick, Minority Counsel; Andrea Woodard, Minority Professional Staff Member; and Kiley Bidelman, Minority Clerk.

Ms. LOFGREN. The Subcommittee on Immigration and Citizenship will come to order, a quorum being present.

Without objection, the Chair is authorized to declare a recess of the Subcommittee at any time. I want to welcome everyone to this afternoon's hearing: Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System.

I'd like to remind the Members that we've established an email address and distribution list dedicated to circulating exhibits, motions, or other written materials that Members might want to offer as part of our hearing today. If the Members would like to submit materials, please send them to the email address that has been previously distributed to your office, and we will circulate the materials to the Members and staff as quickly as we possibly can.

I also ask all Members to please mute your microphones when you're not speaking. This will help prevent feedback and other technical issues. You can unmute yourself anytime you seek recognition.

This hearing will explore the essential role of immigrant physicians in the provision of general and specialized healthcare in the United States. Access to high-quality healthcare has long been an issue of great importance throughout the United States and, unfor-

tunately, for many, access to healthcare has been lacking due to a scarcity of physicians in their area.

Our immigration system has long contemplated a need for physicians. Throughout the pandemic, immigrants in healthcare fields have served on the front lines and have been a driving force behind the research that led to the development of vaccines and cutting-edge COVID–19 treatments. Unfortunately, our antiquated immigration system discourages these needed physicians from coming to and remaining in the United States, which exacerbates a serious level of physician shortages.

This hearing will allow the Subcommittee to hear from Witnesses who will discuss the current and future demand for physicians, the current process for foreign physicians to complete medical residencies and remain permanently in the United States, as well as the need for reforms to our immigration laws as they pertain to physician immigration.

Now, I've Chaired the Immigration Subcommittee in this Congress and in prior years, and one of the things I'm committed to doing is making sure that less Senior Members of the Committee also have an opportunity to sit in the Chair, have the opportunity to shape a hearing, and have the experience of presiding.

With that in mind and, without objection, my colleague, Representative Mary Gay Scanlon, will preside over this hearing, give her public statement, and recognize our esteemed Ranking Member, Mr. McClintock.

So, I now recognize Ms. Scanlon for her opening statement and ask her to take the virtual Chair.

Ms. Scanlon.

Ms. SCANLON. Thank you, Chair Lofgren. I thank you virtually as I take the virtual Chair. So, thank you for the opportunity to Chair today's hearing to discuss the importance of immigrant physicians in our healthcare system.

The United States is currently facing a shortage of physicians. According to the U.S. Department of Health and Human Services, more than 86 million people live in areas with an insufficient number of primary care physicians. The coronavirus pandemic has exacerbated existing shortages as physicians across the country have been under extreme strain, causing some of them to leave their jobs. Sadly, some of our most dedicated frontline physicians have lost their lives in the fight against this pandemic.

Immigrant physicians have been on the forefront of this fight, putting themselves in harm's way, even when for some of them their death would leave family members without status and at risk for deportation.

Foreign nationals make up about 25 percent of the population of those obtaining graduate medical education in the United States. The Educational Commission for Foreign Medical Graduates, the Philadelphia organization that certifies and sponsors foreign physicians who undergo medical training in the United States, reports that over 70 percent of the physicians they sponsor for training are pursuing graduate medical education in a primary care specialty. We cannot continue to attract foreign physicians to this country with an immigration system that doesn't take their dedication into consideration.

Now, our current immigration system makes it difficult for immigrant physicians to work in the United States. For example, while our immigration laws seek to encourage immigrant physicians to work in rural and medically underserved areas, the pathways to legal status and work authorization in such areas are insufficient.

The Conrad 30 program, which helps place immigrant physicians in underserved areas, only allocates a maximum of 30 slots in each State. My home State of Pennsylvania, which has the fourth highest number of immigrant physician exchange visitor trainees in the United States, in part because we have such a robust medical training system in the region, nearly always has more than 30 applicants for its Conrad slots.

Additionally, the pathways to green cards for immigrant physicians involve decades-long backlogs for individuals from countries like India and China. These long waits discourage physicians from remaining in our country when they know they can travel elsewhere and obtain permanent residency in a matter of months.

The lack of physicians is exacerbated by the fact that our population is aging. As more and more people in our country reach retirement age, we will need additional doctors to meet our Nation's healthcare needs. Presently, 34 percent of the demand for physicians comes from patients 65 and up, what is projected to only increase in the coming years. Meanwhile, over two of every five physicians in the United States will be 65 or older within the next 10 years. So, those retirements are also creating additional pressure.

It's imperative that we work to fix this problem now, to ensure that Americans have access to the medical care they need. Immigrants play an important role in alleviating the physician shortage. It's especially important that we address the problems immigrant physicians face as they disproportionately fill jobs in general medicine and gerontology, which face staffing shortages, and underserved areas that badly need medical care.

I'm looking forward to discussing the significant contribution of immigrant physicians to our healthcare system and the proposals to improve our immigration system to better utilize their talents. This is a bipartisan problem that requires bipartisan solutions, and I'm committed to working with my friends and colleagues across the aisle to find those solutions.

So, I wish to thank all our Witnesses for appearing today, and I'm looking forward to hearing your perspectives.

So, it is now my pleasure to recognize the Ranking Member of the Subcommittee, the gentleman from California, Mr. McClintock, for his opening statement. We're so glad to see you here today.

Mr. MCCLINTOCK. Thank you, Madam Chair. Thank you for your kind words.

In the time that the Democrats controlled the Executive Branch, roughly 2 million illegal immigrants have been apprehended by Customs and Border Protection and, of these, roughly a million have been admitted into our country. That doesn't include the hundreds of thousands of got-aways who've evaded apprehension while the Border Patrol has been inundated by migrants responding to the unmistakable open borders invitation that this Administration issued on day one.

It is quite clear this policy is deliberate. As Secretary Mayorkas bragged last month, and I quote: "We have fundamentally changed immigration enforcement in the interior. For the first time ever, our policy explicitly states that a noncitizen's unlawful presence in the United States will not, by itself, be a basis for the initiation of enforcement action." Now, let me repeat that so it sinks in. Quote: "A noncitizen's unlawful presence in the United States will not, by itself, be a basis for enforcement action."

Fellow Americans, if our immigration laws are not going to be enforced, we have no immigration laws. If we have no immigration laws, we effectively have no border. if we have no border, in very short order we will have no country, just this vast international territory between Canada and Mexico.

No civilization has ever survived a mass migration on this scale that the Democrats have been actively encouraging, aiding, and abetting since they took power. History warns us that countries that either cannot or will not secure their borders simply aren't around very long.

Now, in this deliberately created border chaos, individuals on the terrorist watch list are entering our country. Previously deported aliens who have committed murder and other crimes continue to enter our country.

Now, this is the Immigration Subcommittee of the House Judiciary Committee. Republicans have begged the majority to address this crisis since they created it. Instead, the Subcommittee has had five hearings, including this one. In four of the five, the Democrats have focused on bringing additional foreign nationals into the United States.

They have yet to explain how American workers are helped by flooding the market with cheap foreign labor, or how our schools are made better by flooding classrooms with non-English-speaking students, or how our streets are made safer by refusing to deport criminal illegal aliens as the law requires. They have yet to explain how our hospitals are made more accessible by packing emergency rooms with illegal aliens demanding care.

Instead, their solution is to import still more foreign doctors to treat the exploding foreign population. Enough.

As we will hear, there are thousands of U.S. citizens who have earned their medical degrees, at enormous cost, some carrying over $100,000 in debt to do so, but they cannot be placed in residency programs that make it possible for them to practice medicine.

Furthermore, foreign nationals are already admitted to practice medicine in this country through a large number of visa programs. They qualify for J visas: 353,000 were issued in 2019. How many physicians were included? We don't know. They qualify for H–1B visas: 188,000 were issued in 2019. How many physicians among them? Unknown. They qualify for O visas, 18,000 were granted in 2019. How many physicians were included? Again, unknown. They qualify for TN visas: 21,000 were issued. How many physicians? Unknown.

Yet, as we will hear, the physician shortage in the United States is largely of our making. We have the doctors. We just don't match them with the residency programs they need to enter practice. Now, don't you think that just maybe we ought to put American

physicians first? Don't you think just maybe we should take control of our borders before we encourage more foreign nationals to cross it? Don't you think just maybe we ought to enforce our immigration laws before our jails, our schools, our prisons, and our hospitals are completely overwhelmed?

The American people are awakening to the damage that's being done by the left's open border policies. The proceedings today are just another attempt by the left toward meaningless borders. The American people know what that means to their families, their prosperity, their communities, their safety, their schools, and their healthcare.

Now, when we put Americans first, we enjoyed the lowest unemployment rate in 50 years, the lowest poverty rate in 60 years, and the fastest wage growth in 40 years. I believe the American people are going to want those days back very soon, and that includes securing our borders. They're going to have the chance to set things right very soon, in about 266 days, I believe.

I yield back.

Ms. SCANLON. Thank you for that, Mr. McClintock.

I will now recognize the Chair of the Judiciary Committee, the gentleman from New York, Mr. Nadler, for his opening statement.

Chair NADLER. Thank you, Madam Chair.

Our country has long relied on foreign-educated physicians to supplement the domestic physician workforce. Today's hearing invites us to explore the role that immigrant physicians play in the provision of healthcare in the United States, including essential services they provide to Americans in rural and medically underserved areas.

I also appreciate the opportunity to examine how our broken immigration system has made it difficult for such physicians to remain in our communities and continue to provide critical care to those in need.

Today, approximately 200,000 foreign medical graduates work as physicians in the United States. Immigrants account for more than 50 percent of physicians practicing geriatric medicine, approximately 40 percent of those practicing critical care and internal medicine, and nearly one-quarter of those practicing general medicine.

Even before the COVID–19 crisis, experts were projecting that our country would experience a significant shortage of physicians in the near future. Due to the aging population and other factors, the American Association of Medical Colleges estimated a shortage of nearly 140,000 physicians by 2033.

The COVID–19 outbreak has brought this problem into sharper focus. The pandemic has taken an enormous mental and physical toll on physicians in the United States, exacerbating existing shortages and making these projections even more dire.

In response, Governors throughout the country, including in my home State of New York, implemented emergency measures, such as relaxing licensing requirements, to increase the pool of available physicians. Yet, many States still struggle to meet the demand for care.

Unfortunately, our outdated immigration system only adds to the problem. Although foreign-educated physicians can come to the

United States to complete their medical training, their temporary visa options are limited. Without a visa classification that is designed specifically for them, foreign physicians are forced to deal with the challenges of the flawed system that was designed decades ago.

After completing their training, if they want to stay here permanently and continue to treat patients in their communities, they must overcome additional obstacles. For example, the Conrad 30 program, which is intended to facilitate the placement of immigrant physicians in underserved areas by shortening the visa application process, only allows 30 such physicians in each State to benefit from this program. If a physician is fortunate enough to be allocated—to be allotted one of those visas, many must then wait for years and often decades for an immigrant visa to become available.

Over the years, various bills have been introduced that would improve the physician immigration system. Some would exempt certain physicians from the numerical limits on immigrant visas. Others would remove or ease the current barriers while streamlining and improving processing. We should explore these and other options.

We have an obligation to ensure that all Americans have ready access to quality medical care today and in the future. To do that, we must ensure that our immigration system facilitates rather than blocks the admission of the best doctors from around the world.

I want to thank Chair Lofgren and Ms. Scanlon for holding this valuable hearing. I thank all of today's Witnesses for participating in this important discussion. I yield back the balance of my time.

Ms. SCANLON. Thank you, Mr. Nadler.

It is now my pleasure to introduce our Witnesses for today's hearing.

Dr. David Skorton is the President and CEO of the Association for American Medical Colleges, which is a nonprofit institution that represents the Nation's medical schools. So, these are American medical schools, teaching hospitals, health systems, and academic societies.

Prior to becoming the President and CEO of the Association of American Medical Colleges in 2019, Dr. Skorton served as the 13th secretary of the Smithsonian Institution and as the President of two universities: Cornell University and the University of Iowa. Dr. Skorton received both his BA and his M.D. from Northwestern University.

We also welcome Dr. Raghuveer Kura. He's an interventional nephrologist at the Poplar Bluff Regional Medical Center. Following his medical education at the Armed Forces Medical College in Pune, India, Dr. Kura came to the United States in 2003 to undergo graduate medical education in internal medicine and nephrology at Penn State Milton S. Hershey Medical Center and College of Medicine.

Dr. Kura is the only nephrologist serving the small town of Poplar Bluff, Missouri. In 2021, Dr. Kura received his green card under the EB–1 category as a, quote, "alien of extraordinary ability," end quote. Despite the freedom of movement his green card af-

fords, Dr. Kura has chosen to remain in Poplar Bluff, a medically underserved area, to treat his patients.

We also welcome Kristen Harris, principal of Harris Immigration Law, LLC. Having practiced immigration law exclusively for the past 17 years, Ms. Harris advises healthcare entities across the United States regarding immigration, including sponsorship of physicians, researchers, allied healthcare professionals, and technical professionals, as well as E-Verify and I–9 compliance.

Additionally, Ms. Harris works with the American Medical Association, the American Association of Medical Colleges, and the Educational Commission for Foreign Medical Graduates, which is based in Philadelphia, on physician immigration issues. Ms. Harris received her bachelor's degree from Yale University and her JD from the University of Michigan Law School.

We are also joined by Kevin Lynn. Mr. Lynn is the co-founder of Doctors Without Jobs and the Executive Director of Progressives for Immigration Reform. Previously, Mr. Lynn served in a variety of roles in the private sector, including as a director at Ryan, LLC, and as a senior manager at Ernst and Young. Mr. Lynn has served in a volunteer capacity at several organizations, including Respect Farmland, Democracy for America, and the 1992 Ross Perot campaign. Mr. Lynn was a captain in the United States Army and received an associate of arts degree from Kemper Military College.

So, we welcome all of our distinguished Witnesses and thank them for participating in today's hearing.

I'll begin by swearing in our Witnesses. I'd ask that you each make sure your audio is on and that we can see your face and your raised right hand while we administer the oath.

I think, Dr. Kura, you need to unmute as well.

Do you each swear or affirm under penalty of perjury that the testimony you're about to give is true and correct, to the best of your knowledge, information, and belief, so help you God?

Dr. SKORTON. I do.

Dr. KURA. I do.

Ms. HARRIS. I do.

Mr. LYNN. I do.

Ms. SCANLON. Thank you so much.

Let the record show that the Witnesses answered in the affirmative.

Please note that each of your written statements will be entered into the record in its entirety. We'll just ask everyone, Witnesses and Members of Congress, to keep their mute button on when they're not speaking so that we can try to minimize chaos.

Witnesses, I'd ask that you summarize your testimony in 5 minutes. To help you keep track and stay within the time, there is a timer on your screen which you'll see.

So, Dr. Skorton, if you could lead us off, I'd appreciate it.

STATEMENT OF DR. DAVID J. SKORTON

Dr. SKORTON. Thank you, Chair Nadler, the Honorable Scanlon, Chair Lofgren, Ranking Member McClintock, and the Members of the Subcommittee.

Immigration is the bedrock of the United States. It is because of our diversity of backgrounds, cultures, and ideas that we have

thrived, not in spite of it. I have been fortunate to work in education, government, and healthcare, and have seen firsthand the value immigrants bring to this country across the board, even in my immigrant father's family-owned shoe store.

Approximately 23 percent of physicians practicing in the U.S. identify as foreign born. These physicians help improve access to care, particularly for patients in rural and other underserved areas, but many face significant challenges to enter and remain in the U.S. Physician diversity has been widely recognized as key to excellence in medicine and quality care. Physicians from other countries have a unique cultural perspective which can affect patients' health and their healthcare experiences.

The importance of physicians from other countries was seen acutely during the pandemic but is amplified each year as a result of growing nationwide health workforce shortages. The AAMC projects the overall physician shortage will grow to a total of up to 124,000 physicians by 2034. Simply put, we need more doctors from everywhere.

Academic medicine has responded by increasing enrollment by 35 percent over the last two decades, including opening 30 new medical schools and 6 more have applied to be considered for accreditation. However, increasing medical school enrollment without commensurate increases in graduate medical education residency positions has no effect on the size of the workforce, because medical residency training is required for licensure and medical practice.

The AAMC recommends a multipronged approach that includes increasing the number of Medicare-supported residency positions, as well as improving the immigration processes for physicians and for teaching hospitals.

Residency program directors seek the best candidates, regardless of citizenship status or national origin, through a highly competitive selection process, and some students may be unable to find a residency position in the U.S. Last year, 55 percent of non-U.S. graduates of international medical schools matched to a residency program. Comparatively, 93 percent of U.S. seniors matched to a residency program, and 99 percent of U.S. medical school graduates enter residency or full-time practice within 6 years. I can confidently say that physicians from other countries are not displacing graduates of U.S. medical schools.

For non-U.S. physicians who are fortunate to make it through rigorous medical education, examinations, screening, and obtain a residency position, the 3 months between the match and program start dates is a critical immigration window. The AAMC humbly offers to work with the Subcommittee on ways to help ensure the physician immigration process is predictable, expedient, efficient and better aligned with the continuum of medical education, training, and State licensure.

In addition, the AAMC supports the Conrad 30 program that has recruited 15,000 physicians to rural and underserved communities over the last 15 years by waiving the J–1 visa home country return requirement. The AAMC endorses the bipartisan Conrad State 30 and Physician Access Reauthorization Act, which, among other improvements, would allow the program to expand beyond 30 slots per State if certain nationwide thresholds are met.

We are glad that Congress has recognized the vital role of the National Health Service Corps by steadily increasing funding and believe the number of Conrad 30 waivers should likewise be increased for the first time in two decades.

The AAMC also urges Congress to pass a permanent pathway to citizenship for individuals with DACA status, such as the bipartisan Dream Act of 2021 or the House-passed American Dream and Promise Act of 2021. The 34,000 current healthcare providers with DACA status encompass a diverse, multiethnic population, who are often bilingual and more likely to practice in underserved communities.

Finally, the AAMC supports reducing green card backlogs and prioritizing healthcare workers through the bipartisan Healthcare Workforce Resilience Act.

Thank you again for the opportunity to testify regarding the critical importance of physician immigration to the U.S. healthcare system.

[The statement of Dr. Skorton follows:]

Statement by David J. Skorton, MD
President and Chief Executive Officer, Association of American Medical Colleges,
before the
House Committee on the Judiciary, Subcommittee on Immigration and Citizenship,
hearing, titled
"Is There a Doctor in the House?
The Role of Immigrant Physicians in the U.S. Healthcare System"
February 15, 2022

Chair and members of the subcommittee, I am honored to testify on behalf of the AAMC (Association of American Medical Colleges) regarding the importance of physician immigration to the U.S. health care system, including the critical role physicians from other countries play in safeguarding our nation's health and well-being by alleviating physician workforce shortages in underserved communities and diversifying our health care workforce to help improve the health of all. To that end, the AAMC recommends expanding the State Conrad 30 J-1 visa waiver program and enacting a permanent pathway to citizenship for Deferred Action for Childhood Arrivals (DACA) participants, among other immigration reforms to recruit and retain physicians, as delineated below.

The AAMC is a nonprofit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 16 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals employed across academic medicine, including more than 186,000 full-time faculty members, 94,000 medical students, 145,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. As such, the AAMC also supports improving the immigration pathway for students, researchers, faculty, and other health professionals in addition to physicians.

The AAMC works closely with the Educational Commission for Foreign Medical Graduates (ECFMG), the sole U.S. Department of State-designated sponsor for foreign national physicians engaged in U.S. residency and fellowship training programs on J-1 visas. To practice in the U.S., physicians from other countries must complete rigorous educational curricula and U.S. examinations. The ECFMG verifies credentials and screens the individuals themselves in partnership with the Specially Designated Nationals (SDN) list maintained by the Office of Foreign Assets Control of the U.S. Department of Treasury. Only then are fully qualified physicians from other countries eligible to apply and to compete for medical residency positions at U.S. teaching hospitals.

The U.S. health care workforce and the patients they serve rely on physicians from other countries, particularly in rural and other underserved areas. According to AAMC analysis of American Medical Association 2020 physician practice data, approximately 23% of active physicians practicing in the U.S. identified as foreign born, many of whom are now U.S. citizens or permanent residents. Their contributions are more profound than just a number indicates. Physician diversity has been widely recognized as key to excellence in medicine and quality care. Physicians from other countries have a unique cultural perspective — not just based on their nationality, race, or ethnicity, but also regarding the immigrant experience, which can affect patients' health and their health care experiences.

The importance of physicians from other countries is amplified as a result of growing nationwide health workforce shortages. The Health Resources and Services Administration (HRSA) estimates that in 2019 the U.S. had a shortage of 13,758 primary care physicians and 6,100 psychiatrists; other specialties also are experiencing current shortages that are not measured by HRSA. The AAMC projects the overall physician shortage will grow to a total of between 37,800-124,000 physicians by 2034, including shortages of primary care physicians between 17,800-48,000 and between 21,000-77,100 across non-primary care specialty physicians.[1] AAMC's workforce projections assume steady levels of physician immigration—significant reductions of physicians from other countries would drive up these projected shortages.

The academic medicine community has responded to consistent shortage projections and, since 2002, the number of first-year students in medical schools has grown by nearly 35% as schools expanded class sizes and 30 new schools opened;[2] currently, there are six additional medical schools that have applied to be considered for accreditation.[3] While U.S. medical schools continue to increase enrollment, medical school enrollment without commensurate increases in graduate medical education (GME) residency positions has no effect on the size of the workforce because GME training is required for licensure and medical practice in all states (and is critical to ensuring patient safety and quality of care). The entrance of physicians from other countries is also limited by the number of overall GME positions available. The AAMC supports the Resident Physician Shortage Reduction Act of 2021 (H.R. 225, S. 834) to add 14,000 Medicare-supported GME positions over seven years. To partially address this need, the AAMC was pleased to see the end of the nearly 25-year freeze on Medicare funding for GME with the Consolidated Appropriations Act, 2021 (P.L. 116-260), which will add 1,000 new Medicare-supported GME positions, as well as the proposed increase of 4,000 new Medicare-supported GME positions in the House-passed Build Back Better Act (H.R. 5376).

Physicians from other countries are not displacing graduates of U.S. medical schools. According to the National Residency Matching Program (NRMP), in 2021, 92.8% (19,866) of seniors from U.S. MD schools matched to residency programs.[4] After the NRMP Supplemental Offer and Acceptance Program (SOAP), only 552 U.S. MD seniors were left without a position in 2020.

[1] https://www.aamc.org/media/54681/download
[2] https://www.aamc.org/media/9936/download
[3] https://lcme.org/directory/candidate-applicant-programs/
[4] https://www.nrmp.org/wp-content/uploads/2021/08/MRM-Results_and-Data_2021.pdf

Studies have shown that more than 99% of all U.S. medical school graduates enter residency or enter full-time practice in the United States within six years after graduation.[5] Comparatively, in 2021, 54.8% (4,356) of non-U.S. graduates of international medical schools matched to residency programs.

Residency program directors seek the best candidates, regardless of citizenship status or national origin, through a highly competitive selection process, and after rigorous evaluation some students may be unable to find a residency position in the United States. Numerous factors can contribute to a student not matching, including not being competitive in first-choice specialty; medical licensure exam scores; poor interviewing or interpersonal skills; not applying to, interviewing for, or ranking enough programs; concerns raised in the Medical Student Performance Evaluation (also known as the "Dean's Letter"); professionalism concerns; school reputation; or poor SOAP strategy.[6,7]

The AAMC provides regularly updated resources, tools, effective practices, and other materials to support students, medical school advisors, and program directors in the residency selection process. U.S. medical schools assist unmatched students with residency application guidance, finding residency vacancies, mental health support services, student debt management, and in pursuing master's degree programs or additional research and clinical experiences to enhance their competitiveness. The AAMC is deeply committed to improving the transition from medical school to residency — from the beginning of a student's specialty research and selection process through the completion of residency and on to clinical practice. Supporting the well-being, training, professional development, and equitable treatment of all medical students and residents is critical to the health of the nation.

Predictable, expedient, and efficient immigration processes for physicians and teaching hospitals improve U.S. health care and benefit patients.

Thousands of physicians from other countries who are currently in the U.S. treating patients and roughly 4,300[8] new immigrant physicians who match each year to medical residency programs at U.S. teaching hospitals encounter significant barriers to remain in or enter the country. This is because the U.S. immigration and visa systems are not optimally designed for the health professions and the extended continuum of medical education, training, and state licensure. For example, the 3-month window between when physicians match to residency programs in late March and program start dates on or around July 1, requires certainty in U.S. Citizenship and Immigration Services (USCIS) processing that will enable new medical residents to enter the country in a timely fashion, start training, and treat patients. As a result, premium processing for

[5] Sondheimer HM, Xierali IM, Young GH, Nivet MA. Placement of US Medical School Graduates Into Graduate Medical Education, 2005 Through 2015. JAMA. 2015;314(22):2409–2410. doi:10.1001/jama.2015.15702
[6] Sondheimer HM. Graduating US Medical Students Who Do Not Obtain a PGY-1 Training Position. JAMA. 2010;304(11):1168–1169. doi:10.1001/jama.2010.1316
[7] Bumsted, Tracy MD, MPH; Schneider, Benjamin N. MD; Deiorio, Nicole M. MD Considerations for Medical Students and Advisors After an Unsuccessful Match, Academic Medicine: July 2017 - Volume 92 - Issue 7 - p 918-922 doi: 10.1097/ACM.0000000000001672
[8] https://www.nrmp.org/wp-content/uploads/2021/08/MRM-Results_and-Data_2021.pdf

additional fees has become the norm, yet even premium processing has been suspended in 2015, 2017, and 2019 during this critical window between matching and program start dates, creating disruptions and uncertainty.

Most physicians from other countries enter the U.S. for residency training on temporary nonimmigrant J-1 "exchange visitor" or H-1B "specialty occupation" visas. Both visa pathways have pros and cons. While the AAMC believes the J-1 visa is the most appropriate pathway for residency training and supports a balanced approach that prevents international "brain drain," the 2-year home-country return requirement can pose a very substantial barrier for retaining physicians that U.S. teaching hospitals have invested in training. The H-1B visa does not have a 2-year home-country return requirement, but is designed for temporary employment, more expensive than J-1 visas, subject to numerical caps, and sometimes not long enough to cover the full duration of residency training.

Recently, teaching hospitals and H-1B applicants have been subject to additional requests for evidence (RFE) that often necessitate hiring immigration attorneys and drive up costs. Frequently, these RFEs are regarding H-1B prevailing wage data, which is incongruent with medical residency where all residents in the same training year at the same teaching hospital have the same stipend level rather than a traditional salary. In fact, using regional or market data beyond the institution-level can unintentionally require different stipends for these physicians than their peers. Ultimately, prevailing wage determination for medical residents is an unnecessary and counterproductive administrative burden for teaching hospitals.

The COVID-19 pandemic has further illustrated the importance of physicians from other countries, as well as how immigration reforms can help improve access to care. Emergency immigration policy changes improved patients' access to physicians by exempting providers from certain COVID-19 travel restrictions, extending visa stays, and allowing temporary flexibility for practice location or switching employers. In light of this success, ongoing workforce shortages, and multiple public health crises, Congress should consider expanding some of these reforms and/or making them permanent. For example, we were pleased the USCIS published guidance expediting the issuance of Employment Authorization Documentation for essential health care workers in response to COVID-19, and we believe this should be standard practice. Increasing predictability for physicians from other countries and their employers, reducing backlogs or prioritizing physician applications, and streamlining physician processing throughout the immigration pathway ultimately benefits most the U.S. patients these providers will treat.

AAMC urges Congress to permanently authorize and expand the State Conrad 30 J-1 visa waiver program.

The State Conrad 30 J-1 visa waiver program has been a highly successful program for underserved communities to recruit both primary care and specialty physicians after they complete their medical residency training. This program allows up to 30 physicians per state to remain in the U.S. in underserved communities (including rural and urban community health

centers) after completing medical residency on a J-1 visa, which otherwise requires physicians to return to their home country for at least 2 years.

At minimal administrative cost to the federal government, the Conrad 30 program has brought more than 15,000 physicians to underserved areas over the last 15 years. That is comparable to (if not more than) the National Health Service Corps (NHSC) scholarship and loan repayment programs for U.S. citizens. Yet while Congress has rightly recognized the vital role the NHSC plays in caring for our nation's most vulnerable patients by steadily increasing funding, most recently with $800 million in supplemental funding in the American Rescue Plan, Conrad 30 waiver limits have not been increased in two decades. The Conrad 30 program also allows states and governors more flexibility in specialty choice and practice location to recruit physicians with the most appropriate skills where they are most needed.

The AAMC endorses the bipartisan Conrad State 30 and Physician Access Reauthorization Act (H.R. 3541, S. 1810), which among other improvements would allow Conrad 30 to expand beyond 30 slots per state if certain nationwide thresholds are met. We applaud this bipartisan reauthorization proposal for recognizing these physicians as a critical element of our nation's health care infrastructure, and we support the expansion of Conrad 30 to help overcome hurdles that have stymied growth of the physician workforce.

Importantly, H.R. 3541 would also allow three Conrad 30 slots per state to be used by academic medical centers, permit "dual intent" for J-1 visa physicians seeking graduate medical education, and establish new employment protections and a streamlined pathway to a green card for Conrad 30 participants.

AAMC urges Congress to enact legislation for a permanent pathway to citizenship for DACA participants.

AAMC supports a permanent pathway to citizenship for individuals with DACA status, including approximately 34,000 health care providers.[9] Medical school applicants and matriculants with DACA status continue to increase year after year, with more than 200 currently enrolled in medical school or completing their residency training. DACA and the corresponding work authorizations for the 34,000 health care providers enhance our nation's health care capacity at a time we can ill-afford to lose valuable personnel. As 33 health professional education organizations presciently warned the Supreme Court in an October 2019 amicus brief:

> The risk of a pandemic … continues to grow, since infectious diseases can spread around the globe in a matter of days due to increased urbanization and international travel. These conditions pose a threat to America's health security—its preparedness for and ability to withstand incidents with public-health consequences. To ensure health security, the country needs a robust health workforce. Rescinding DACA, however, would deprive the public of domestically educated, well-trained, and otherwise qualified

[9] https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/?_ga=2.263308748.1987884036.1644598394-852236830.1644598394

health care professionals who have been provided education in reliance on their ability to continue to work in the United States as health care professionals.[10]

The COVID-19 pandemic has also pulled back the curtain on longstanding social, economic, and health inequities in the United States that providers participating in DACA can help address. Health professionals with DACA status encompass a diverse, multiethnic population, who are often bilingual and more likely to practice in underserved communities hit hardest by a pandemic.

The AAMC urges Congress to pass a permanent pathway to citizenship for individuals with DACA status, such as the bipartisan Dream Act of 2021 (S. 264) or the House-passed American Dream and Promise Act of 2021 (H.R. 6). These bills would ensure that these undocumented Americans are able to continue their employment, education, training, and research in the health professions.

AAMC supports reducing green card backlogs and prioritizing health care workers.

AAMC supports addressing the backlog of applications for green cards by lifting per country caps that are impeding physicians entering the U.S. from certain countries. At the same time, we are concerned that limiting the aggregate number of green cards each year only shifts the problem from one country to another. This is particularly problematic for nurses who, depending on state licensure requirements, may not be eligible for H-1B specialty occupation visas and instead apply directly for immigrant visas and green cards, potentially facing decade-long wait times while overseas.

To break these backlogs, the bipartisan Healthcare Workforce Resilience Act (H.R. 2255, S. 1024) would authorize the recapture of unused immigrant visas and redirect them to 25,000 immigrant visas for professional nurses and unused 15,000 immigrant visas for physicians. Importantly, these visas would be issued in order of priority date, not subject to the per country caps, and premium processing would be applied to qualifying petitions and applications.

Thank you again for the opportunity to testify on the importance of physicians from other countries and the critical roles they play in the U.S. health workforce. Ultimately, our nation's health security depends on access to providers and maintaining a sufficient physician workforce, through fair, predictable immigration policies that help recruit and retain foreign physicians from diverse backgrounds to rural and other underserved communities. The AAMC looks forward to working with the House Judiciary Committee and Congress on a balanced approach to immigration and citizenship policy that attracts individuals who want to contribute to improving the health of our nation and people everywhere.

[10] https://www.aamc.org/media/37271/download?attachment

Ms. SCANLON. Thank you, Dr. Skorton, and thank you for your well-timed presentation.

Dr. Kura, you're up next. You have 5 minutes.

STATEMENT OF DR. RAGHUVEER KURA

Dr. KURA. Chair Nadler, Chair Lofgren, Chair Scanlon, Ranking Member McClintock, and the Honorable Members of the Committee, it is an honor to speak with you today on this urgent public health issue. Thank you for the opportunity to offer my perspective on an issue I understand firsthand as an immigrant physician serving in rural and underserved areas.

The United States is in the midst of a healthcare workforce crisis. We are facing an ever-growing shortage of doctors, exacerbated by the COVID–19 pandemic. The reality is this healthcare worker shortage existed before the pandemic and will continue to harm communities, particularly rural and underserved communities, absent congressional action.

I came to the United States in 2001, completed my residency in internal medicine, a fellowship in nephrology at Penn State University on a J–1 visa. As a condition of my visa, after completing my residency, I either had to return to India for 2 years before applying for a new visa or apply for a Conrad 30 program, which waived the 2-year home residency requirement if I would practice in a designated underserved area for a minimum of 3 years.

Upon arriving in Missouri, I learned of patients traveling 80 miles to see the nearest nephrologist. In fact, I was the only nephrologist in the area 24/7 for the past 11 years to serve the community I now call home.

Despite the visa restrictions, serving in southeast Missouri for the last 11 years has been an incredibly fulfilling mission. I supported building a new dialysis unit in 2015, which now has about 90 patients receiving dialysis every other day, along with 18 staff members. Currently, I'm the director of one inpatient and three outpatient dialysis units across southeast Missouri.

I am proud to support my patients, their families, my staff, and the local economy in southeast Missouri, but these visa restrictions have greatly impacted many physicians like me and the communities we serve. For many international physicians, the pathway to permanent residency will take decades, limiting our career mobility and jeopardizing the immigrant status of our children.

Doctors on the temporary H–1B visa may only work for their visa sponsors and are not allowed to start their own practices, work outside the specific practice area, or even volunteer. These restrictions are not hidden from international physicians like me, but they inevitably impact our patients with sometimes life-and-death consequences.

The COVID–19 pandemic complicated these issues when highly skilled physicians could not lend support to hospitals in need due to their visa restrictions. Legislation to confront this challenge is pending before Congress and could help save American lives.

I would like to share how these issues personally affected me, my family, and my patients. The H–1B visa mandates every physician to apply for a renewal every 3 years, leaving the country for a stamp on their passport to freely move across the border.

In 2019, I chose to go to Canada, as it was closer and would allow me to quickly return to my patients, who must have a supervising physician on site to receive their care. Unfortunately, my renewal was delayed due to an unfortunate administrative processing issue, even though I had been in the country for 16 years and was preapproved for the green card.

The added stress of finding a physician to cover for me while dealing with the complicated immigration process took a toll on me and my family. The uncertainty was so stressful that I began applying for jobs in Canada and received offers of employment, but I did not want to leave my patients. So, I reached out to my representative for help and was able to come back to my patients in a timely fashion.

Given this overwhelming need, Congress should take a closer look at the bipartisan legislation for further incentivizing physicians like me to serve in underserved areas. The Conrad 30 reauthorization would strengthen the incentives for international physicians to complete their residencies in the United States and practice in underserved areas, maximizing the return on investment that Congress makes in graduate medical education. This legislation would also provide greater clarity to physicians who fulfill their visa obligations, strengthening the incentives to serve in rural and underserved areas.

In 2020, after applying for EB–1 extraordinary ability visa, I was fortunate enough to get my green card. I am grateful that my family no longer has to deal with the uncertainty of my H–1B status, but there are many physicians like me who are not so lucky.

Thank you again for the opportunity to speak with you today. I look forward to answering your questions.

[The statement of Dr. Kura follows:]

Statement of Dr. Raghuveer Kura
Physicians for American Healthcare Access

February 15, 2022

Is There A Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System

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

My name is Dr. Raghuveer Kura. I am a Nephrologist in Poplar Bluff, Missouri, and one of the founders of Physicians for American Healthcare Access (PAHA). Chair Lofgren, Ranking Member McClintock, and Honorable Members of the Committee, thank you for the opportunity to share my experience as an immigrant physician in the United States.

The United States is in the midst of a health care workforce crisis. We are facing an ever-growing shortage of doctors, exacerbated by the COVID-19 pandemic. The reality is this health care worker shortage existed before the pandemic, and will continue to harm communities, particularly rural communities, absent action from Congress.

I came to the United States in 2001 to complete my residency and fellowship in Nephrology on a J-1 visa at Penn State Health Milton S. Hershey Medical Center. As a condition of my visa, after completing my residency, I either had to return to India for two years before applying for a new visa, or apply for the Conrad 30 J-1 Visa Waiver Program, which waives the two-year home residency requirement if I would practice in a designated underserved area or health professional shortage area for a minimum of three years. Upon arriving in Missouri, I learned of patients traveling 80 miles to see the nearest Nephrologist. In fact, I was the only nephrologist serving the Poplar Bluff community, on call virtually 24/7 to serve my new community I called home.

Despite the visa rules and restrictions, serving in Southeast Missouri for the last 20 years has been an incredibly fulfilling mission. I supported building a new dialysis unit in 2015 which now has about 90 dialysis patients receiving dialysis every other day, along with 18 staff members. Currently, I'm the Medical Director of one inpatient and three outpatient dialysis units across southeast Missouri. I am proud to support my patients, their families, my staff, and the local economy in southeast Missouri.

But these visa restrictions have greatly impacted many physicians like me and the communities we serve. For many international physicians, the pathway to permanent residency will take decades, spanning one's career, limiting our career mobility, and jeopardizing the immigrant status of our children. Doctors on the temporary H-1B visa may only work for their visa sponsors

and not allowed to start their own practices, work outside their specific practice area or even volunteer.

These restrictions are not hidden from international physicians like me when we embark on our careers in the United States, but they inevitably impact our patients with sometimes life and death consequences. The COVID-19 pandemic complicated these issues when highly skilled physicians could not lend support to hospitals in need due to their visa restrictions. Unfortunately, legislation to confront this challenge did not pass Congress when it could have saved a lot of American lives.

I would like to share how these issues personally affected me, my family, and my patients prior to the pandemic. The H1-B visa mandates every physician to apply for a renewal every three years, leaving the country for a stamp on their passport in order to freely move across the border. In 2019, I chose to go to Canada as it was closer and would allow me to quickly return to my patients, who must have a supervising physician on site to receive their care. Unfortunately, my renewal was delayed due to an unforeseen administrative processing issue, even though I had been in the country for 16 years and was pre-approved for a green card. The added stress of finding a physician to cover for me while dealing with the complicated immigration process and an unknown wait time took a toll on me and my family. The uncertainty was so stressful that I began applying for jobs in Canada, and received several offers of employment. But I didn't want to leave my patients, so I reached out to my representatives to help. Thanks to Senator Blunt's casework team, who worked with the White House and State Department to expedite the process, I was able to get my visa and return, helping to ensure my patients had the care they desperately needed.

I co-founded PAHA in the hopes of addressing the difficulties physicians like me face in providing care to our patients due to our outdated immigration laws. It is a major milestone for PAHA that I am testifying today on this important issue that touches every district across the country. For nearly five years, PAHA and its members have been working tirelessly to call attention to health care workforce issues, and explain how our immigration system makes it harder for highly skilled international physicians to practice in this country that desperately needs them. Through this work, we have met with countless dedicated staff in the House and Senate, medical associations, and immigration organizations, identifying several issues contributing to our health care workforce shortages, and a handful of solutions to begin addressing them.

First, there are simply not enough residency programs and clinical training sites for American medical students to complete their training. While interest in pursuing medical school has grown in the last two decades, the number of residency slots has not kept pace, making it difficult for students to find residency positions and appropriate clinical training sites. And those who do rarely settle down in rural communities like mine. [i]

Longstanding staffing shortages continue to put pressure on hospitals b ottom lines. If hospitals do not have the staff, some beds and wards cannot be used. In Missouri, staffing shortages have been a contributing factor in causing nine acute hospitals in rural Missouri to close since 2014, leaving 44 counties with no hospital. This means that many of my patients lack meaningful access to specialized care, and must travel hours to receive care if they are able.

Because of severe staffing shortages in my state, I travel nearly 160 miles by car every day to take care of my patients. Every week, I find myself calling around, looking for someone qualified to help. I have been taking care of COVID-19 patients in the intensive care unit, providing emergent dialysis and slow dialysis. My presence is required to keep the services going, and a backup plan for my absence due to COVID-19 is not in place.

For many physicians like me, the prospect of coming to the U.S. and enduring the long wait for a green card while working and raising a family is not practical. According to the Cato Institute, there are more than 1 million petitions for working immigrants and their families approved and they are waiting for their green cards.[ii] Cato estimates that more than 200,000 Indians who have petitions approved could die of old age before they receive that permanent legal status.

The green card backlog for physicians is a burden we live with because our mission and training centers on our patients. But this situation keeps immigrant physicians, their families and ultimately their patients in limbo. Throughout the COVID-19 pandemic, this situation placed great strain on our communities when we could not lend our expertise to other communities in need. Because of the restrictions on H-1B employment described above, physicians in H-1B status could not travel, work or volunteer in the areas that needed the most support if they were not already sponsored to work in those areas. Doing so would risk violating one's visa which could result in deportation.

Unfortunately, many of these challenges are not easily solvable and will take time and federal investment. But we must try. There are a number of bipartisan solutions that would make it easier for American physicians to pursue their residencies, as well as improve our immigration system to incentivize international physicians to practice in underserved areas long-term.

The Conrad 30 J-1 Visa Waiver Program provides each state with up to 30 slots for international medical graduates completing their residencies. In exchange for waiving the J-1 two-year home residency requirement, these physicians must practice in a federally-designated health professional shortage area or underserved area. Bipartisan legislation would improve this long-standing program, clarifying the pathway to a green card for eligible physicians and allowing states to expand their program if certain conditions are met.[iii] This is meant to further incentivize highly-trained physicians to practice in areas that struggle to recruit American physicians.

To address the green card backlog, the Healthcare Workforce Resilience Act is bipartisan legislation which would help clear this longstanding backlog for physicians who have been serving on the frontlines of a pandemic for over two years.[iv]

These two bills are small steps that would make a significant difference in communities that lack access to meaningful health care services, and ensure that the pipeline of future physicians remains robust as we seek to strengthen our health care system after a grueling two years.

In 2020, after applying for the EB-1 extraordinary ability visa, I was fortunate enough to receive my green card. I am grateful that my family no longer has to deal with the uncertainty of my H-1B status, but there are many physicians just like me who are not so lucky. Thank you again for the opportunity to testify on their behalf today.

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[i] https://www.aamc.org/news-insights/medical-school-enrollments-grow-residency-slots-haven-t-kept-pace
[ii] https://www.cato.org/publications/immigration-research-policy-brief/backlog-skilled-immigrants-tops-1-million-over
[iii] https://www.congress.gov/bill/117th-congress/house-bill/3541?q=%7B%22search%22%3A%5B%22hr3541%22%2C%22hr3541%22%5D%7D&s=1&r=1
[iv] https://www.congress.gov/bill/117th-congress/house-bill/2255?s=5&r=2

Ms. SCANLON. Thank you, Dr. Kura.

Ms. Harris, you're now recognized for 5 minutes.

STATEMENT OF KRISTEN A. HARRIS

Ms. HARRIS. Thank you.

Good afternoon, Chair Lofgren, Chair Scanlon, Ranking Member McClintock, and the Members of the Subcommittee. Thank you for the opportunity to speak with you today about the need for improvements to our Nation's physician immigration system.

My name is Kristen Harris, and I am an immigration attorney that has represented hundreds of hospitals, healthcare systems, physician practice groups, clinics, and foreign national physicians for more than 17 years. The opinions I am expressing today derive from years of physician immigration practice.

At no time have Americans been in greater need of high-quality, U.S.-trained foreign national physicians. Dr. Kura and his dedication to his patients exemplifies how critical these physicians are to addressing our healthcare access issues.

Unfortunately, our current system is suboptimal, at best, in its ability to attract and retain the most talented physicians in the world to treat and care for Americans. We have outdated laws on our books that include barriers to retaining U.S.-trained foreign national physicians.

Today, I bring you concrete examples of missed opportunities caused by our current physician immigration system. In each case, we have a willing employer, a U.S.-trained physician, and Americans in need of a doctor.

One, we need to improve and expand the Conrad 30 program. Under this program, doctors in J status who will otherwise have to leave the U.S. at the end of their training can stay here if they treat patients in a medically underserved area for 3 years. Each State is allotted only 30 waivers per year, a limit that was last raised in 2002.

The program has successfully brought thousands of U.S.-trained physicians to medically underserved communities, but it can do more if it is expanded and improved. States like Texas, Indiana, California, Pennsylvania, and many more regularly max out of their 30 slots early in the year.

For example, our firm represents an independent safety net hospital in one of the poorest cities in Massachusetts. The hospital sponsored an Indian-born, U.S.-trained primary care physician for a Conrad waiver. It timely filed the application. The physician was fully eligible, but the State program had maxed out for the year and the physician was not among the lucky 30 that year. By the time the recommendations were announced, he was out of options and moved to Canada with his family to practice there. This happens time and again. By expanding the number of waivers available to each State, Congress can solve this problem.

Two, we need to improve the J waiver options for Federal agencies, such as the VA and HHS, to carry out important programs, such as treating veterans and the medically underserved. The statute provides for greater opportunities than is administered by the agencies at present. For example, my firm represents nephrology practices, including a practice that continues to find U.S.-trained

J–1 physicians who are ready, willing, and able to start treating dialysis patients but for their need for a J waiver. They haven't been able to do that.

Any one such nephrologist can cover 13 practice sites stretched across a five-county area, including outpatient dialysis clinics and rural areas in Indiana so remote and so underserved that the Department of Labor does not have sufficient wage data for doctors. Unique patient visits from one physician can exceed 200 patients in a month, yet this practice cannot apply to the HHS program to keep these physicians in the U.S. because they have received subspecialty training. This must change.

Three, we need to change the H–1B category for U.S.-trained physicians. Many physicians applied for the H–1B visa after completing their training, but there is an H–1B cap or limit which can serve as a barrier to physician immigration. For example, our firm represents a family-owned medical practice in Texas. For months, they have searched for a U.S.-trained and licensed primary care physician to start patient care yesterday. They found the perfect candidate, who's bilingual and ready to relocate from Peru to Texas. Unfortunately, before the doctor can start working here, she must first participate in the random H cap lottery held in March. Statistically, the odds are against her getting selected at all. Even if the doctor does win the lottery and her H is approved, her visa won't allow her to start treating Texans until October, at the earliest. This is at least 8 months of lost care and coverage. This must change. Congress should exempt physicians from the H cap limit to address our Nation's immediate healthcare needs.

Fourth and finally, the employment-based green card system needs to be fixed to keep our U.S.-trained doctors in the country on a permanent basis. Doctors born in India can wait for over a decade before they're permitted to even file their final step for a green card, due to current per-country limits, even when their services to the medically underserved have been deemed to be in the national interest by USCIS. This is wrong. These physicians fill an immediate need for Americans and, therefore, should be permitted to file a green card immediately, just as with immediate relatives of U.S. citizens.

Healthcare access is a bipartisan constituent issue that requires bipartisan solutions. The solutions presented today are well within congressional reach, and our Nation will benefit from Congress working together to improve healthcare access for all Americans by making it easier for us to retain our U.S.-trained physician workforce.

Thank you again for the opportunity to testify and thank you for your attention to this critical issue.

[The statement of Ms. Harris follows:]

HARRIS
IMMIGRATION LAW

Testimony of

Kristen A. Harris

Principal Attorney, Harris Immigration Law, LLC

"Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System"

Before the

House Committee on the Judiciary

Subcommittee on Immigration and Citizenship

February 15, 2022

Introduction

Chair Lofgren, Ranking Member McClintock, and members of the subcommittee, thank you for providing the opportunity to submit written testimony regarding the role of foreign national physicians in the U.S. healthcare system, and how our immigration system may be improved to better actualize their potential to address our nation's chronic physician workforce shortages.

My name is Kristen Harris and I am the founding attorney of the law firm Harris Immigration Law, LLC in Chicago, Illinois. My past and present professional affiliations include membership in the American Immigration Lawyers Association (AILA), the International Medical Graduate Taskforce (IMG Taskforce), and the American Health Lawyers Association (AHLA). I have served in leadership roles with these organizations, including as a member of the AILA Board of Governors and AILA Chicago Chapter Chair, as Immigration Affinity Group

Chair of AHLA, and as Advocacy Chair/Co-Chair of the IMG Taskforce from 2007 to 2017. As an attorney and a graduate of the University of Michigan Law School, I have practiced immigration and citizenship law for more than seventeen years. I have represented hundreds of hospitals, healthcare systems, physician practice groups, clinics and foreign national physicians seeking to navigate the difficult maze of the U.S. immigration system. My firm provides counsel to the American Medical Association, the Association of American Medical Colleges, and the Educational Commission for Foreign Medical Graduates on occasion with regard to physician immigration issues. However, the opinions I am expressing today are my own, and derive from my years of physician immigration practice as well as participation in physician immigration reform efforts.*

Throughout my years of working with U.S.-trained foreign national physicians and U.S.-based medical institutions, it has become readily apparent that our U.S. immigration system is suboptimal at best in its ability to attract and retain the most talented physicians in the world to treat and care for Americans. Some of the current inefficiencies in U.S. physician immigration are vestiges of a prior era, in the mid-1990s, when there were concerns among stakeholders about a physician surplus. This has been followed by decades of well-chronicled and chronic physician shortages in our nation, yet the outdated laws remain on the books, encoded in statute as well as regulations and administrative practice. As my testimony will reveal, the existing pathways for foreign national physicians who have been trained in the United States are limited, complicated and largely not designed to retain qualified physicians. There are important legislative reforms that have been introduced or can be proposed to rectify this problem, coupled

with administration actions to bet taken, to help ensure that our health care system is better equipped to meet the needs of all Americans.

Retaining U.S.-trained Foreign National Physicians in the United States

Given the chronic and increasing physician shortages experienced by our nation, which have been further exacerbated by the COVID pandemic, our country would benefit greatly from Congress improving our immigration laws to more readily retain physicians who have already completed their Graduate Medical Education (GME) training in the United States. Retaining these physicians in the United States post-GME would help ameliorate the ongoing, national physician shortage. In addition, U.S.-trained foreign national physicians already play a unique role in addressing chronic shortages within medically underserved areas and populations, often in connection with healthcare shortage-driven legislation and programs. If we expand those programs and increase the benefits for foreign national physicians to participate in such programs, we could further leverage the skills and expertise that these talented doctors provide to our nation.

Foreign National Physicians and Graduate Medical Education

Prior to beginning a U.S. GME program and even prior to participating in the National Residency Match Program (NRMP), the competitive GME placement program called "the Match," to enter such a program, all foreign national physicians must first be vetted as to formal education and clinical skills by the Educational Commission for Foreign Medical Graduates (ECFMG). Foreign national physicians who succeed in matching with a GME program generally obtain a temporary nonimmigrant visa (NIV) to enter the United States and carry out

the program.[1] Foreign nationals pursue their GME programs in the United States primarily in one of two different temporary, nonimmigrant visa statuses – J-1 or H-1B. Foreign national physicians' ability and options to remain in the United States post-GME are determined, in part, by whether they have carried out their training in J-1 or H-1B status.

Physicians Completing GME in J-1 Status; Challenges to Remaining in the U.S. Post-GME

The overwhelming majority of foreign national physicians carrying out GME in the U.S. do so in J-1 status.[2] J-1 physicians are "exchange visitors" sponsored by ECFMG[3] to participate in approved, accredited GME training programs throughout the United States.[4] The J-1 option is less costly for host GME programs than is H-1B sponsorship. Additionally, the J-1 program involves the efficiencies of ECFMG and its timely issuance of a DS-2019 between the Match in March and consular appointment prior to commencement of the Post Graduate Year (PGY) on July 1, as compared with the difficulty of attaining of an H-1B petition approval from U.S. Citizenship and Immigration Services (USCIS) in the same time frame.

All J-1 physicians carrying out GME in the United States are subject to a two-year "return requirement," requiring that they return to their home country with their newly acquired training if they wish to change to certain types of nonimmigrant status (e.g., H-1B) or seek lawful permanent residence, or "green card" status.[5] Such physicians must either fulfill or obtain

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[1] The number of foreign national physicians who carry out GME pursuant to work authorization based on a status other than a nonimmigrant visa, such as recipients of Deferred Action for Childhood Arrivals (DACA) or those holding temporary protected status (TPS), are not statistically significant as relative to nonimmigrant visa holders. *See*, AMA-IMG Section Governing Council, International Medical Graduates in American Medicine: Contemporary challenges and opportunities (2010), tbl.13.
[2] Immigration and Nationality Act (INA) § 101(a)(15)(J), 8 U.S.C. § 1101(a)(15)(J). *See also* 8 C.F.R. § 214.2(j), 22 C.F.R. §§ 62.
[3] 22 C.F.R. § 62.27(b).
[4] There are a number of different categories of J-1 exchange visitors depending on the purpose or type of exchange. Most of the categories, including J-1 clinical physicians, are detailed in the federal regulations governing J-1 visas. *See* 22 C.F.R. §§ 62.20-62.32.
[5] INA § 212(e), 8 U.S.C. § 1182(e).

a waiver of this return requirement if they wish to remain in the U.S. in the common H-1B status after they complete their GME programs.[6]

Unlike other J-1 programs, nonimmigrants completing GME in J-1 status cannot have the home country return requirement waived based solely on a statement of no objection by their home country.[7] Instead, they must either obtain a waiver a) based on persecution of the J-1 principal or exceptional hardship to a qualifying family member[8] or b) through a service-based waiver sponsored by an Interested Government Agency.[9] Service-based options include a 3-year commitment to work at a Veterans Affairs facility or in an U.S. Department of Health and Human Services ("HHS")-designated shortage area by recommendation by a State Department of Health through the Conrad State 30 J Waiver Program. Options also include J waivers sponsored by any Interested Federal Agency.[10] Current federal agencies that sponsor such waivers include the Appalachian Regional Commission ("ARC"), the Delta Regional Authority ("DRA"), and HHS. Past participating agencies have included the U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Agriculture (USDA). If the physician does not complete the 3-year service requirement, then the physician becomes subject to 2-year return requirement once again.[11]

Nearly half of all new J-1 physicians are from either Canada, India, or Pakistan as the country of nationality or last residence, none of which have marked country conditions that

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[6] There are other visa types, such as the O-1 visa for individuals with extraordinary ability or achievement, for which physicians are eligible prior to fulfillment or waiver of the 2-year return requirement. However, these are uncommon as relative to the H-1B visa as a basis of post-GME employment for physicians.
[7] INA § 212(e), 8 U.S.C. § 1182(e).
[8] 8 C.F.R. § 212.7(c)(5).
[9] INA § 214(l); 8 U.S.C. § 1184(l). Note: J waivers to pursue research rather than clinical service are also an option. However, given the relatively low usage of research waivers, this waiver type is not included within the discussion of other, service-based waivers provided for at Section 214(l).
[10] *Id.*
[11] INA § 214(l)(2)(B); 8 U.S.C. § 1184(l)(2)(B).

generally lend themselves to successful persecution or hardship waivers.[12] Instead, most J-1 physicians who seek to remain in the United States do so through a service-based waiver. The current options could be readily expanded and improved to facilitate retaining these physicians and leveraging their talents to address chronic healthcare worker shortages within the United States. The most popular service-based J waiver program has been the Conrad State 30 Program, so-named because each state is permitted to recommend up to 30 physician waivers per fiscal year. The more populous states, such as Texas, Florida, Massachusetts, California, and Illinois consistently receive more than 30 applications for these 30 slots, and this trend has grown. For Fiscal Year 2021, by April 2020, more than 27 states had already filled their slots or "maxed out" their program, with an additional 12 states having only a few waiver spots available, with 5 months remaining in the fiscal year.[13] Meanwhile, pursuant to most state department of health guidelines, physicians must attest throughout the process that they are not simultaneously pursuing a J waiver through an alternate or back-up path. The physicians who are not selected in a "maxed out" state must scramble to find another alternative before completing their final PGY in the U.S.

This demonstrates that despite our physician shortage, there are US GME-trained physicians available to work in shortage areas who are thwarted in efforts to remain due to limitations imposed by our immigration laws. Physicians who have played by the rules and timely filed their J waiver applications are nonetheless unable to stay and serve the medically underserved in the United States. I have witnessed this in my own practice as well as being

[12] ECFMG J-1 Visa Sponsorship: Top 10 Nations of Origin for Exchange Visitor Physicians 2020 Calendar Year, EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES, https://www.ecfmg.org/images/EVSP-Data_Countries_3.17.21.png (data current as of Jan. 13, 2021). *See* INA § 212(e), 8 U.S.C. § 1182(e) for criteria for persecution and hardship waivers.

[13] Letter from International Medical Graduate (IMG) Taskforce, to Jessica Stewart, Director, Agency Coordination, HHS, et. al. (Apr. 7, 2020), at p. 1 submitted as part of the record of this hearing.

aware of this happening repeatedly based on reports from physician immigration bar colleagues. For instance, my firm represents an independent, safety-net hospital; the hospital treats patients in one of the poorest cities in Massachusetts where more than two-thirds of the patients are covered through charity care, Medicaid, Medicare, or other government-based payments. The hospital opted to sponsor a primary care physician from India who was training in the U.S. in J-1 status for one of the Conrad State 30 J waivers available for Massachusetts. The hospital and physician timely filed the J waiver application while the physician was still in his final year of GME. However, more than 30 physicians applied for the 30 Massachusetts slots, and the physician – although entirely eligible for a waiver -- was simply not among the fortunate 30 to be recommended by the state department of health. When the results of the review process were announced by the state department of health, most other populous state programs had long since closed their application window, and there was not another viable geographic option for the physician and his family.[14] The physician opted to leave the U.S. to practice in Canada with the intention of settling down there rather than returning to the U.S. By way of comparison, other physicians who were granted Conrad J waivers sponsored by the same, safety-net hospital have consistently fulfilled their 3 years of service, most have remained after the 3 years, and, in one case, a Conrad J waiver physician became a part of the medical leadership team for the hospital. These U.S.-trained physicians are not ones we want to lose.

Another situation that exists is when J waiver physician candidates find their prospective employers after the very short windows of opportunity of Conrad 30 programs have closed for the fiscal year and thus are required to depart the U.S. after finishing their GME. For instance, I

[14] In many states, the Conrad program is filled on the first day of application in states that are first-come, first-served, or in the first "window" of application. In first-come, first-served states, the demand can be so high that hospitals have engaged professional line-sitters to stand in line outside the state department of health, to be in line overnight for a better place in line when the state department of health's doors open for the morning.

represent nephrology practices, a subspecialty of internal medicine focused on the diagnosis and treatment of diseases of the kidney, who would readily sponsor J waiver physicians and would otherwise be eligible but for the Conrad 30 cycle timing and demand for slots, given that the programs fill up in the fall and max out almost immediately. Additionally, nephrologist candidates are not eligible for the HHS clinical J waiver, given that they will necessarily complete a subspecialty fellowship prior to treating patients, and thus do not qualify as "primary care" physicians.[15] These doctors often have an ambit that stretches throughout wide swaths of a given state, including rural areas as well as poor inner-city neighborhoods, and safety-net hospitals as well as dialysis clinics. Based on an informal survey of a representative client's physician performance numbers, if such foreign national physicians are permitted to remain within the U.S. at the end of their GME training, any one such physician could treat over 220 unique patients per month, including hospital visits, between and among 13 different cities and townships, distributed over 5 counties, including rural areas that are so remote that the U.S. Department of Labor (DOL) does not have statistically sufficient numbers to publish a prevailing wage. The impact on patients and our healthcare system as a whole that results from not retaining even one such physician is significant, particularly for geographically diffuse, rural patient populations.

Legislative Proposals and Proposed Administrative Actions

to Facilitate GME to Post-GME Transition for J-1 Physicians

It is imperative that Congress improve the immigration system so that the United States can better retain U.S.-trained foreign physicians. One simple means of increasing the number of J-1 physicians remaining in the United States is to make changes to the Conrad 30 provisions of

[15] *See* 45 C.F.R. § 50.5(b).

the Immigration and Nationality Act (INA).[16] One recommended structural change would be to amend the current statute to permit the 30 slot-per-state limit to rise and fall as a function of demand on an individualized, state-by-state basis rather than remaining as a hard-and-fast ceiling that was last raised nearly 20 years ago, in 2002.[17] The Conrad State 30 and Physician Access Reauthorization Act (H.R. 3541) (hereinafter, the "Conrad Reauthorization Bill"), which was introduced in the House in May 2021, contains such provisions.[18] Passage of the Conrad Reauthorization Bill will bring important relief to underserved populations and J-1 physicians alike. Another legislative improvement would be to permit qualifying physicians who timely but unsuccessfully applied to a State Conrad 30 to extend their status to remain in the United States to re-apply for such service in the next fiscal year. This is a much needed legislative fix provided for in the Conrad Reauthorization Bill.[19] Another means of increasing the overall number of Conrad physicians would be to restore a Conrad 30 "slot" to an issuing state in instances when a physician relocates to another state in cases of extenuating circumstances, also provided for in the Conrad Reauthorization Bill.[20] Finally, another means of adjusting the numbers upward based on need would be the inclusion of J waivers sponsored by Academic Medical Centers, to exceed the 30 slots by up to three additional slots per state, in the event a given state has "maxed out" its default 30 slots. This is also provided for in the Conrad Reauthorization Bill.[21]

Similarly, expansion of the HHS clinical J waiver program would also help better retain U.S.-trained J physicians. At present, the program is efficiently run and has no statutory annual

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[16] *See* INA § 214(l); 8 U.S.C. § 1184(l).
[17] *See* 21st Century Department of Justice Appropriations Authorization Act § 11018(a), Pub. L. No. 107-273 (2002).
[18] *See* Conrad State 30 and Physician Access Reauthorization Act (H.R. 3541), § 5(a) [hereinafter Conrad Bill].
[19] Conrad Bill, *supra* note 18, § 4(d).
[20] Conrad Bill, *supra* note 18, § 4(f).
[21] Conrad Bill, *supra* note 18, § 5(b).

limit or "cap," like the Conrad 30 program. Physicians and their employers need not be victims of fate or be subject to unknown demand levels prior to applying, which makes the HHS clinical J waiver program a very attractive option. However, the current program limits eligibility to facilities located in health professional shortage areas (HPSAs) that have scores of 7 or higher. In contrast, the authorizing regulations are much broader, and would permit primary care physicians to carry out their service in any "primary care Health Professional Shortage Area (HPSA) or Medically Underserved Area or Population (MUA/P)," and psychiatrists to work in any Mental Health HPSA, with no specification as to a minimum score.[22] These are all areas that HHS itself has already designated as shortage areas. Accordingly, as a matter of policy, HHS should expand its clinical J waiver program to the fullest extent of the current regulations.

Further, the program could readily be expanded beyond the current primary care limitations, so long as the healthcare service would be rendered in an HHS-designated shortage area, just as is the case with the Conrad 30 J waiver program. At present, even subspecialists meeting a critical need in underserved communities, such as nephrologists, cannot apply for a J waiver through the HHS program. Because HHS is eligible under the statute to recommend J waivers as an Interested Federal Agency, the agency should expand its program by promulgating new regulations that better reflects the broad nature of the statute. There are no restrictions in the statute that require Interested Federal Agencies to limit their programs to primary care physicians.[23]

Physicians Completing GME in H-1B Status; Challenges to Remaining in the U.S. Post-GME

Some foreign national physicians carry out their U.S. GME in H-1B status, which

[22] 45 C.F.R. § 50.5(c).
[23] *See* INA § 214(l)(1)(C)-(D), 8 U.S.C. § 1184(l)(1)(C)-(D)

presents its own immigration challenges.[24] First, most post-GME employment is subject to what is known as the "H-1B cap," the annual limit on first-time H-1B petitions.[25] Second, these physicians will generally have already expended a minimum of three years of the overall six-year limit in H-1B status by the time they complete even the most basic, primary care residency program.[26] The H-1B program as it exists requires improvements if we wish to retain U.S.-trained foreign physicians in this category.

Managing the H-1B Cap: Transitioning from Cap-Exempt to Cap-Subject H-1B Status

Virtually all physicians pursuing GME training in H-1B status do so at institutions exempt from the annual H-1B cap, such as an institution of higher education or a related or affiliated non-profit.[27] However, when they seek post-GME employment, many H-1B physicians will be subject to the annual H-1B cap because their new employer is not an institution of higher education or a related or affiliated non-profit or a nonprofit or governmental research organization.[28] In immigration terms, such physicians have not been "counted against" the H-1B cap during the course of their GME training. All H-1B petitions filed for individuals who have not previously been counted against the H-1B cap and who will be employed by cap-subject employers will be subjected to the H-1B lottery in the hopes of being randomly selected for an H-1B cap number. If they are not selected, then their ability to stay in the United States and practice medicine becomes severely limited.

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[24] 8 C.F.R. § 214.2(h).
[25] The regular H-1B cap is comprised of 65,000 first-time H-1B visas for applicants who hold at least a bachelor's degree or its equivalent. An additional 20,000 H-1B visas are made available each fiscal year for individuals holding a master's degree (or higher) awarded by an accredited college or university in the United States (commonly known as the "U.S. Master's cap").
[26] 8 C.F.R. § 214.2(h)(13)(iii); 8 C.F.R. § 214.2(h)(15)(ii)(B)(1).
[27] INA § 214(g)(5)(A)-(B), 8 U.S.C. § 1184(g)(5)(A)-(B). USCIS has held that U.S. GME does not constitute a qualifying degree, and accordingly a physician is not eligible to participate in the lottery for the 20,000 visas of the "Master's mini-cap" solely as a result of GME training.
[28] INA § 214(g)(5), 8 U.S.C. § 1184(g)(5).

The distinction between whether post-GME employment can be "H-1B cap-exempt" or whether it must be H-1B "cap-subject" is critical. In each of the past several years, the forthcoming fiscal year's supply of cap-subject H-1B visas have been exhausted in the first window of opportunity preceding the start of such fiscal year. USCIS subjects all H-1B cap registrations to a random "lottery" system. Only registrations randomly selected in this lottery will be considered and adjudicated by USCIS; the remainder are summarily "rejected," without any adjudication on the merits. Last year, 308,613 registrations were received in March 2021 for the 85,000 H-1B visas available for Fiscal Year 2022.[29] Forty-eight percent (48%) of those registrations were "U.S. Master's Cap" registrations,[30] which have an inherently greater chance of selection, as they are permitted two "bites at the apple," given that their registrations participate first in the initial, general lottery for the first 65,000 visas and, if not selected, then also in the second, limited lottery for the 20,000 U.S. Masters' Cap visas.

Unfortunately, most H-1B physician candidates do not qualify for consideration under the "U.S. Master's Cap", as they routinely have obtained their medical degree from abroad and because, as currently defined in the statute, completion of GME does not qualify as a "degree."[31] As a result, nearly all foreign national physicians are on equal footing with H-1B candidates who hold just a Bachelor's degree (or the equivalent of a Bachelor's degree based on a combination of education and experience). This subjects GME physicians to a game of chance in which their odds of selection are at the lowest of all lottery participant types. If the physician's registration is not selected in the cap, then he or she will have no means to obtain an H-1B visa to continue to

[29] *H-1B Electronic Registration Process*, U.S. CITIZENSHIP & IMMIGRATION SERV., https://www.uscis.gov/working-in-the-united-states/temporary-workers/h-1b-specialty-occupations-and-fashion-models/h-1b-electronic-registration-process (last updated Nov. 19, 2021).
[30] *Id.*
[31] *See* INA § 214(g)(5)(c); 8 U.S.C. § 1184(g)(5)(C); 8 C.F.R. § 214.2.

work in the United States for the vast majority of healthcare sector facilities.[32]

In addition to lottery concerns, there are timing issues specific to H-1B cap petitions. Given how the law is structured, cap-subject H-1B registrations, filed in March each year, cannot request a start date prior to October 1 of the same calendar year, regardless of when the H-1B petition is approved.[33] This means that even if a physician's petition is selected in the registration process, the physician will be unable to provide patient care from end of the postgraduate year (PGY) on June 30th of a given year until work authorization is approved for the physician, at the earliest on October 1 of the same year. The loss of work authorization for the interim three months, in terms of the inability to provide patient care, particularly during a pandemic, is not negligible. Additionally, given visa backlogs at U.S. Consulates and inherent risks involved with consular processing, which have been compounded by the COVID pandemic,[34] a qualified physician can be delayed outside the U.S. who finds himself or herself in this "cap gap" situation between the end of the PGY and the start of the fiscal year.

As an additional complication, H-1B physicians seeking post-GME employment must typically have full licensure to practice in the state of service at the time the H-1B petition is adjudicated.[35] Given certain state licensure restrictions, some physicians may not be able to attain the full licensure required by an H-1B petition until after the window has closed in March

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[32] The sole employment opportunities H-1B trainee physicians can pursue in the U.S. in post-GME H-1B employment where they have not won the lottery are at an "institution of higher education," a non-profit entity that is sufficiently affiliated with or related to an institution of higher education, or a qualifying research organization. *See* INA § 214(g)(5)(A)-(B); 8 U.S.C. § 1184(g)(5)(A)-(B).

[33] October 1 is the first day of the fiscal year, and hence the first effective date available. H-1B petitions may not be filed more than six months prior to the first effective date. As a result, April 1 or the first federal government business day thereafter becomes the first date of filing for a first-time cap-subject H-1B petition. *See* 8 C.F.R. § 214.2(h)(8)(iii)(A)(4).

[34] *See* American Immigration Lawyers Association, *Reopening America - How DOS Can Reduce Delays and Eliminate Backlogs and Inefficiencies to Create a Welcoming America*, June 29, 2021, available at https://www.aila.org/DOSreopening

[35] INA § 214(i)(2)(A), 8 U.S.C. § 1184(i)(2)(A); 8 C.F.R. § 214.2(h)(4)(viii).

to register for the H-1B cap. While the physician need not be eligible at the time of H-1B registration, he or she must be eligible prior to the 90-day deadline that adheres upon selection of the registration. This may not always be attained in time, depending on which "tranche" the registration is selected in[36] and the timing of the given state's licensing board.

Institutions of higher education, teaching hospitals, and other nonprofit institutions "related to or affiliated with" institutions of higher education are exempt from the cap,[37] but often encounter difficulty in convincing USCIS of such exemption. They also experience marked inconsistency in adjudications from one petition to the next filed by the same qualifying employer. Similarly, physician groups and other for-profit employers, called "third party petitioners," may file an H-1B petition exempt from the cap if the physician is to be "employed at" a cap-exempt institution.[38] These petition types have also encountered inconsistent adjudication, which could be rectified with legislative improvements, so as to better reassure physicians and their cap-exempt-eligible employers. For example, one means of standardizing adjudications for teaching hospitals would be to categorically exempt from the H-1B cap employment of a physician at any facility which hosts an ACGME-accredited residency or fellowship program.

Managing the Six-year Limit in H-1B Status

Typically, an H-1B nonimmigrant has available a total of only six years of H-1B status before he or she must depart the U.S. for at least one year.[39] Accordingly, physicians who

[36] USCIS conducts an initial selection of H-1B registrations and notifies selected registrants that their registration has been selected to file an H-1B cap petition. If additional H-1B visa numbers remain available after the initial selection is conducted, USCIS can conduct subsequent selections among the registrations submitted for the fiscal year.
[37] INA § 214(g)(5), 8 U.S.C. § 1184(g)(5).
[38] *Id.*
[39] INA § 214(g)(7), 8 U.S.C. § 1184(g)(7); 8 C.F.R. § 214.2(h)(13)(i).

complete a traditional, three-year base residency program in the U.S. in H-1B status will usually have only three of their six years remaining when they enter the U.S. workforce as a fully trained physician. H-1B physicians who proceed to a chief residency position and/or fellowship in U.S. GME will have exhausted four or more years of H-1B status, and subspecialist physicians can readily exhaust their 6 years of H-1B status within GME alone.

A physician's six-year limit of H-1B status may be lifted, and H-1B status may be extended in 1 or 3 year increments, but only if a qualifying employment-based application in connection with the pursuit of lawful permanent residence, (i.e., a "labor certification application" or an "I-140 immigrant petition") is submitted to the government before the end of the physician's fifth year of H-1B status.[40] If the "labor certification" path is the only qualifying application available to initiate a green card case, then significant lead time is required before the end of the physician's fifth year of H-1B status, as the DOL imposes recruitment and other pre-filing requirements that can often involve seven months or more before the labor certification can be filed. The DOL has clarified that residency and fellowship positions cannot qualify for labor certification or an immigrant petition, on the basis that these positions do not involve a "permanent" offer of employment. [41]

Legislative Proposals to Facilitate GME to Post-GME Transition for H-1B Physicians

There are several ways to ease the path for U.S.-trained H-1B physicians to remain in the U.S. that would simultaneously address chronic, specific shortages, such as rural, medically

[40] American Competitiveness in the Twenty-First Century Act of 2000 (AC21), Pub. L. No. 106-313 § 106(a).
[41] *See Matters of Albert Einstein Med. Ctr. & Abington Mem'l Hosp.* (BALCA *en banc,* Nov. 21, 2011), *available at* https://www.aila.org/infonet/balca-matter-of-einstein-and-abington-11-21-11.

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underserved areas, as well as the nationwide physician workforce shortage more generally. First, the statute could be amended to provide H-1B cap exemption for physicians at the same facilities that are now eligible for service-based J waivers, based on a qualifying offer of employment at a VA facility or at facilities located in an HHS-designated shortage area. Because work authorization in the H-1B category is always employer-specific, if the physician resigned or was terminated from such employment, the H cap exemption pursuant to that service-based employment would cease on the date of employment.[42] Second, the statute could be amended to expand the U.S. Master's Cap to include ECFMG-certified medical degrees and/or completed U.S. GME programs as qualifying bases for eligibility.[43] Third, the statute could provide for "cap gap" relief akin to that permitted at present for students whose work authorization expires before October 1 and whose employers have filed an H-1B petition before October 1.[44] Expanding this relief to physicians the year that they complete their U.S. GME would eliminate disruption in work authorization and allow these foreign national physicians to change status in the United States, without having to depart the United States to get a new visa after their final PGY concludes on June 30th before re-entering the U.S. to start their first, cap-subject GME employment on or after October 1. This would avoid delays and uncertainty related to the consular process, which have become unprecedented during the COVID era because of continued consular backlogs and limited consular operations. An uncertain date of return for a physician candidate wreaks havoc with safety-net employers and small physician practices who are counting on scheduling every day of on-staff physician care as compared with costly locum tenens staffing. Cap gap work-authorization for U.S.-trained physicians would add a quarter of a

[42] *See* 8 C.F.R. § 214.2(h)(8)(ii)(F)(6)(ii) (providing for cessation of cap exemption upon termination of concurrent, cap-exempt employment).
[43] This would require amending INA § 214(g)(5)(C), 8 U.S.C. § 1184(g)(5)(C).
[44] As a point of comparison, *see* 8 C.F.R. §214.2(f)(5)(vi)(A)(providing for "cap gap" in F-1 category).

year of or more of physician coverage in what would otherwise be unproductive time until the fiscal year began on October 1.

Statutory amendments could also be made to address the 6-year "clock" issues encountered by physicians training in H-1B status. The statute could be amended to toll the remainder of the 6-year clock during a physician's subspecialty fellowship training. A physician demonstrating acceptance to an ACGME-accredited fellowship program or an ACGME-recognized nonstandard training program and H-1B qualifying employment in connection with such training would thus be able to specialize without incurring additional time against 6-year limitation on the initial stay H-1B status. The "clock" would resume on day 1 for the first post-GME employment within the United States.

Post-GME to Permanent Stay – Improving and Expanding Physician Paths to the Green Card[45]

To help address our nation's ongoing physician workforce shortage, we must improve the ability for U.S.-trained physicians to remain in the United States permanently. In immigration terms, this means expanding and improving their paths from nonimmigrant visa status to lawful permanent resident, or "green card," status.

At present, physicians pursuing an employment-based green card must do so through the preference system, which is subject to annual numerical limitations and per-country limits based upon country of birth and category of occupation. Most physicians pursue their green card in the employment-based second preference advanced degree category, also called the "EB-2

[45] The discussion of helpful legislative actions in this testimony is not intended to be exhaustive. For instance, the Healthcare Workforce Resilience Act (H.R. 2255), which was introduced in the House in March 2021, and which would provide physicians with recaptured immigrant visa numbers, would also assist in retaining U.S.-trained foreign national physicians.

category."[46] The ability for a physician to file the final step in the green card process for this category in any given month is determined by visa availability, announced by the U.S. Department of State in its monthly Visa Bulletin. Whereas for most months of most years the EB-2 category is "current" for doctors born outside of India or China, there are substantial waits for physicians born in either India or China. By significant measure, most of the physicians in the United States born abroad are from India, comprising over one-fifth of the total foreign-born physician community, with Chinese-born physicians making up slightly over 5% as the second most common foreign country of birth.[47] For instance, projecting forward future wait times based upon this month's Visa Bulletin, physicians born in India who are pursuing a green card in the EB-2 category would need to wait approximately nine years from the time of filing either the first of a labor certification application or an immigration petition until being able to file an adjustment of status application within the U.S.[48] Physicians born in China would need to wait approximately three years between the initial qualifying filing and being able to file the final step in the green card process.[49] As they wait to become lawful permanent residents, they lose agency over their own careers and may have children who will age out of the process to becoming lawful permanent residents and potentially fall out of lawful derivative status as they age.

One way to facilitate foreign national physicians obtaining lawful permanent resident

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[46] *See* INA §203(b)(2); 8 U.S.C. §1153(b)(2). Some physicians pursue a green card in the EB-1 category, either on the basis of Extraordinary Ability or Outstanding Professor/Researcher, pursuant to section 203(b)(1)(A) and 203(b)(1)(B), respectively. However, these physicians are in the minority and the immigrant petitions in these categories are subject to markedly inconsistent adjudications by USCIS, as relative to other employment-based paths for physicians.

[47] *Which Countries Do Immigrant Healthcare Workers Come From?*, NEW AMERICAN ECONOMY RESEARCH FUND (Apr. 4, 2020), https://research.newamericaneconomy.org/report/immigrant-healthcare-workers-countries-of-birth/.

[48] *See* Visa Bulletin for February 2022,U.S. DEP'T OF STATE,https://travel.state.gov/content/travel/en/legal/visa-law0/visa-bulletin/2022/visa-bulletin-for-february-2022.html(including the priority date of January 1, 2013 for the EB-2 India "Final Action Dates" Chart and the priority date of September 1, 2013 for EB-2 India within the "Dates for Filing" Chart).

[49] *See id.* (including the priority date of March 1, 2019, for the EB-2 China "Final Action Dates" Chart and the priority date of April 1, 2019 for the EB-2 China within "Dates for Filing" Chart).

status is to exempt them from the per-country limits of the employment-based preference system entirely, which would reduce the nine-year wait and three-year wait mentioned above to zero for physicians born in India and China, respectively. This would permit such physicians to file for the final step and adjust to green card status immediately upon proving their eligibility and admissibility, as is the case for immediate relatives of U.S. citizens.[50] The "America Creating Opportunities for Manufacturing, Pre-Eminence in Technology, and Economic Strength Act of 2022''(H.R. 4521) recently passed by the House of Representatives would so amend the statute. Per section 80303 of the Act, a foreign national holding a "doctoral degree" in a qualifying program of study, including "medical residency and fellowship programs," with a pending or approved immigrant petition in the EB-1 or EB-2 category would be eligible to file the final step in a green card case pursuant to such petition, without being subject to visa retrogression or backlog from per-country limits.[51]

Alternatively, rather than exempting all physicians from the per-country quota, the statute could be amended to permit only a subset of physicians to adjust outside of the preference system, so as to increase the immigration benefits of practicing in a medically underserved area. For instance, the statute could be amended so that Physician National Interest Waiver (PNIW) physicians could adjust to green card status outside of the per-country limits; the PNIW category requires physicians to commit to and fulfill an aggregated five years of full-time service in an HHS-designated shortage area.[52] At present, the immigrant visas obtained through the PNIW path exclusively reside within the EB-2 category. As noted above, given longstanding visa

[50] *See* INA §201(b)(2)(A)(i); 8 U.S.C. §1151(b)(2)(A)(i).
[51] Note that whereas "doctoral degree" is not defined within the bill or elsewhere in the INA and does not track with more the traditional phrase of "advanced degree" within the INA to refer to medical degrees, it would appear the intention of the drafters to include medical degrees within the meaning of "doctoral degree," as otherwise the reference to medical residency and fellowship programs in the program of study definition would be rendered meaningless. It is anticipated this would be effectuated as part of the technical corrections process.
[52] *See* INA §203(b)(2)(B)(ii); 8 U.S.C. §1153(b)(2)(B)(ii).

retrogression, physicians born in India or China at present have years of waiting in line in the EB-2 category before being able to "adjust" to green card status. Additionally, because this path remains exclusively in the EB-2 preference category under current statute, the applicants do not have the flexibility to file their green card applications in another EB category for which they may be eligible and that has better visa availability.

For instance, in October 2020, when the wait for an EB-3 immigrant visa was much better than for an EB-2 immigrant visa due to less demand for EB-3 visas, doctors who had a labor certification-based, or PERM-based, green card case had greater flexibility than PNIW physicians who had completed five years of service in a medically underserved community. Further, because the PNIW option resides only at the EB-2 category rather than in the EB-1 or EB-3 category, physicians whose work has been proven to be in the national interest may have to wait longer to become a lawful permanent resident than their colleagues practicing outside of underserved areas or, for that matter, lesser skilled professionals whose work may not be in the national interest. Additionally, unlike the Conrad program, which includes "FLEX spots," for physicians treating medically underserved patients and populations at locations that do not otherwise qualify, the PNIW program does not at present have this flexibility. As such, there is not the incentive for FLEX J waiver physicians to remain in their communities for an additional two years under this option.

In order to expand the utility of the PNIW to address chronic physician workforce shortages, it would be most effective to permit participating physicians to apply for their green card status outside of the numerical and per-country limits on immigrant visas. This would be a significant benefit for physicians born in India and China, the top two countries of birth, as noted

above. The Conrad Reauthorization Bill provides for this.[53] Another way to improve the public healthcare benefits of the PNIW program would be to expand the qualifying service to include treatment of underserved populations at facilities that are not located within a HHS-designated shortage area, also as provided for in the Conrad Reauthorization Bill.[54] This would permit continuity of care for the patient populations served by Conrad J waiver physicians carrying out their 3-year service commitment in what are known as "FLEX slots."

Another way to improve green card access for physicians would be to remove the public recruitment and labor test requirement that currently pertains to the vast majority of employment-based physician green card cases. Most employment-based physician cases are pursued through the labor certification path, also called "PERM." The PERM path requires the sponsoring employer to test the U.S. labor market to establish that there are no able, willing, qualified, and available U.S. workers for the offered green card position.[55] The required recruitment for physicians includes two Sunday print newspapers, a 30-day job order with a State Workforce Agency, and advertising in three additional outlets, over a minimum 60-day period of recruitment.[56] This path can be financially burdensome to employers, particularly safety-net hospitals or independent physician practices operating with narrow margins, as the employer is required to pay not only for the attorney fees involved in the process but also for the costly advertisements required by the DOL, including print ads.[57]

In contrast, DOL has pre-certified certain occupations, such as registered nurses and physical therapists, known as "Schedule A occupations," where the agency has determined there

[53] Conrad Bill, *supra* note 18, §3.
[54] Conrad Bill, *supra* note 18, §6(b).
[55] *See* INA §§ 212(a)(5)(A), 8 U.S.C. §§1182(a)(5)(A); 20 C.F.R. pt. 656.
[56] *See* 20 C.F.R.§§656.17(e)-(f).
[57] 20 C.F.R.§§656.12(b).

are not sufficient U.S. workers who are able, willing, qualified, and available for the occupations.[58] Given the well-established physician shortage, DOL has a reasonable basis to add physicians to the list of such occupations. This would have the effect of enabling physicians and their employers to concurrently file the labor certification application and the immigration petition directly with USCIS, without undergoing the recruitment and labor certification process in the DOL program first. Alternatively, DOL could limit the pre-certification to those offered physician positions located in HHS-designated shortage areas.

Either one of these modes of pre-certification would be a welcome relief, as well as being legally permissible and common-sense action. Requiring employers to perform a labor market test for physicians in the midst of a well-documented, decades-long national physician shortage is unnecessary. As noted above, employers can incur significant financial costs in connection with the current labor certification process. Additionally, there are lengthy processing delays at DOL related to the labor certification application processing, and labor certification application processing times have sometimes reached up to ten to twenty months, including audit time. Avoiding these delays by permitting direct application to USCIS through Schedule A designation would better help our country retain foreign national physicians by providing them with means to adjust to lawful permanent resident status, or "green card," status more quickly.

These legislative and administrative solutions will not only address our current physician shortage, which has reached crisis levels due to the COVID pandemic, but will also send an important message to foreign national physicians that their services are essential to all Americans. By reducing delays in the green card process and removing unnecessary obstacles, U.S.-trained physicians will be less likely to take their skills to other countries either because

[58] *See* 20 C.F.R. §656.5.

better opportunities are available elsewhere or in order to keep their own families together.

Benefits to U.S. Healthcare System of Retaining U.S.-trained Foreign National Physicians

Retaining U.S.-trained foreign physicians is one of the best ways to ameliorate the ongoing general national physician workforce shortage. Foreign national physicians fulfill a uniquely beneficial role in the U.S. healthcare landscape. Workforce analysts have found these physicians to be more likely to provide primary care, more likely to work at Critical Access Hospitals, more likely to accept new Medicare patients, new Medicaid patients and State Children's Health Insurance Program ("SCHIP") patients, more likely to treat a higher percentage of ethnic or racial minorities, and more likely to treat patients in poverty pockets and medically underserved areas.[59] Further, J waiver physicians appear to be more likely to remain in medically underserved areas after program completion than U.S. medical graduates participating in the National Health Service Corps ("NHSC"), which is the U.S. medical graduate program most similar to service-based J waiver programs. Twenty-eight percent (28%) of foreign national physicians who obtain J waivers continue to practice in their underserved locations after five years, as compared with a retention rate of 11% for US medical graduates participating in the NHSC.[60] Our current immigration laws, such as the Conrad 30 J waiver program and the PNIW option, are already designed to attract talented foreign national physicians to serve these populations, but need to be updated to ensure that the physicians stay and continue providing care in these communities.

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[59] THE PHYSICIAN IMMIGRATION BOOK 56-76 (Robert Aronson ed., 2011-2012 ed.).

[60] AMERICAN MEDICAL ASSOCIATION (AMA)-INTERNATIONAL MEDICAL GRADUATE (IMG) SECTION GOVERNING COUNCIL, INTERNATIONAL MEDICAL GRADUATES IN AMERICAN MEDICINE: CONTEMPORARY CHALLENGES AND OPPORTUNITIES- 15 (2010), *available at* https://www.slideshare net/drimhotep/internationalmedicalgraduatesinamericanmedicinecontemporarychallengesandopportunities.

Additionally, the quality of care provided by foreign national physicians to the U.S. population does not appear to suffer from the fact that they typically obtain their medical degree from abroad before U.S. GME training. A study conducted by Harvard University researchers of more than 1.2 million hospitalizations at U.S. hospitals nationwide found that International Medical Graduates (IMGs) (i.e., those physicians who obtained their medical degrees from abroad), had lower patient morbidity rates than their U.S. medical graduate peers.[61] Another study focused on patient outcomes comparing non-U.S. citizen IMGs as relative to U.S. citizen IMGs and U.S. medical graduates based upon in-patient records found that patients treated by non-U.S. citizen IMGs had significantly lower mortality rates than patients cared for by doctors in the latter group.[62]

Conclusion

Given our nation's ongoing national physician workforce shortage as well as chronic maldistributions, and the beneficial role foreign national physicians fulfill in our healthcare delivery system, it is imperative to improve our country's immigration law and policy to better leverage this unique resource. I have outlined here but a few legislative proposals and administrative actions that can be undertaken. No one of these taken in isolation will fix our chronic issues, and, indeed, even the creation of a multi-phase new visa, such as an "M.D." visa, would not suffice to resolve healthcare delivery issues without other simultaneous improvements outside of immigration law, such as increased funding for GME slots and the resolution of

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[61] Yusuke Tsugawa, Anupam B. Jena, E. John Orav & Ashish K. Jha, *Quality of care delivered by general internists in US hospitals who graduated from foreign versus US medical schools: observational study*, BMJ (2017), *available at*https://www.bmj.com/content/356/bmj.j273.

[62] John J. Norcini, John R. Boulet, W. Dale Dauphinee, Amy Opalek, Ian D. Krantz&Suzanne T. Anderson, *Evaluating the quality of care provided by graduates of international medical schools,* 29(8) HEALTH AFFAIRS1461-8 (2010).

*While this testimony is my own, I gratefully acknowledge the assistance of Harris Immigration team members Sophie Novak and Denise Soriano for their assistance with related research and preparation, as well as ECFMG for information regarding immigration data on J-1 sponsored foreign national trainees.

underlying healthcare access issues. However, as a matter of public policy, in the face of an ongoing pandemic, making modest, budget-neutral modifications to our existing immigration laws is a good place to start.

Ms. SCANLON. Thank you very much.

Mr. Lynn, you are now recognized for 5 minutes.

I think we need you to unmute.

I think we're still having a technical problem. It looks like you unmuted.

Not hearing anything yet.

No. I can see that you're talking, but it's not coming through.

Can our tech folks help us here?

Okay. Let's suspend the hearing for a minute while we work on the technical issue, and we will be back in a minute. Our tech folks are working on it. So, the Committee will suspend.

[Pause.]

Ms. SCANLON. We'll resume. You are recognized for 5 minutes.

Mr. LYNN. Thank you very much.

Ms. SCANLON. Sure.

STATEMENT OF KEVIN LYNN

Mr. LYNN. Chair Lofgren, Chair Scanlon, Ranking Member McClintock, and the distinguished Members of the Subcommittee, thank you for allowing me the opportunity to discuss the consequences of immigrant physicians in the U.S. healthcare system.

The United States is facing a doctor shortage; however, it is a shortage of our own making. In recent years, thousands of American medical doctors have been denied the right to practice medicine. This is one of the most unreported stories and one of the most ignored situations by our elected officials and medical community, leadership in America, including our medical schools, and the various governing bodies who represent physicians.

In 2018, Progressives for Immigration Reform started the Doctors Without Jobs project to build awareness of the number of U.S. citizen doctors graduated from medical schools who were not matching to residency positions each year while foreign-trained physicians were. This encouraged more doctors to advocate for themselves and push back against graduate medical education profiteers.

The match is the mechanism by which medical school graduates move into medical residencies at teaching hospitals. It is a process managed by the National Resident Matching Program. Please understand that without a medical residency, a doctor cannot practice medicine, and a residency may require 3–7 years to complete, depending on the specialty.

Each year, over 7,000 U.S. citizens and lawful permanent resident medical graduate physicians, which include seniors and prior year graduates, do not match for a medical residency, all of whom are qualified, ready, and willing doctors who have been sidelined and are waiting to serve their communities now, a situation we worked to draw attention to at the start of the pandemic so that they might be deployed. Our call went unanswered.

There is much more to this story that should concern the subcommittee. In 2021, over 4,000 noncitizen foreign-trained physicians received residencies in the U.S. This is an enormous increase from 10 years prior where 2,700 foreign-trained physicians received residencies.

Between 2011 and 2021, more than 40,000 non-U.S. citizen, foreign-trained physicians were given U.S. taxpayer-funded residencies. Each residency costs taxpayers 150,000 a year. So, we are subsidizing foreign doctors. Many foreign-trained physicians arrive in the U.S. for residency training via the J–1 visa, a cultural exchange visa. In addition, foreign-trained physicians arrive via the H–1B visa program to work directly in hospitals.

In 2020, over 3,500 labor condition applications were filed for 4,252 workers for the occupation of medical doctor. Of those, over 3,000 were approved. In addition, over 5,000 applications to extend from prior years were also approved.

Every country prioritizes its citizens. Canada, the last holdout, has changed its policy to prioritize Canadian citizens and permanent legal residents a couple years ago. Failure to prioritize Americans is emblematic of our medical establishment preferring to import foreign healthcare workers instead of making necessary investments that would broaden medical education and improve our healthcare delivery infrastructure.

This doesn't just cause problems here at home. A 2020 Migration Policy Institute article titled "Global Demand for Medical Professionals Drives Indians Abroad Despite Acute Domestic Healthcare Worker Shortages," describes the brain drain and the harm it does to India's healthcare system. The same can be said for countries in sub-Saharan Africa, where healthcare professionals are also lured to the U.S., U.K., and Canada.

A poor country's loss is a rich country's gain. The estimated financial benefit to the United States from luring physicians from sub-Saharan Africa is believed to be in and around $846 million. The sending countries lose about $2.1 billion from the investments made in their doctors who leave.

According to survey data, in 2020, roughly 70 percent of doctors in the U.S. were born here, about 20 percent were naturalized, and 7 percent are noncitizens. These percentages have remained fairly consistent over the past 10 years.

Every area of American endeavor has been impacted by relentless importation of foreign workers, starting with lower paying work, seasonal hospitality workers, and then on to manufacturing, to technology workers, and now to doctors, who have spent at least 8 years and hundreds of thousands of dollars to practice the healing arts, a very specialized profession, only to be sidelined and saddled with debt they are unlikely to be able to pay off if they can't practice medicine.

The demand and enthusiasm to enter the medical profession is there. Applications to medical schools are at an all-time high, as are enrollments in the Nation's nursing programs. We have thousands of physicians in line waiting for residency training. We need more residency positions, and we must prioritize U.S. citizens and lawful permanent residents.

Thank you for your time.

[The statement of Mr. Lynn follows:]

Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System

– Testimony of Kevin Lynn, Founder of Doctors Without Jobs –

Chairwoman Lofgren, ranking member McClintock, distinguished members of the subcommittee, thank you for allowing me the opportunity to discuss the consequences of immigrant physicians in the U.S. healthcare system.

The United States is facing a doctor shortage.[1] However, it is a shortage of our own making. In recent years, thousands of American medical doctors – U.S. physicians – have been denied the right to practice medicine. This is one of the most unreported stories, and one of the most ignored situations by our elected officials and medical community leadership in America, including our medical schools and the various governing bodies who purport to represent physicians.

In 2018, Progressives for Immigration Reform (PFIR) started the Doctors Without Jobs (DWJ) project to build awareness of the number of U.S. citizen doctors graduating from medical schools who were not "matching" to residency positions each year, while foreign-trained physicians were. This encouraged more doctors to advocate for themselves and push back against graduate medical education profiteers.

The "match" is the mechanism by which medical school graduates move into medical residencies at teaching hospitals. It is a process managed by the NRMP – the National Resident Matching Program.

Please understand that without a medical residency a doctor cannot practice medicine. And a residency may require three to seven years to complete, depending on the medical specialty.

Each year, over 7,000 U.S. citizens and lawful permanent resident medical graduate physicians which includes seniors and prior-year graduates do not match for a medical residency.[2]

All of whom are qualified, ready and willing doctors who have been sidelined and are waiting to serve their communities now, a situation we worked to draw attention to at the start of the pandemic so that they might be deployed. Our call went unanswered.

There is much more to this story that should concern this subcommittee. In 2021, 4,356 noncitizen foreign-trained physicians received residencies in the U.S. This is an enormous increase from ten years prior when 2,721 foreign trained physicians received residencies.[3]

Between 2011 and 2021, more than 40,000 non-U.S. citizens/foreign-trained physicians were given U.S.-taxpayer-funded residencies. This is all data from the NRMP.

Each residency costs taxpayers about $150,000 a year, so we are subsidizing foreign doctors.
Many foreign-trained physicians arrive in the U.S. for residency training via the J-1 visa, a cultural exchange visa.

In addition, foreign trained physicians arrive via the H-1B visa program to work directly in hospitals. In 2020, 3,508 labor condition applications (LCAs) were filed for 4,252 workers for the occupation of

medical doctor of those, 3,004 were approved. In addition, another 5,232 applications to extend from prior years were approved.[4]

Every other country prioritizes its citizens. Canada, the last holdout, has changed its policy to prioritize Canadian citizens and permanent legal residents.[5]

Failure to prioritize Americans is emblematic of our medical establishment preferring to import foreign healthcare workers instead of making the necessary investments that would broaden medical education and improve our healthcare delivery infrastructure.

This doesn't just cause problems here at home. A 2020 Migration Policy Institute article, "Global Demand for Medical Professionals Drives Indians Abroad despite Acute Domestic Healthcare Worker Shortages," describes the brain drain and the harm it does to India's healthcare system.[6] The same can be said for countries in Sub-Saharan Africa where healthcare professionals also are lured to the U.S., UK and Canada.

A poor country's loss is a rich country's gain. The estimated financial benefit to the United States from luring physicians from Sub-Saharan Africa is $846 million. The sending countries lose about $2.1 billion from the investments made in their doctors who leave.[7]

According to American Communities Survey data, in 2020, roughly 70 percent of doctors in the U.S. were born here. About 20 percent were naturalized. Some 7 percent are noncitizens. These percentages have remained fairly consistent for the past 10 years.[8]

Every area of American endeavor has been impacted by the relentless importation of foreign workers. Starting with lower-paying work, seasonal hospitality workers, and then on to manufacturing jobs, to technology workers and now to our doctors, who have spent at least eight years and hundreds of thousands of dollars to practice the healing arts, a very specialized profession, only to be sidelined and saddled with debt they are unlikely to be able to pay off if they can't practice medicine.[9]

The demand and enthusiasm to enter the medical profession is there. Applications to medical schools are at an all-time high,[10] as are enrollments in the nation's nursing programs.[11]

In closing, we have thousands of physicians in the line waiting for residency training. We need more residency positions and we must prioritize U.S. citizens and lawful permanent residents.

Thank you for your time.

Footnotes

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[1] U.S. physician shortage growing, AAMC, 26 June 2020
https://www.aamc.org/news-insights/us-physician-shortage-growing

[2] NRMP
https://www.nrmp.org/match-data-analytics/residency-data-reports/

[3] ibid

[4] H-1B LCA Data on U.S. Physicians: 2011-2021
https://econdataus.com/physician20data.htm#lca

[5] CMA Policy on Equity and Diversity in Medicine Encouraging for International Medical Graduates
https://cmajblogs.com/cma-policy-on-equity-and-diversity-in-medicine-encouraging-for-international-medical-graduates/

[6] Global Demand for Medical Professionals Drives Indians Abroad Despite Acute Domestic Health-Care Worker Shortages, Migration Policy Institute, 23 January 2020
https://www.migrationpolicy.org/article/global-demand-medical-professionals-drives-indians-abroad

[7] Diagnosing Africa's medical brain drain, Africa Renewal, December 2016 to March 2017
https://www.un.org/africarenewal/magazine/december-2016-march-2017/diagnosing-africa's-medical-brain-drain

[8] Census Data on U.S. Physicians: 2011-2020
https://econdataus.com/physician20data.htm#census

[9] Medical school graduate sees nearly all of his $440,000 in student loans discharged
https://finance.yahoo.com/news/medical-school-graduate-440000-student-loans-discharged-151422886.html

[10] Applications to medical school are at an all-time high. What does this mean for applicants and schools? AAMC, 22 October 2020
https://www.aamc.org/news-insights/applications-medical-school-are-all-time-high-what-does-mean-applicants-and-schools

[11] Student Enrollment Surged in U.S. Schools of Nursing in 2020 Despite Challenges Presented by the Pandemic, American Association of Colleges of Nursing, 1 April 2021
https://www.aacnnursing.org/News-Information/Press-Releases/View/ArticleId/24802/2020-survey-data-student-enrollment

'I Am Worth It': Why Thousands of Doctors in America Can't Get a Job

Medical schools are producing more graduates, but residency programs haven't kept up, leaving thousands of young doctors "chronically unmatched" and deep in debt.

https://www.nytimes.com/2021/02/19/health/medical-school-residency-doctors.html

Rich Countries Lure Health Workers From Low-Income Nations to Fight Shortages

Huge pay incentives and immigration fast-tracks are leading many to leave countries whose health systems urgently need their expertise.

https://www.nytimes.com/2022/01/24/health/covid-health-worker-immigration.html?searchResultPosition=1

For committee members interested in connecting with the following doctors who are listed below without contact information, please reach out to Kevin Lynn.

One Doctor's Quest for Residency

Many assume that a U.S. medical school graduate will have a rewarding future as a doctor. But for Dr. Doug Medina, a 2011 Georgetown University School of Medicine graduate with a doctorate in allopathic medicine, the outcome was starkly different.

Dr. Medina hasn't been chosen for a medical residency. Without residency training, he can't work as a doctor licensed to practice. In their personal lives, non-practicing doctors such as Dr. Medina struggle to pay back the student loans for a medical education that carries a steep price tag.

According to data from the National Resident Matching Program (NRMP), about 94 percent of U.S. medical school graduates do place in residencies each year. That number may sound good, but it means the remaining 6 percent of doctors are in professional limbo after committing years of their lives to a very specialized education.

"The problem is a serious flaw in policy that is not protecting U.S. citizen medical students," says Dr. Medina, who never failed any clinical training or any course work during medical school, earned honors in five Acting Internship clinical rotations in his final year of medical school, passed the United States Medical Licensing Exam (USMLE) Step 1, 2 and 3, and has published research at the Research Institute on Addictions.

According to NRMP statistics, in the last ten years thousands of U.S. citizens graduating from U.S. medical schools – up to 2,000 each year – and more from medical schools outside of the U.S. didn't receive medical residencies.

For the same ten-year period though, more than 36,000 foreign-trained physicians (FTPs, non-U.S. international medical graduates) on H-1B and J-1 visas have been given U.S. residencies. Looking just at 2020, federal Medicare dollars funded residency training positions for about 4,200 non-U.S. international medical graduates (IMGs).

There's increasing anecdotal evidence that the profession is showing the same trend lines as with technology workers being displaced by H-1Bs over the last 20 years. The 4,200 IMGs given taxpayer-funded residencies in 2020 is up from 2,700 in 2011, edging up each year since then, per NRMP data. There are a number of residency training programs that select a high number of non-U.S. citizen IMGs over U.S. medical students. According to a story in *Time*, one internal medicine program reported that 60 percent of its incoming residents are on, or are to be on, H-1B visas.

With a 6.7 percent interest rate, Dr. Medina's original $300,000 in student loans have expanded to more than $400,000. Dr. Medina has filed formal grievances with the Association of American Medical Colleges and the Liaison Committee on Medical Education. But to date, Dr. Medina's complaint hasn't been acknowledged.

After a part-time, graveyard shift working as a patient intake specialist in Las Vegas, where he earned $30/hr., Dr. Medina was laid off during the pandemic. He landed in Southern California working as a clinical documentation specialist at a lower pay rate. He continues to persist in his pursuit to obtain a medical residency.

“I haven’t given up,” Dr. Medina says. “If I continue to address the immigration policy issues, maybe this will help other students as well.”

Dr. Medina offers several solutions, including:

- The State Department should reduce to 2,000 annually the total IMGs who receive residencies. This would keep the pipeline for foreign doctors open, but create more opportunities for U.S. graduates.

- Medical schools should provide greater assistance to graduates so they can find residency training or alternative careers.

- Make ERAS application fees affordable. It shouldn’t cost more than $8,000 to apply for a job in the U.S.

- Prioritize Preliminary Years at Affiliate Training Hospitals for U.S. medical students.

- Prioritize Preliminary Years in the Supplemental Offer Acceptance Program (SOAP) for U.S. medical students. Every U.S. medical student should have a one-year Preliminary Year position before the Association of American Medical Colleges allows non-U.S. citizen IMGs to be hired for these positions.

How and Why to Pay for more Residency Positions

By Dr. Mimi Oo

Medicare funds residency positions and US citizens/ LPRs have contributed to the funds since they started working. Therefore, the residency positions should be prioritized for those US Citizen/LPR medical graduates regardless of whether they attended American Medical Schools or International Medical Schools.

During or before the 1990s there weren't enough applicants to residency positions and legislators had innovative ideas and came up with J1 and H1B visas to bring in physicians from all over the world to assist with the shortage. Now that we have more than enough US Citizen/LPR medical graduates we need to rethink how we are recruiting physicians for the US.

Medical Residency is Graduate Medical Education. The government gave out federal loans to the US Citizens to attend medical schools, be it American or International and these medical graduates are burdened with huge loans. They should be able to finish their graduate medical education and should have secure spots for them to finish the education.

Since unmatched doctors cannot practice as medical doctors America is losing more than 1.4 billion a year (7409 unmatched US citizen/LPR medical graduates potential earnings of $200,000x7000).

As Medicare funds for residency were capped since 1997, we should find alternative solutions to expand the pot of funds. We could add more Non discretionary funds

-from Dept of Labor as this is a workforce issue

-from Dept of Education as this is Graduate Medical Education

- and from Dept of Health as this concerns America's Health.

Additional funds from all 3 depts will ease the burden on Medicare and we will be able to expand residency positions. This can happen only at Congressional level.

In other countries, a student attends medical school straight after high school for 6 to 7 and a half years including residency. After that, you graduate and are licensed to practice. In America, a student attends undergraduate for 4 years, after passing MCAT, attends medical school for 4 years, passes the USMLEs and graduates. Even as a medical graduate, his/her education is deemed unfinished until one finishes the 3 to 5 years of residency training (Graduate Medical Education). Thus, the US government has an obligation to train these medical graduates as the loans came from the federal

government and the MDs should not have to repay them until they are fully trained or obtain a license.

Residency positions should be reserved for those who have not gone through residency and should not be given away to those who have gone through residency in other countries. These full fledged physicians from other parts of the world could be hired as physicians by the hospitals themselves directly (as in Mayo clinic and other hospitals in the US) and not encroach upon Medicare funds contributed by US Citizens and LPRs.

I am unaware of other countries allowing US unmatched medical graduates to come and train in their medical residencies.

America is the richest country/ leader in the world and it is such a shame to see that it ranks at 52 in the world's patient population ratio (2.59:1000)

Be it traditional residency or collaborative practices, we need more medical doctors to practice/be licensed and it is the Congress's responsibility to make it happen.

Stuck in the Middle

An American doctor who fell through cultural cracks on the way to residency becomes a strong advocate for change.

Assistant physician Dr. Faarina Khan is not letting challenging circumstances stop her from paving the way for other doctors in the same boat.

Growing up in a Pakistani-American family in Chicago, Dr. Khan graduated high school and chose to attend Dow International Medical College (DIMC) in Karachi. This decision was influenced by comparatively lower costs than American medical schools, eliminating the burden of student loans. It was also an opportunity to connect with extended family and immerse herself in the culture.

The five-year program is patterned after the India/United Kingdom model and is comparable to a four-year MD degree in the United States. But unlike U.S. medical schools, DIMC does not build the U.S. Medical Licensing Exam (USMLE) into the curriculum. During her year-long post-grad clinical internship at the medical school's hospital, in order to be ready to apply for medical residency immediately upon completion of the internship, Khan also studied for and took the USMLE Steps 1 and 2.

But she has not matched to a residency since graduating from medical school in 2015. Now five years out, she is an "old" graduate in the eyes of residency program directors who favor those within two years of medical school graduation. Cultural factors are at play as well.

"Because international medical graduates are stereotyped as visa-requiring foreigners with limited English proficiency, they overall are assumed to be ignorant of American norms and the usual way of doing things," Khan explains. "But I was born and raised in the U.S. I'm in the middle – an American, but an IMG (international medical graduate)."

Khan chose to channel her frustrations at not landing a residency into keeping her clinical skills current and advocating for unmatched doctors. Since 2018, she has been licensed as an assistant physician in the state of Missouri, and has served as the Chief Assistant Physician for the Medina Clinic in Grandview since March 2020, a role that entails coordinating her assistant physician colleagues in addition to continuing to provide clinical care to the uninsured patients who make up the clinic's core demographic. She also volunteers for the Missouri Disaster Medical Assistance Team as an assistant physician to aid with COVID-19 testing/screening and staffing facilities whose workforce was negatively impacted by the pandemic.

Missouri is one of the few states that licenses assistant physicians, who work under the supervision of a practicing primary care MD in medically underserved areas.

"The state has 360 actively licensed assistant physicians and about 100 of them are actively volunteering or being paid," explains Khan.

Utah's licensing program uses the Missouri model, but has stricter criteria; Utah licensees only have six months to find a collaborating physician to work under before their licenses expires. Arkansas and Kansas have used a similar concept, but cater only to graduates from medical colleges in their respective states.

In addition, Khan is serving as interim president of the newly formed nonprofit National Association of Assistant/Associate Physicians (NAAP). The organization's goal is to bring the group up to the recognition and funding levels of similar groups advocating for other medical professionals, like nurse practitioners and physician assistants.

One important area of focus is improving workforce development and instituting a range of base pay for assistant physicians, some of whom are making minimum wage or nothing at all. A major reason behind this is that Medicare does not yet recognize assistant physicians as billable providers. If an assistant physician is a billable provider, s/he can get paid for services just as physicians and mid-level providers can. NAAP has been working with a Missouri state representative to request that the Centers for Medicare and Medicaid Services (CMS) recognize and subsequently include assistant physicians as billable providers.

Khan is also one of several cofounders of the nonprofit American Society of Physicians (ASP), which is working to empower the unmatched physicians in the U.S. According to data from the National Resident Matching Program, in the last ten years, thousands of U.S. citizens who graduated from medical schools outside of the U.S. did not match to a residency. This is in addition to as many as 2,000 medical school graduates of U.S. medical schools each year who don't get residencies.

In the last ten years as well, more than 36,000 foreign trained physicians (FTPs, non-U.S. IMGs) on H-1B and J-1 visas have been given U.S. residencies. Looking just at 2020, federal dollars from Medicare underwrote residency training positions for about 4,200 non-U.S. IMGs.

"Unmatched MDs are stuck flipping burgers or driving for Uber just to survive," Khan said. "This is not why we went to medical school. We want to be able to save lives with our knowledge and training, but we are hampered by a senseless centralized residency matching system with too many middlemen. The U.S. healthcare system has sadly deteriorated into nothing more than another business."

Given these sobering statistics, a major goal of ASP is to encourage state legislators to support key pieces of legislation (such as the Resident Physician Shortage Reduction Act) that will

ultimately increase the number of residency training positions. Khan is advocating for assistant physician laws in other states to allow eligible U.S.-based medical graduates to serve in patient care roles under direct supervision.

“Contrary to popular belief, we don’t have a physician shortage – what we actually have is a training shortage,” Khan explains. “We are trying to fix a very broken system with education and awareness, and simply bridge the gap between medical school and residency while helping to alleviate the healthcare shortage in areas of greatest need,” she added.

Khan would like to think that her home country would be willing to be supportive in her efforts to help Americans with their healthcare needs. “There are so many MDs who give up, but that is not in me. Even if I can’t implement significant change soon enough to benefit myself or my current colleagues, being able to clean things up long-term and smooth the journey for future U.S. doctors is still worth putting in the effort now.”

*Postscript – Dr. Khan did match for a residency in 2021 and is now working with an underserved community in the state of Oregon

Doctor Open to Serving in Rural America

Dr. Esther Raja
Utica, NY

It is unethical to have citizens from other countries replace American doctors. American physicians who want to be trained in residency programs in the U.S. are sitting on the sidelines. There are simply not enough residency training slots and no alternate pathway or jobs to compensate for a growing population of doctors.

There should be some backup plan to licensing. The U.S. needs more doctors than are being trained. So apprenticeships, more slots or alternate pathways need to be created or developed. Talent is being squandered. Doctors are being prevented from achieving their goals and have the additional burden of medical school loans.

While preparing for my USMLE exams, I attended a one-month pharmacovigilance training program offered by an Indian recruiting company (globalpharmatek.com). They were training Indian citizens with H-1B visas. After the training, only H-1B visa holders were recruited for jobs with pharmaceutical companies such as Johnson & Johnson, while I and other Indian Americans who were Caribbean medical school grads were denied jobs. I later learned that these visa holders had to sign contracts committing half of their hourly wages to the recruiting company. American citizens were not tied to such a contract, because it is illegal.

It's my understanding that residency programs run by foreign program directors offer a majority of residency spots to J-1 visa holders from their home countries, while Americans are sidelined. This has to stop. We need American medical grads and American international medical graduates to be prioritized in the residency matching system.

There are many private practice physicians who are open to training medical school graduates, who want to expand residency programs to private practice. The current residency programs, especially for family practice, often focuses on hospital-based medicine, which is not primary care.

I am one of the unmatched ECFMG (Educational Commission for Foreign Medical Graduates) certified graduates with more than $170,000 in medical school loans, which went into collections. I have completed all of my clinical training in Atlanta in all the required and elective specialties. I am willing to go to any underserved area of the United States for my residency training in primary care or family medicine. I am well versed in the American health care system and have excellent physician-patient and communication skills. I cannot see myself practicing medicine in any country other than this country that I call home.

Florida Med School Grad Ready to Practice Family Medicine

I have not yet been able to match with a residency program. Residency program directors have expressed that I am a "risk" to their passing board rates due to my repeated attempts to pass the USMLE Step 2 CK. I addressed my academic issues with complete transparency and received the needed testing accommodations from the National Board of Medical Examiners (NBME). Unfortunately, my application has been rejected.

Here's more of my story.

1. U.S. citizen. Born and raised in Florida.
2. Graduated from high school as valedictorian in 2005 with a 4.6 GPA. Also completed my AA degree during high school.
3. Attended Florida State University and majored in Exercise Physiology. Completed the pre-med track. Graduated in 2008, with honors.
4. Gap Year: Taught high school chemistry and physical sciences.
5. Completed the Bridge to Clinical Medicine Program, earning a Master's Degree in Biomedical Sciences.
6. Graduated medical school in spring 2017, having passed USMLE Step 1 (first attempt), USMLE Step 2 CS (first attempt) and USMLE Step 2 CK (fourth attempt).

My entire life has been dedicated to the pursuit of medicine. Now as a medical graduate with no residency training, I struggle to find career options that are reflective of my knowledge and experience. My total debt is $430,000. My student loans are currently in deferment. From 2015-2019, I spent thousands of dollars in the residency match process. Due to financial constraints, I did not apply in the 2020 cycle. I am not certain of the best path from here. Returning to school is not a viable option, as I have maxed out my student loan allowances. I continue to apply each cycle and when opportunities become available outside of the application cycle.

Now, I offer success coaching to undergraduate students in an effort to help them enter and complete medical school successfully. I have also been a source of support to medical students who struggle academically or fail to match. I desire the opportunity to fulfill my aspiration of being a board-certified, practicing family medicine physician. In the meantime, I will do everything in my power to help pre-medical and medical students not face a similar path.

The United States is not lacking in American medical graduates. Some of us are simply not granted the opportunity to enter residency training and have a medical career.

War, Refugee Camp Survivor Wants Opportunity to Give Back

I am one of the thousands of American doctors who is unemployed.

As a first-generation immigrant who survived the Gulf War in 1991, I lived through the prosecution of Saddam's regime and escaped the second war in 1998. My family and I immigrated from one country to the next. Eventually, we ended up living in a refugee camp in North Africa, waiting for salvation, not knowing where we would end up next. After three years of waiting and following every legal channel, we were finally granted resettlement to the United States.

The U.S. was the only country that offered me the right to be acknowledged as a sovereign individual and citizen. Hearing the success stories of many other immigrants, I was restless to be part of the American dream. I wanted to give back to my community, state and country. I was more than eager to start my journey. I started my five-year journey, between working different jobs and spending hundreds of hours in libraries, sleeping in my car, building up my resume and finishing my medical boards – all of this to be able to apply for residency training. But the reality was that I wasn't able to work as a medical doctor in the country that welcomed me.

I blamed myself until I started doing some research. I went through the National Residency Matching Program (NRMP) statistics, and to my astonishment I discovered I wasn't alone. There are thousands of American doctors suffering the same fate.

Encountering persecution and living in refugee camps taught me to be grateful for what I have, to work hard and to not to be afraid of censorship. But the policies and the large numbers of applicants for residency versus the actual number of residency slots have pushed me to be an advocate for the large number of unmatched MDs. This situation requires immediate surgical intervention!

OBGYN Denied Residency Opportunities Because of Graduation Year?

Iman Khalil

Sterling, VA

I was a professor of OBGYN in medicine at Cairo University, the first and largest medical school and teaching hospital in the Middle East. I finished my residency, master's degree and Ph.D. of OBGYN at Cairo University (Egypt) and completed a fellowship in reproductive endocrinology at Cochin Hospital in Paris, France.

I married an American citizen and was planning to move to live with him in the United States. But faced with the fact that I could not practice medicine before passing the USMLE exams, I stayed in my home country and studied for the USMLE, while working a full-time job as a physician and caring for my child and ill father.

I passed all the USMLE steps and then decided to move to the U.S. after nine years of marriage. I applied for The Match three successive years, paying more the $3,000 each year, without a single interview. Why? I believe it's because the programs filtered my application by year of graduation.

I tried to search for a health care job. I emailed hospitals and universities, often more than 100 emails per day, Either I received no reply, or was told I had to be licensed to work in the position, even as a medical assistant.

I am thinking about going home to practice my profession in my birth country and leaving everything in the U.S.

U.S. Doctor Asks for Residency, Employment and Dignity

I am a U.S. citizen and graduated from a well-known medical program, UAG School of Medicine (UAG SOM). To date, I have not been given the opportunity to enter into a federally funded residency program in the United States. Without a residency training position, I'm not able to practice medicine and obtain a health care provider license number, nor can I pay back my federal government loans.

I passed the United States Medical Licensing Exams (USMLE) in order to become eligible to enter a federally funded residency training program. I've spent more than $10,000 applying to residency programs in order to get a job, post medical school, so I can provide for my family and pay my federal loans. Today, I owe approximately $400,000 in federal loans. Every year federal loan interest piles on due to me being jobless/left without a federal residency training position.

I am just one of the thousands of American doctors who has not been accepted into federal training positions, while foreign doctors have been given residency positions over Americans. In other nations, native doctors are given preference. But in 2020 alone, more than 4,000 doctors were issued visas to begin federal residency training positions.

Meanwhile, just shy of 6,000 Americans were denied federal training positions. There are many downsides to this situation. Other countries lose on their investment of their medical graduates, and many of the sending countries have doctor shortages. American medical graduate are left jobless. From the standpoint of patients, many American patients prefer a native medical doctor for a variety of sound reasons.

The ECFMG says there is a doctor shortage in the U.S. when there is no doctor shortage. They do this because they make millions of dollars every year from foreign doctors through fees to the ECFMG.

We need to give American doctors a fighting chance at residency, employment and dignity. I want to provide my daughter and family a decent future.

Hire American Doctors First

Since graduating from a medical academy in Ukraine with a pediatric surgery residency, I have spent thousands of hours in the OR working overtime.

In the U.S., I passed all the required exams to become ECFMG certified, worked as a surgical assistant where I assisted with all types of surgeries. I also now work as a GI assistant in the digestive health department in the Chicago Advocate Medical system, where I assist with regular basic and interventional procedures. I've also participated in a research study with colo-rectal surgeons which will be part of an international study guide.

With all this, I still have not matched to a residency position at a teaching hospital. I want to be a practicing doctor in the United States, a country that has a tremendous shortage of doctors in multiple communities. I – and many like me – am ready and willing to help. We must put our own citizen doctors to work first, and then supplement any unfilled residency spots with J-1 and H-1B visa holders – not the opposite which is the current situation.

U.S. Medical School Grad is Unmatched with $475k in Debt, and Growing

I graduated from a U.S. medical school five years ago, but remain unmatched and with $475,000 in student loan debt for which interest is capitalizing at around $50K per year. These loans are currently in hardship deferral for which time is running out.

As far as finding a "job" while reapplying for residency, it has been extremely difficult. Temporary contract work in the gig economy offers no benefits and is basically minimum wage. For other jobs, recruiters either provide no response or say that I am overqualified, refusing to believe that I have difficulty getting into a residency program as an American graduate. Under these circumstances, it's challenging to raise funds to apply to hundreds of residency programs, while also trying to take care of the everyday costs of living.

At the medical school I attended, about 80 percent of the internal medicine residency program is comprised of non-U.S. citizen graduates from foreign medical schools. It is a large medical center in the middle of a predominantly African-American city, yet the medical trainees are not concerned about the patient population, based on the complaints patients commonly make.

As a rotating third-year student, many patients have expressed excitement in seeing me care for them as a U.S. citizen who is more culturally attuned to their issues. They have numerous times in direct comparison complimented me for offering more empathetic care. In general, the patients have little trust that many of the foreign-trained medical residents care for the health of their patients.

The resident class is so skewed toward foreign medical graduates that U.S. graduates are often the "loners" at academic meetings and clinical rounds. Many foreign medical graduates as senior residents and program directors advocate for other foreign medical residents on admission committees over U.S. graduates. The policies concerning who gets admitted to a program are therefore clearly "lax" and lacking any structure that aligns with the priorities and interests of the United States of America and American citizens whose tax dollars fund residency programs.

American citizens live among the patients they care for and can better relate to the cultural and socio-economic factors impacting their care. Studies have shown that patients fare better when their caregiver is reflective of the population they serve. U.S. graduates also have a massive burden of federal and private student loans that is not shared by foreign medical graduates. No other country has a system whereby it is possible to prioritize other countries' medical graduates over its own.

This selection system for residents is critically broken and is causing undue suffering to American graduates and, as such, long-term damage to critical U.S. interests. There are thousands of American graduates on the sidelines waiting for residency positions, but they are overlooked in preference for foreign medical graduates.

This problem can be corrected by a system whereby medical residency programs must give priority to U.S. graduates. In particular, a medical residency position should not be filled by a foreign medical graduate if there is a qualified U.S. medical graduate in the applicant pool. This is not radical, anti-immigration solution, it is simply about taking care of American interests first.

One of the most fundamental problems leading to unmatched U.S. graduates is that a U.S. medical education is based on an abridged model where medical students graduate but need to “match” into a residency in order to be a license-eligible independent practitioner. Imagine having a party at your house but allowing the neighbor’s children to eat all the prepared food while your own children starve! These facts concerning this critical capstone phase – especially making it open to the entire world without any sort of explicit prioritization – sets up many U.S. graduates for years – or a lifetime – of misery from lost time, wages and general progress in their lives and careers. It is virtually a career death sentence not to match into a residency.

No other profession in America gives degrees to people who are not license-eligible, and then they have to compete with the world for a chance to finish their training as an independent professional!

We must stop wasting the lives of intelligent, educated American citizens. We must stop stealing physicians from other less developed countries and act responsibly. We must finally take care of our own and put Americans first.

A Doctor who was Homeless

I was only five when I first said I wanted to be a doctor, and my passion for becoming a physician has not wavered since. I earned a bachelor's degree from the University of California Davis and a medical degree from Ross School of Medicine.

I worked full-time to pay for college and volunteered in different health care settings before entering medical school. However, my dream of being a practicing physician has been crushed after earning a medical degree in 2009. After a thousand job applications, excluding residency applications, I only had one job interview for a research assistant at the Stanford School of Medicine, one week before I became homeless.

With research, publication and volunteering in clinics, I still had no residency and more than $300K in student loans. Again, I was unemployed for two years, but did not let residency program rejections crush my passion. After thousands of job applications, and just before my last unemployment check, in December 2013, I received one interview for a medical assistant (MA) teacher assistant. Yes, only one interview and for a teacher assistant position, while holding a medical degree. Now I am working as an assistant professor for basic science.

For several years, we have been told there is a "shortage of doctors" in the U.S. and yet there are thousands of American doctors who are unemployed or barely making it through life. Holding a medical degree without a license has negatively affected many of us and our loved ones – socially, emotionally, mentally and financially.

You Can't Go Home Again

I am a graduate of the University College Dublin (Ireland) School of Medicine. Although I was born and raised in Massachusetts, I went to medical school in Ireland where I had extended family. I stayed to complete a residency in family medicine. I worked full time in that specialty for more than 10 years. I owned and operated a thriving practice of 2,500 patients. I always maintained a good standing within the Irish medical community, with the highest level of commitment to my patients and further education.

Due to unforeseen family circumstances, I had to return permanently to Massachusetts a few years ago. I am fully prepared and committed to the hard work of repeating a residency in this country; however, the barriers that I face in the U.S. are almost insurmountable.

Apart from passing several exams to get an ECFMG certificate, the requirement to begin practicing here, I am expected to gain U.S. experience through clinical externships for a number of months. These externships often cost thousands of dollars per month. I am also strongly advised to obtain research experience and volunteer. The match process only happens once per year at the cost of thousands of dollars, and often needs to be repeated year after year. I would be happy to do all of these things; however, the stark reality for me is that, according to all of the residency programs I have contacted and from examining previous residency match data, my chances of matching to a residency program are slim.

It is difficult to justify spending a large sum of money, effort, time and, most importantly, emotional investment when I know that there are so many U.S. citizen medical graduates that are unable to practice medicine here due to intense global competition.

When I hear of the worsening physician shortage in this country, which was highlighted with the 2020-2021 pandemic, I am saddened by the fact that so many other U.S. physicians with vast experience from around the world are repeatedly passed over year after year.

I am asking for a reasonable chance to gain a residency position in my own country. Please prioritize U.S. citizen physicians for these Medicare-funded positions.

U.S. Doctor Washes Dishes, Works at Fast Food Restaurants

I am a foreign graduate physician and naturalized U.S. citizen who has had difficulties for the past few years securing a residency spot in my desired specialty, which is internal medicine.

Soon after I came to this beautiful country, I started looking for a job, like many other migrants. I was naïve enough to believe that my skillset as a physician would secure me a job in a hospital or outpatient facility.

I was forced to apply for other jobs. After numerous unsuccessful attempts, I decided to work in hospitality (washing dishes, Papa John's, Jimmy John's, WaitersToGo and many others).

Years passed, and I completed all my U.S. Medical Licensing Exams to get closer to the ultimate goal that is more aligned with my skills, working as a physician.

But ECFMG certification wasn't the whole requirement to be able to apply for residency programs. I needed recommendation letters. Unfortunately, most hospitals charge applicants who want to observe an attending physician for a month or two. There is a fee of at least $500/week, and few hospitals offer free observance, unless you have a relationship with the attending you want to observe.

This highlights that whoever has the financial support wins the game, which is matching into a residency program.

I worked nearly a year in one of Harvard's affiliated hospitals and around the same time in one of Florida's well-known university hospitals. During this time, I got to know many foreign graduates, like myself, who were working hard for little money, and among them were many on J-1 visas.

They were fine working without compensation since their visa extensions are in the hands of faculty physicians who want them as free laborers in the research sector. The ridiculous fact about these volunteer research positions is that they are in high demand among J-1 visa applicants. Many of these individuals each year match into residency programs where they have friends and connections.

I've known many who had failed attempts on their step 1 or clinical skill exam make it to residency. Dr. William Pinsky, President and CEO of the Educational Commission for Foreign Medical Graduates (ECFMG), stated that we need these talented individuals who happened to be IMGs (international medical graduates) on J-1/H-1B visas and are well-deserved for residency positions.

My question to Dr. Pinsky is why not ask the program directors of community and university

affiliated hospitals to be a little transparent about their selection criteria. Let's see how many of these future physicians met program requirements fair and square!

I hope that U.S. citizens and Green Card holders come together to break this chain of corruption in the residency match.

Ms. SCANLON. Thank you, Mr. Lynn.

Thank you for your testimony. We'll now proceed under the 5-minute Rule with questions, and I'll begin by recognizing myself.

Dr. Skorton, let me start with you. As you described in your testimony, the AAMC has done a great deal of research on the physician shortage. According to that research, what are the main drivers of physician shortage in the United States?

Dr. SKORTON. Thank you, Chair Scanlon. There are really five factors.

First, one is the happy fact that our country is growing.

Second, the fact that our country is aging. With age, as was mentioned in opening remarks from the Members of the Subcommittee, will come the necessity of greater need for healthcare.

Third, the healthcare workforce is aging. I'm an example of that. I'm proudly in the over-65 crowd. At a certain point, like every other kind of worker, the medical worker in the over 65 will decide to retire. Because of the big hump of humanity in the boomers, we're seeing more retirement.

Fourth, as I mentioned in my opening remarks, and I'll reiterate very briefly, just the fact that we've increased the number of first-year medical students by over a third is not enough to make a difference because of the need for graduate medical education slots. We're still not getting the job done, something about which we all, I believe, agree.

Finally, a special more recent phenomenon, and that is the stress of COVID–19 on the country, of course, has been dramatic and terrible. It has also been dramatic and terrible on the healthcare workforce. We have lost people to COVID. We have lost people to behavioral health problems, even suicide, related to the stresses of COVID, as best exemplified by Dr. Lorna Breen in New York, at New York-Presbyterian Allen Hospital.

Then this has led to some physicians deciding that they wanted to retire earlier than planned, or if not retire, to perhaps reduce their hours.

So, those five factors are the ones that we believe are leading to this continuing shortage. Let me just take a quick prerogative, since I have the floor, to say that we need doctors in all disciplines. Certainly, primary care and behavioral health, but also every specialty that you can imagine. We need them in urban areas. We need them in rural areas. We need them in well-served areas. We need them in underserved areas.

Thank you.

Ms. SCANLON. Thank you, Dr. Skorton.

Dr. Kura, we appreciate the excellence and dedication that you and your non-USA-born colleagues bring with your attendance at U.S. medical colleges and research institutions and your treatment of folks in our communities.

You noted in your testimony that you're the only nephrologist in the area that you serve. Has your employer attempted to recruit other nephrologists to that area, and, if so, why weren't those efforts successful?

Dr. KURA. Thank you, Congresswoman Scanlon. Yes. When I first came to Poplar Bluff, it was back in 2010, I never thought I would be staying here for more than 3 years. Once I start hearing

stories from the patients and the amount of stress they have to go through that made me decide that I have to [inaudible] 2012, I reached out to my nearest dialysis folks and said, I want to build a dialysis unit for people, because they're not able to get adequate footing here. So, that helped me start a new dialysis unit and was done by 2015. The dialysis unit at that point had only about 15–20 patients. Now, it has 90 patients, and the volume is increasing.

Yes, we do need more nephrologists. We have an advertisement out there for the past 10 years to get nephrologists or to hire nephrologists. I need a partner. I cannot be working like this for the next 10 years. I was 35 when I started this and I'm 46 now.

There is always a shortage of physicians and staff here, but people do not want to come here due to its geographical location. There is not a lot to offer other than healthcare here. People want to fly out. The best thing they say—the first thing they say, how far is St. Louis from here? It's about 2.5 hours. So, that deters them from coming to rural areas as such.

I want to grow this place. I want to help people here. I have established my roots. I have established relationships with my patients. I mean, they know my family. Unfortunately, I am not able to get help. We need a legislative Act to get more help.

Thank you.

Ms. SCANLON. Thank you.

Ms. Harris, can you very briefly add what would be the number one thing you think Congress should do to help ease this issue? I know your extended testimony is in the record.

Ms. HARRIS. Okay. Thank you. I think one of the biggest fixes, honestly, would be to exempt physicians—there are a number of ways to do this—from the per-country limits. That would be huge.

Ms. SCANLON. Thank you. I see my time has expired.

I believe, Representative McClintock, you're recognized for 5 minutes.

Mr. MCCLINTOCK. Well, thank you very much.

Mr. Lynn, do we have data on how many American healthcare workers have been fired from their jobs because they declined mandated vaccinations? I have seen one report putting the number at over 10,000.

Mr. Lynn, you're muted.

Mr. LYNN. Thank you, Ranking Member McClintock. I have not been studying data on fired physicians, but I know, anecdotally speaking, in California, where I lived for 20 years, as well as here in Pennsylvania, and where I have relatives in New York, I have many family Members who are in the healthcare industry, and they're being literally threatened with either take the jab or quit.

Mr. MCCLINTOCK. Well, I would think 10,000 fired because, in their own medical judgment, they should not be taking the vaccine, that's a significant number. Now, we're told the growing population needs more doctors, and that makes sense as far as it goes, but much of the population growth has been because of an unprecedented increase in foreign nationals entering the country, both legally and illegally. Seems to me this is putting us in a feedback loop where the more foreign nationals enter the United States, the more foreign doctors we're told we need to import. Is this a sustainable strategy?

Mr. LYNN. No. The strategy itself is unsustainable, because ultimately you cannot have infinite growth on a planet with finite resources. Roughly 80 percent of all population growth in the United States is attributable to immigrants and the children of immigrants. I myself am the child of an immigrant.

So, we have to understand that there is a push factor as well as a pull factor in this. Yes, a rising population is certainly a factor. We have also been seeing a move to States, such as the Carolinas, to the Southwest, to States like Georgia, of populations over the past three decades.

Because we froze the number of residencies in 1997, we have not been able to, one, build teaching—or expand medical education programs in these areas and expand teaching hospitals in these areas.

Mr. MCCLINTOCK. So, we basically made it more difficult for us to produce doctors among Americans, correct?

Mr. LYNN. Absolutely. That is absolutely the case. The costs are just so prohibitive as well. Despite that, there's huge demand.

Mr. MCCLINTOCK. Can you share with us a couple of stories of medical school graduates in Doctors Without Jobs who've not been able to get jobs as physicians in the U.S.?

Mr. LYNN. Oh, absolutely. The co-founder of Doctors Without Jobs, Dr. Doug Medina, was never able to match. I know of at least several that I can tell you point-blank where some have talk about suicide. Well, imagine you're straddled with over $400,000 in debt and your income is—you're getting income from Uber as well as working a job that might be paying $15 an hour working on a dock, which is someone that I know is doing that, and you have over $400,000 in student loans and the interest is accumulating.

Mr. MCCLINTOCK. These are physicians who have received their medical degree, so it's not a question of competence.

Mr. LYNN. Absolutely. All of them have received either a medical degree here in the United States or in a foreign degree program.

Mr. MCCLINTOCK. Has the rate of unmatched physicians increased or decreased in recent years?

Mr. LYNN. It actually increased. Last year, it was 1,431 U.S.-trained physicians; and total, it was over 7,000. So, we actually saw an increase in the unmatched numbers from U.S. medical schools and a small decrease in U.S. citizens, lawful permanent residents who studied abroad.

Mr. MCCLINTOCK. Now, let's be clear on this point. If you're not matched—if you receive your medical degree, you are a medical doctor, but you cannot match with a residency program, you can't practice medicine. Do I have that right?

Mr. LYNN. That's absolutely correct, sir.

Mr. MCCLINTOCK. That is a situation that is affecting over 10,000 U.S. doctors at this moment?

Mr. LYNN. Absolutely. All of them could have been deployed during COVID. There were opportunities to do that, particularly July 1, 2020, when foreign-trained physicians needed to be at their residency positions.

Mr. MCCLINTOCK. Okay. So, we've refused to match over 10,000 Americans who have their medical degrees. We fired 10,000 healthcare workers because, in their professional medical judgment, they should not be receiving a vaccine. That's 20,000 right

there. Yet, we're told the only answer is import more foreign nationals. Does that pretty much sum up this hearing so far?

Mr. LYNN. It does sum it up. There's just this bias to not really address the infrastructure problems, the hard problems that require investment in Americans and American institutions. As always, the panacea is to import foreign workers, again, whether it's—

Ms. SCANLON. The gentleman's time has expired.

With that, I would recognize Mr. Nadler for 5 minutes.

Chair NADLER. Thank you, Madam Chair.

Dr. Skorton, AAMC has conducted a great deal of research on the provision of healthcare in the United States. Can you discuss how living in a medically underserved area impacts a person's health? Does this include a decrease in the likelihood that they'll seek out regular medical checkups?

Dr. SKORTON. Thank you, Chair Nadler. It's a very, very important question. I am glad to have a chance to answer it.

There are really two big issues here. In any underserved area, whether it's in an urban area, a rural area, any underserved area, people, by definition, will not have access either to preventive services, for example, like cancer screening, or to therapeutic services.

Noncommunicable chronic diseases like the type that Dr. Kura deals with, kidney failure, hypertension, diabetes, heart disease, these are things that require ongoing medical care, as well as cancer screening. One of the big concerns that we have, Mr. Chair, in terms of COVID is people stepping away from getting cancer screenings during COVID.

In addition to those things that I mention, behavioral health services are at a premium, and we need that very, very much in our country for a wide variety of reasons, including the epidemic of substance use disorders. So, that's one set of things.

The other set, which is huge, is in addition to these healthcare or medical-related items, there are the so-called social determinants of health. It turns out that the things that affect our health most strongly are these social determinants of health, the ability to live in an area where we have clean air, clean water, safe streets and so on are very, very important. The precursors to social determinants of health, racism and poverty, have an enormous effect on people and frequently in underserved areas.

So, there are the medical issues and then there are the social determinants of health, and both of these contribute to the problems.

Thank you for the question, sir.

Chair NADLER. Thank you.

Dr. Kura, since receiving your green card, you and your wife can now live and work anywhere in the United States. Why have you chosen to remain in Poplar Bluff, Missouri?

Dr. KURA. Thank you, Chair Nadler, for the question. As I have mentioned, I have come to Poplar Bluff about 10 years ago. As time went on and I had my children and my wife is a physician, too. She works about 30 miles from here at a place called Sikeston. I built the dialysis unit, seeing the need that there are patients who need more room. There's growing population. There's aging population.

I started working more, and although I had restrictions to do what I could. Being on a visa, I could establish—I could get a loan

from a bank. I built a dialysis unit. Now, it has about 18 staff Members. This dialysis unit has grown. Now, I'm the director.

I consider this as my home now. I have been in India for about 25 years, and I have been in the United States for almost 20 years. This I consider as my home, and this place called Poplar Bluff is where I grew. I have my roots. My patients know my children. It's difficult for me to just pack my bags and go, detach from my patients, who look upon me as their family. I cannot just leave this place. I have to proceed with what I have at this moment.

Chair NADLER. Ms. Harris, we heard from Dr. Kura about some of the challenges he faced from the difficulties he experienced obtaining his visa abroad, the logistical challenges once in the United States, and the long wait on the green card backlog. Would you say that his—that this experience is a common one for physicians coming to the United States, especially from countries like India?

Ms. HARRIS. Yes. Unfortunately, I can say that he actually exemplifies the problems that we see again and again.

If I could just take a quick moment to say in what ways:

> (1) Is the way he went straight from graduate medical training to a medically underserved area and then stayed there.
>
> (2) The fact that even though he started there over 10 years ago, and even though he filed what's called a Physician National Interest Waiver Petition, even though he worked there for 5 years in an underserved area, he still didn't get to file his last green card step until he was able to prove he had extraordinary ability in the EB–1 category.

So, this is a real example of our system being broken and not showing the benefits and appreciation and incentives to somebody who might not have Dr. Kura's altruism to stay in that area. So, it's a real example of how broken our green card system is.

One other thing that's very sad, and often happens to physicians and their patients, when they go to get a visa abroad, they are planning on coming back. Their patients are planning on them coming back on time. So, with a mere week or 2, or several months to a consulate, which might not seem huge from their perspective, when it comes to these physicians and their medically underserved patients, it's really, really significant when they get held up abroad at the consulate.

Chair NADLER. Thank you.

My time has expired. I yield back

Ms. SCANLON. Thank you very much.

I see Mr. Buck isn't with us right now. So, I recognize Representative Biggs for 5 minutes.

Mr. BIGGS. I thank the Chair.

This is the fifth hearing that the Immigration Committee, this Subcommittee held this Congress. None of hearings have focused on the Biden border crisis. None of the memorandums that the majority has prepared for the five hearings even mention the border crisis, which means that the context of this hearing is out of whack a little bit. Based on the materials prepared and circulated by the majority, you wouldn't even know that there is a border crisis. Perhaps you're in denial.

Maybe you're in denial that we are experiencing the worst border crisis in our history. Maybe you're in denial that the policies implemented by President Biden and Secretary Mayorkas are making the crisis worse. Maybe you're hoping that if you don't acknowledge

the crisis, the American people will not realize just how big a crisis we have on the southern border.

If that's the plan, I don't think it will work. Since President Biden took office, CBP has encounter more than 2 million illegal aliens at the southern border, that doesn't include the got-aways. During that time, DHS has released hundreds of thousands of illegal aliens into our communities by some estimates over 800,000, all in violation of the law. During that time, Secretary Mayorkas has abused the very limited authority that Congress is giving him to Perl aliens into the country by Perling at least 70,000 illegal aliens into the country. That's not normal. I suspect that the actual numbers are probably higher.

Additionally, we know that CBP is interdicting only a small amount of the illegal drugs that cross our border. The estimate that I was told by CBP individuals just 2 weeks ago was that maybe 5–10 percent, and that includes Fentanyl, which according to CDC data, has killed more Americans, aged 18–45, than COVID did in the last 2 years.

What the majority focused on today, not the Biden border crisis and not Secretary Mayorkas' failures. Majority won't call Secretary Mayorkas to testify before this Committee, which has jurisdiction.

I once again, Madam Chair, I call upon our Committee Chair to request a full hearing with Senator—excuse me, Secretary Mayorkas so we can conduct proper oversight. Democrats are here today arguing that we need to import more foreign doctors, but I have not heard a single one of them criticize President Biden's vaccine mandate, which forced hospitals to fire doctors.

In fact, in her opening statement, Representative Scanlon, mentioned many numbers of causes, and many reasons why doctors and healthcare providers are leaving the field in droves and that we don't have enough doctors. She left out one reason, and I'll only mention one today: For more than a year, doctors, nurses, and other healthcare professionals were on the forefront, the front lines of providing care during the COVID outbreak.

Many of them, including—many folks, including some on this Subcommittee, praised these professionals and heroes. While we face the shortages in the medical field highlighted by the Chair and others on the Subcommittee, some of these same supporters changed course and demanded that tens of thousands of these heroes, who chose not to be vaxxed be terminated from their jobs. That doesn't make sense to me. President Biden effectively fired all the unvaccinated healthcare workers in America.

So, here's the way to think of it, it is one article talking about more than 30,000 healthcare workers out of jobs in New York alone because of vax mandates. At the same time, what adds to the strangeness of all of it is that you have doctors being fired for not receiving a COVID–19 vaccine, but hospitals allowing COVID–19 positive healthcare workers to continue working. If we need more doctors, then a logical first step would be not to fire the doctors we currently have, unless they are incompetent.

Mr. Lynn, thanks for being here today. There has been a systematic effort by some to replace American workers with foreign workers. Thanks for your work that you're shedding light on this area.

Mr. LYNN. Thank You.

Mr. BIGGS. Is there a reason, Mr. Lynn, that foreign-born medical school graduates are getting taxpayer-funded residency positions over American doctors?

Mr. LYNN. I'm gobsmacked by it. It would be one thing—prior to 1980, there was a situation that existed where we weren't filling the residencies available. So, you could see where at that point there would be some mechanism to help fill that with foreign-trained physicians and we did. However, that is not the case today. As I've testified, there are thousands of doctors every year who are U.S. citizens, or here—or lawful permanent residents that are not getting residency positions. They've gone through 8 years of education. It's not like when you're in an attorney you're told that, well, you have to pass the bar in a specific State. I don't think anyone told them that your chances of becoming a doctor after you've graduated as a doctor were 50/50 or one in 10. I think that would be a little fairer if they would begin on informing them of the current day risk. No, I don't see a need at this point to continue with the number of foreign-trained physicians. We have the doctors right here in the U.S.

Mr. BIGGS. Mr. Lynn, my time has expired.

Madam Chair, I have two articles I'd like to submit to the record, one entitled, "Termination of Unvaccinated Healthcare Workers Backfires as Biden Pledges Help Amid COVID Surge." Another entitled, "Health Officials Let COVID Infected Staff Stay on the Job." I'll provide those copies to the Committee.

Ms. SCANLON. Without objection. Thank you.

Mr. BIGGS. Thank you.

[The information follows:]

MR. BIGGS FOR THE RECORD

Termination of unvaccinated health care workers backfires as Biden pledges help amid COVID surge

foxnews.com/us/terminated-health-care-workers-joe-biden-vaccine-mandates-national-guard

Emma Colton

Joe Biden
Published December 28

More than 30,000 health care workers are out of jobs in New York alone due to vaccine mandates

close

President Biden is deploying military doctors and health care workers to bolster hospitals amid the spike in omicron variant cases. But in the last few months, thousands of health care workers across the nation have been terminated over refusing to comply with vaccine mandates, leaving health care providers in the lurch with staffing shortages while bracing for more patients.

"We're mobilizing an additional 1,000 military doctors and nurses and medics to help staff hospitals," Biden said Monday during the COVID-19 Response Team's regular call with the National Governors Association.

President Biden and first lady Jill Biden speak with the NORAD Tracks Santa Operations Center on Peterson Air Force Base, Colo., via teleconference in the South Court Auditorium on the White House campus in Washington, Friday, Dec. 24, 2021. (AP Photo/Carolyn Kaster) (AP Photo/Carolyn Kaster)

HOSPITALS FEAR STAFFING SHORTAGES AS VACCINE DEADLINES LOOM

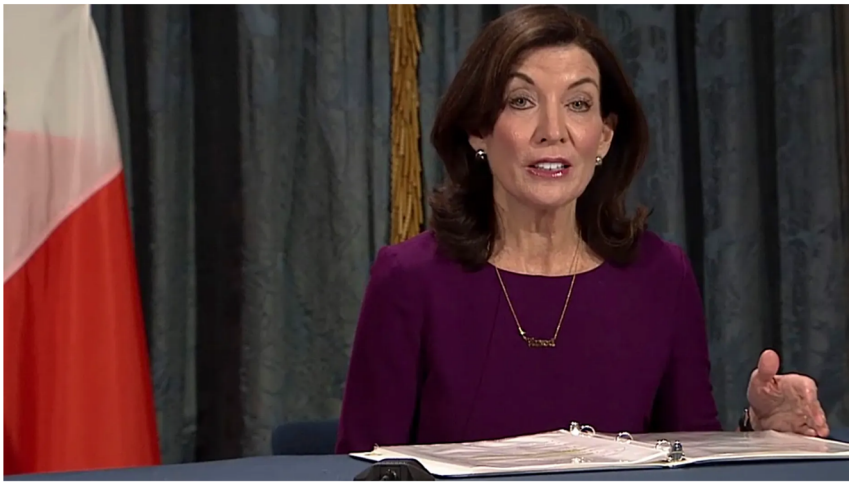
"FEMA is deploying hundreds of ambulances and EMS crews to transport patients. We've already deployed emergency response teams in Colorado, Michigan, Minnesota, Vermont, New Hampshire, and New Mexico. We're ready to provide more hospital beds as well."

In New York state, Gov. Kathy Hochul declared a state of emergency over the omicron variant and called in the National Guard to assist with nursing homes. She added that hospitals in the state at over 90% capacity could be ordered to stop elective procedures to focus on the surge. Biden said testing facilities will also be opened in the state.

Four months ago, disgraced former New York Gov. Andrew Cuomo announced a vaccine mandate for health care workers, and those who did not comply faced termination.

Since then 31,858 health care workers at nursing homes, hospitals and other health providers have been terminated, furloughed or forced to resign because they would not comply with the mandate, according to New York health data provided to Fox News. The

total number of inactive employees in the state due to the vaccine mandate sits at 37,192 as of Dec. 21, according to the data.



In this image taken from video, New York Gov. Kathy Hochul speaks during a virtual press conference, Thursday, Dec. 2, 2021, in New York. Multiple cases of the omicron coronavirus variant have been detected in New York, health officials said Thursday, including a man who attended an anime convention in Manhattan in late November and tested positive for the variant when he returned home to Minnesota. (AP Photo)

More than 2,350 nursing home staffers alone were fired for not complying. The New York National Guard deployed 120 members to 12 nursing homes and long term care facilities to assist with staffing shortages this month.

Nurses who still have jobs in the state have been sounding the alarm on the staffing shortages for months, and are bracing for it to only get worse.

LAST YEAR'S HEROES, THIS YEAR'S SCAPEGOATS: FRONTLINE WORKERS LIVELIHOODS AT STAKE OVER VACCINE MANDATES

"We have a massive nursing shortage," Eric Smith, the statewide field director for the New York State Nurses Association, told the New York Daily News last month. "We have a vacuum in the double and triple digits all across the New York area."

Omicron has been detected in every state, and various states keep breaking records for daily coronavirus cases due to the spike. COVID cases have increased by 48% over the past week across the nation, and the average daily cases sit at 182,682, according to Johns

Hopkins. Hospitalizations for the omicron variant, however, have so far been lower than other variants, with hospitals nationwide seeing a 2% increase in patients.

Massachusetts and New Jersey are among the states seeing spikes. Vaccine mandates in those states also led to hundreds of firings and resignations.

Across three health care systems alone in Massachusetts, there have been 506 confirmed firings over vaccine mandates. The Massachusetts Department of Public Health did not immediately provide Fox News with data on total firings and resignations over the mandates.

The state is grappling with staffing shortages this month and moved to cut some nonessential, elective services and procedures by 50%, and Republican Gov. Charlie Baker activated 500 National Guard members to assist hospitals.

Hauppauge, N.Y.: Health care workers protest against being forced to get the Covid-19 vaccine, outside the New York State Office Building in Hauppauge, New York on Long Island on Aug. 27, 2021. (Photo by Alejandra Villa Loraca/Newsday RM via Getty Images) (Alejandra Villa Loraca/Newsday RM via Getty Images)

While in New Jersey, there have been 238 confirmed firings or resignations across two hospital systems due to vaccine mandates. Fox News asked the New Jersey Department of Health for data on the total number of fired health care workers, but a representative said the department did not have that information.

DOZENS OF MASSACHUSETTS STATE TROOPERS HAVE QUIT OVER COVID-19 VACCINE MANDATE: UNION

New Jersey has not activated the National Guard to assist with omicron spikes, but Gov. Phil Murphy said "everything is on the table" last week when asked about how the state will combat the spikes.

Staffing shortages are occurring while flu cases, which were very low last year during the pandemic, are spiking, notably in Washington, D.C., New Jersey, Kansas and Indiana.

WINCHESTER, VA - AUGUST 10: Striking healthcare workers and relatives of healthcare workers pray during a protest on August 10, 2021 in Winchester, VA. Healthcare workers have gone on strike over a COVID-19 vaccine mandate by their employer Valley Health. (Photo by Duncan Slade for the Washington Post) (Duncan Slade for the Washington Post)

Hospitals in other states grappling with shortages amid the spikes have halted vaccine mandates while also activating the National Guard.

In Ohio this month, hospitals across the state hit the "pause" button on their vaccine mandates, pointing to legal reasons and staffing shortages. And Republican Gov. Mike DeWine activated 1,050 Ohio National Guard members to assist with hospitals.

"We're pretty much running full steam 24 hours a day, particularly with ICU as high as it's been, it really takes a toll on our caregivers," said Ohio Hospital Association director of Media and Public Relations John Palmer.

Iowa meanwhile is spending more than $9 million to hire out-of-state nurses to cope with a spike in hospitalizations. The state will pay nurses through a Kansas company, who will be expected to work 20 hours of overtime at $330 an hour.

DESANTIS SLAMS BIDEN FOR IGNORING 'NATURAL IMMUNITY IN VACCINE MANDATES

The staffing shortages, terminations and now the spikes in omicron cases have not been lost on critics, who are calling the problems "government created."

The White House did not immediately respond to Fox News' request for comment on the activation of military health care workers following thousands of unvaccinated workers being fired.

"The bottom line is: We want to assure the American people that we're prepared. We know what it takes. And as a — as this group of bipartisan governors has shown, we're going to get through it by working together," Biden said Monday on his call with the National Governors Association.

Health officials let COVID-infected staff stay on the job

abcnews.go.com/Health/wireStory/us-hospitals-letting-infected-staff-members-stay-job-82184760

Health authorities around the U.S. are increasingly taking the extraordinary step of allowing nurses and other workers infected with the coronavirus to stay on the job if they have mild symptoms or none at all

By

ADRIANA GOMEZ LICON and JENNIFER McDERMOTT Associated Press

January 11, 2022, 12:23 AM

Health authorities around the U.S. are increasingly taking the extraordinary step of allowing nurses and other workers infected with the coronavirus to stay on the job if they have mild symptoms or none at all.

The move is a reaction to the severe hospital staffing shortages and crushing caseloads that the omicron variant is causing.

California health authorities announced over the weekend that hospital staff members who test positive but are symptom-free can continue working. Some hospitals in Rhode Island and Arizona have likewise told employees they can stay on the job if they have no symptoms or just mild ones.

The highly contagious omicron variant has sent new cases of COVID-19 exploding to over 700,000 a day in the U.S. on average, obliterating the record set a year ago. The number of Americans in the hospital with the virus is running at about 110,000, just short of the peak of 124,000 last January.

Many hospitals are not only swamped with cases but severely shorthanded because of so many employees out with COVID-19.

At the same time, omicron appears to be causing milder illness than the delta variant.

Last month, the Centers for Disease Control and Prevention said that health care workers who have no symptoms can return to work after seven days with a negative test, but that the isolation time can be cut further if there are staffing shortages.

France last week announced it is allowing health care workers with mild or no symptoms to keep treating patients rather than isolate.

In the Phoenix area, Dignity Health, a major hospital operator, sent a memo to staff members saying those infected with the virus who feel well enough to work may request clearance from their managers to go back to caring for patients. Dignity Health hospitals in California have not yet implemented the new guidelines but said it may need to do so in the coming days and weeks.

“We are doing everything we can to ensure our employees can safely return to work while protecting our patients and staff from the transmissibility of COVID-19,” Dignity Health said in a statement.

In California, the Department of Public Health said the new policy was prompted by “critical staffing shortages.'' It asked hospitals to make every attempt to fill openings by bringing in employees from outside staffing agencies.

Also, infected workers will be required to wear extra-protective N95 masks and should be assigned to treat other COVID-19-positive patients, the department said.

“We did not ask for this guidance, and we don’t have any information on whether hospitals will adopt this approach or not,” said Jan Emerson-Shea, a spokesperson for the California Hospital Association. “But what we do know is that hospitals are expecting many more patients in the coming days than they’re going to be able to care for with the current resources.”

Emerson-Shea said many hospital workers have been exposed to the virus, and are either sick or caring for family members who are.

The 100,000-member California Nurses Association came out against the decision and warned it will lead to more infections.

Gov. Gavin Newsom and other state health leaders ''are putting the needs of health care corporations before the safety of patients and workers,” Cathy Kennedy, the association’s president, said in a statement. “We want to care for our patients and see them get better — not potentially infect them.”

Earlier this month in Rhode Island, a state psychiatric hospital and a rehabilitation center allowed staff who tested positive for COVID-19 but were asymptomatic to work.

At Miami's Jackson Memorial Hospital, chief medical officer Dr. Hany Atallah said they are not yet at the breaking point and that workers who test positive are staying away for five days. “We still have to be very careful to prevent spread in the hospital,” he said.

Kevin Cho Tipton, a nurse at Jackson Memorial, said he understands why hospitals are eager to have employees come back after five days of isolation. Yet he worries about the potential risk, especially for patients at higher risk of infection, such as those receiving transplants.

“Yes, omicron is less deadly, but we still don't know much,” he said.

Associated Press writers Amy Taxin, in Orange County, Calif., and Terry Tang in Phoenix contributed to this report.

Ms. SCANLON. Next—I'm sorry. I would recognize Representative Jayapal for 5 minutes.

Ms. JAYAPAL. Thank you, Madam Chair.

The pandemic has taken a tremendous toll on our brave healthcare workers. As countries around the world compete for medical talent, the United States is at a disadvantage. Currently, there are more than 1 million individuals stuck in the employment-based visa backlog. About 16,000 of those people are physicians. These backlogs make it incredibly difficult to attract qualified healthcare workers to come and work here.

Recently, my home State of Washington passed a law allowing internationally trained medical graduates the chance to obtain renewable 2-year licenses to work as doctors. This is an important step. Congress also has to take action to allow immigrant medical professionals the chance to work in their chosen field, and to serve our country in this difficult time.

Dr. Kura, your story resonated very strongly with me. I think I may be the only Member of the Judiciary Immigration Subcommittee to be on an H1B, to have been on an H1B visa. It took me 17 years of an alphabet soup to ultimately get my citizenship. I am grateful to you for your service to our country as a physician.

In your testimony you talk about the difficulties that you faced, the uncertainty of your immigration status, the harassment when coming back into the United States, and more. You already have a very demanding job as the only nephrologist serving your area for many years. I understand it took you almost 20 years just to get your green card. Briefly, can you tell me how receiving your green card changed life for you and your family? Did it open up new opportunities for you to have that green card?

Dr. KURA. Well, a green card is new to me, after longing for that for about 15–11 years of hardship and 9 years of residency fellowship prior to that. A total of about 20 years, I could finally get it in 2020. It is relatively new.

Prior to obtaining green card, I could do only so much. I tried to work in a place called Sikeston. I tried to establish myself in rural areas other than Poplar Bluff. I get a letter from USCIS stating I have to show how many hours I would be spending, at what time I would be spending in which ER, in which ICU, in which hospital. I cannot answer that question. No doctor is—it's impossible for any physician to tell which ER he's going to be—which patient is going to appear in which ICU, where do I have to pull from to get dialysis, or urgently take care of a patient.

I withdrew my application for my extension of H1B, or it is called adjunct H1B. The endpoint is not me. The endpoint is the healthcare that is getting affected because there's nobody else to take care of those patients and the hospitals have to ship them 2 hours away to St. Louis or to Memphis. Such is the condition of current status.

Now, after getting my green card, I could establish myself. I do not have to prove to my sponsors that I am going there, or I am going to a different place to work. I can just apply for my credentials. Once I'm credentialed, I can work in those hospitals and take care of all the patients.

Ms. JAYAPAL. One of things first things you did was to start building an urgent care facility, right?

Dr. KURA. Correct, I am. Now, in my hometown we have only one urgent care. We are seeing about 230–250 patients from 9 a.m.–5 p.m. So, I decided to build one more urgent case. The plans are in place. We're going to start digging next month. This is going to cost me quite a bit, but I'm willing to do that, because this place needs it. The only way I can do this is by the ability to have a green card. If I was on an H1B I don't think I will be able to do this.

Ms. JAYAPAL. Dr. Kura, if you could choose all over again, knowing what you know now, would you still choose the United States, or would you go somewhere else that's more welcoming and allowing of immigrant doctors?

Dr. KURA. Okay, that's a difficult question to answer, because to every person, when they are at the age of 25 or 24, when he looks at the United States, the dream place, it is the land of opportunity. It's the place where I can shine because I'm talented. I closely relate myself to the IT professionals who have come here and are now CEOs of big companies. I'm pretty sure the United States is proud of them. Likewise, I'm in the medical field. Unfortunately, they could get their green cards early and be where they are, but I could not get my green card until about 2 years ago.

So, looking back at everything, if I had a crystal ball, and if I could see myself today talking to you all, I would not probably have chosen the United States. I probably would have gone to Canada to prove my mettle, to prove my worth, I would have been in a better spot. However, after establishing myself, putting my time and effort and energy into this place for such a long time, I cannot detach myself. I'm going to rise. I'm going to go strong at that point.

Ms. JAYAPAL. We are so grateful to you.

Madam Chair, my time has expired.

I just want to point out it can take up to 195 years for those just entering the green card waiting line to receive permanent residency.

With that, I yield back.

Ms. SCANLON. Thank you.

With that, we recognize Representative Buck for 5 minutes.

Mr. BUCK. Thank you, Madam Chair.

Dr. Skorton, I want to visit with you. You mentioned in your testimony that there were five factors that really caused, or caused in part, the issues that we have with the doctor shortage in this country. I think that you really, perhaps because of a liberal bias, perhaps because of other factors, you've really understated some of other issues that exist.

My friend and colleague from California, Mr. McClintock, has pointed out the vax mandate and the serious consequences to our healthcare system as a result of that. My friend from Arizona, Mr. Biggs, has talked about the crisis at the border. We not only have people coming into this country that have diseases that stress our healthcare system, and frankly cause illness and injury to our border security patrol officers, but we also have illegal drugs coming into this country across our southern border that stresses our healthcare system.

Fentanyl has been a scourge in this country. Heroin has been a scourge in this country. Neither of them is produced in this country. They are both imported illegally, mostly across the southern border. We also have an overwhelmed immigration system that just can't handle the kind of things that we're talking about, much less putting on another burden, another stress with the necessity of looking at applications from doctors overseas.

So, I think you really should acknowledge that there are more than five factors that cause the problems that we're dealing with. It's not just an aging population. It is not just a growing population. It is really a series of very poor policy decisions that have been made by the Biden Administration, in particular, had a have caused additional stress to our system.

I have a question for you, Dr. Skorton. I'm wondering, what percentage of doctors that come into this country and or medical students that come into this country and who receive a taxpayer-subsidized, not completely paid for necessarily, but taxpayer-subsidized education and then go to work in areas that are hard to recruit doctors for either rural areas, or some of the more dangerous urban areas. How many of those doctors stay 5–10 years and continue to practice in those areas?

Dr. SKORTON. Thank you very much for your question, Representative Buck.

I don't have the answer to that. I will get back to you very quickly for the record within a couple of days at the most, just so I can answer that question.

Since I've garnered the floor, I just wanted to say two other things very quickly. I think that the Committee and Subcommittee deserves to have some reconciliation between the numbers I'm giving you and the numbers that Mr. Lynn is giving you.

I want to make this offer to Mr. Lynn, we are both children of immigrants. I would like to make the offer to work with the Subcommittee staff and Mr. Lynn so we can reconcile very different numbers that you're hearing so that we can give you something that you can hang your hat on.

The other thing I must say is that I take extreme umbrage for Mr. Lynn characterizing the graduate medical education system as profiteering. It's a negative cost center—

Mr. LYNN. Mr. Skorton, you made 34—

Mr. BUCK. Look, I'm not here to—look, my time. You're both wrong. I don't give up the floor so you guys can argue. You can do that on your own time.

Dr. Skorton, another question. Would you find the number 50 percent, the 50 percent of the taxpayer-subsidized students, medical students in this country, get their taxpayer-subsidized education and leave the country to go back to their country of origin?

In other words, Americans are paying for doctors in other countries to get their medical education and work in those other countries. Would that number surprise you?

Dr. SKORTON. Well, I can't tell you whether it would surprise me or not. I've never looked at that number. What I would have to know, Representative Buck, whether they left because they were unable to get permanent residency in the country or what the rea-

son was. I am very glad to look into that as I told you. I promise you I will get back to the Committee quickly for the record.

Mr. BUCK. Okay. I thank you for getting back to me on that issue.

I do have to say that I am really distressed that the Committee, this Subcommittee, has not addressed some of the underlying causes, and just automatically defaults to a position of bringing in foreign nationals to deal with our medical shortages in this country. I think we've got to look at a much more encompassing and holistic approach.

With that, I yield back, Madam Chair.

Ms. SCANLON. Thank you.

Representative Correa is recognized for 5 minutes.

Mr. CORREA. Thank you, Madam Chair.

First, I want to thank all our Witnesses for joining us here today. It's a very important issue that we have to address, which is really the healthcare of our society today as we age, as we grow in population.

I agree with some of my colleagues. We have to look at all the options, including adding more slots to educate doctors here in America, not only doctors, but nurses. We've been importing nurses from all over the world for decades.

My wife right now, my spouse, is an OB/GYN at Kaiser. I can tell you right now, she's going through burnout. She's working way too many hours. When they call her in because another one of her colleagues can't come in, she just will not say "No." She goes in and it's a tough time.

Thank you to the Witnesses. I have a couple of quick questions for Dr. Skorton. First, confirm you said 23 percent of physicians in the U.S. are foreign-born. Is that correct?

Dr. SKORTON. Yes, sir. That is approximately right.

Mr. CORREA. Did we have a doctor shortage before COVID–19?

Dr. SKORTON. Yes. We've had a doctor shortage for a long time, especially initially in primary care, behavioral health, but it is across all the specialties, yes.

Mr. CORREA. Behavioral health, is that issue of substance abuse, Fentanyl abuse, drug abuse, and mental health? That's what we are talking about, correct?

Dr. SKORTON. Yes, sir. Including substance abuse and mental health in general.

Mr. CORREA. Dr. Skorton, very quickly. You mentioned 30,000 DACA health providers. Are you saying we have 30,000 health providers under the DACA program where they could be deported at any time should the DACA program be terminated?

Dr. SKORTON. I think the specifics would be that they would lose work authorization, Representative.

Mr. CORREA. Okay.

Dr. SKORTON. Thirty-four thousand is the number. They sure could use that if DACA were rescinded.

Mr. CORREA. They are productive Members of our society, paying taxes, saving lives, as my colleague mentioned, frontline workers. Thank you.

Dr. SKORTON. You bet.

Mr. CORREA. Dr. Lynn talked about sidelined doctors' residency mismatch. That brings back nightmares. When my wife and I got married a long time ago, we were praying, hope to God that she would match somewhere in L.A., not Chicago and not somewhere else. Thank goodness that she did match. Stayed here, we got married, and the story is a happy one ever after.

Dr. Lynn, and I'm going to ask Dr. Skorton, I want to find out, what is this thing about a mismatch, about sidelined educated American doctors?

Dr. Skorton, I'm going to give you the opportunity to answer that quickly.

Dr. SKORTON. The only answer that I can give without checking the numbers of Mr. Lynn as I've offered to do is tell you that we depend on the residency training directors to do a very careful job of choosing the people who are most likely to benefit from residency training. As I mentioned at the beginning, within 6 years of that finishing medical school, 99 percent are practicing or are in residency slots. We believe that it's important to allow the residency directors to do what they are doing.

It's also important for me to mention, Representative, that we are very concerned about students who do not match at the double AAMC, very concerned, as are those at the medical schools. They will work with those who didn't match to look at the reasons. Perhaps they matched only against a very, very competitive specialty. Perhaps they didn't apply to enough programs. Perhaps there was something in their application that could be better. The medical schools are devoted to trying to help them. Perhaps Dr. Kura or others know about that particular status. So, we are also very, very concerned about it, sir.

Mr. CORREA. Dr. Skorton, I'd love to take you up on your offer to help us reconcile some of those numbers for this Subcommittees, because this is important for us as policymakers.

You mentioned increase in freshman slots at medical schools, 33 percent? Is that correct?

Dr. SKORTON. Thirty-five percent. Some of it was because of enlarging, and 30 new medical schools, and six more on deck waiting for accreditation.

Mr. CORREA. I say this to you because it's very expensive to educate a doctor. To hear that there's no match here, that doctors are sidelined, there's something here that's wrong. I'd love to work with you trying to figure this one out. At the end of day, 35 percent increase in freshman, I would imagine that's still not going to address the doctor shortage moving forward.

Dr. SKORTON. One thing, Representative, is that we can increase the number of doctors in medical schools even more. If we don't open up that blockage at the graduate medical education level, we will not have more doctors taking care of patients. So, it's been a great thrill to see the two-decade-long freeze lifted just in the last year, year-and-a-half. We are very much hoping that Congress, in its wisdom, will increase funding for Medicare—Medicare-funded GME slots, not for the doctors, but for the patients of America, we hope that that will happen.

Mr. CORREA. Madam Chair. I'm out of time. I yield. Thank you.

Ms. SCANLON. Thank you very much.

Representative Tiffany, you're recognized for 5 minutes.

Mr. TIFFANY. Thank you very, much Madam Chair.

Dr. Kura, it was implied earlier in some questioning that you were not welcomed to America. Did the people of Poplar Bluff not welcome you?

Dr. KURA. No. It's never been that. People of Poplar Bluff love me and continue to love me. I know they will love me in future also. It is the way the system works. I never implied that people did not like me.

Mr. TIFFANY. Okay.

Dr. KURA. I will just expand on that a little bit. When I was flying to come into the United States across the port, I was questioned as to what the full form of H1B is. I do not know the answer to that. I was questioned if I have applied for green card, and how many days I would stay, or how many years I would stay in this country. Well, I've applied for a green card, but I did not get it. Those kinds of questions deter me from coming back into the country.

Mr. TIFFANY. Okay. Thank you very much, Dr. Kura. Thank you for the work that you do.

Mr. Lynn, why were residencies frozen? In earlier questioning, you mentioned that residencies were frozen. Why were they frozen?

Mr. LYNN. I wish I had an answer for that, and I do not. They were frozen in 1997. That just demonstrates that—

Mr. TIFFANY. What's been the impact of that?

Mr. LYNN. Oh, well, the impact is one, as you've seen, the number of residency opportunities based on the number of graduates from medical school, it's not being able to pair up. This is why we're seeing sidelined physicians.

Might I state, I'm happy to submit for the record how I came up with my numbers, because they take into account, for instance, when we did a deep dive into this in 2020, I looked at the matched, the unmatched with interviews, the unmatched without interviews, which is often not reported, and that's how we came up with our numbers.

Mr. TIFFANY. I appreciate that very much.

Mr. LYNN. Yeah.

Mr. TIFFANY. I sure hope you share that with my office. We would really appreciate it.

I remember when I sat on the Joint Finance Committee in Wisconsin that dealt with all things budgets. As a Member of that Committee, we saw the restrictions and what really were barriers to entry. We created more residencies, including in rural parts of the State and those have been filled. So, I think there are ways in which we can deal with this, but it's important that we, as Americans, that policymakers that we create those ways of doing it, including at the State level.

I have to comment in regard to losing physicians, with what's happening with the vaccine mandates, I've seen it locally. I represent a largely rural area in northern Wisconsin. I have had friends who have lost their primary physician as a result of a vaccine mandate. When you think about the Mayo Clinic, which is in our region, they lost 700 employees, now not all doctors, but they lost 700 employees as a result of vaccine mandates. When you see

things like that that are happening, the American public is going to be a little bit skeptical about claiming poverty that we can't get enough physicians here in America when we're driving them out with vaccine mandates.

I'd add one other thing. We heard about bringing all these people in from—bringing doctors in from Africa, India, and places like that. We've been hearing so much about equity. Are we doing the right thing as Americans, taking doctors from poor countries? I pose that is as a rhetorical question. Should we really be doing that? If we're just going to just benefit the United States of America at the detriment for poor countries? For those that are standing on the equity ground right now, how do you support that? Just a rhetorical question.

I would close just by saying this: Why is Secretary Mayorkas not here? Why is he not here? The preeminent issue, certainly one of the top three issues, if not the most important issue facing America right now, is a borderless southern border. Yet, we still have not seen Secretary Mayorkas here. The cynic in me asks the question: Do you want to bring in more doctors because we have for Fentanyl and Methamphetamine overdoses than we've ever seen in America? Is that why we need to import doctors? Is it because of the increased crime, including the sanctuary cities of the Democrat-run cities that have been setting records for murder rates in America? Is that why we have to import doctors? Or is it the human trafficking?

When we see—I've been to the border three, four times in the last 2 years, been to Panama. The number of women that are sexually assaulted are incredible. I say to the advocates for more immigration that sit on this panel, America has deep concerns, Americans have deep concerns about what is going on. Some of this better get fixed, otherwise you're not going to get what you're asking for today, because Americans want the border controlled, and it is not now. When are we going to have that hearing from Secretary Mayorkas?

Ms. SCANLON. The gentleman's time has expired.

Mr. TIFFANY. I yield back.

Ms. SCANLON. Thank you.

Representative Garcia is recognized 5 minutes.

Ms. GARCIA. Thank you, Madam Chair. Thank you to all the Witnesses and for your patience in going through this hearing. It's been a very interesting topic. I know that this hearing alone won't just—adds so much more and highlights the very many contributions that immigrants have made and will continue to make in the United States of America.

To have to face a shortage of health professionals in this country is, at the very least, unfortunate and shameful, especially during this pandemic period.

In my district, studies indicate that Houston has one of the lowest rates of healthcare workers among major U.S. metro areas. The Houston metro area has 3.35 healthcare workers for every 100 residents. That places Houston at number 10 on the list of major metro areas with the lowest share of healthcare workers per capita, including doctors, nurses, and therapists. I can attest to this shortage, because I can tell you that in my district alone, we have one

small community hospital. We are essentially a doctor desert. For the work of the FQHCs and other health clinics provided by the County or the city, we would not have healthcare in my district.

As Members of Congress, we have a duty to our constituents and the Nation to develop a robust and comprehensive healthcare system to meets the needs of all Americans, especially our most vulnerable communities. I know that thousands of healthcare professionals are knocking at our doors every day, ready, willing, and able to provide the essential services that people in my community and across America need. So, we need to do everything possible to keep those doors open.

I wanted to start with you, Dr. Skorton. I, too, am very interested in reconciling those numbers, because it doesn't seem to me to be that easy that maybe 10,000 doctors were fired because they didn't want to get a vaccine, and that maybe 10,000 were matched and that would be enough for the shortage. It is not really quite that simple, is it?

Dr. SKORTON. Well, I think a general statement I could make, Representative Garcia, is that we need more doctors, more American doctors, more doctors from overseas. We need more doctors in this country. Has been said by both—several of the Witnesses today, we need more residency slots. We need more graduate medical education. So, we need to put our shoulder to the wheel and makes sure that this happens. It is critically important. The reason that it's important is that we need to be there for districts like yours and throughout the country, urban and rural, we need more doctors.

Ms. GARCIA. Right. The whole residency thing has really caught my ear, because it is this match question. I have a nascent pediatrician. I remember when she was cited that day and got her match, and she went on to do her residency. Who decides on the number of residencies? What other factors influence that? Surely, they don't sit there and go, Oh, here's the pile of the foreign-trained doctors. We're going to do those first. They don't pick and choose that way. Do they? Do they not use objective criteria to decide who gets matched with whom?

Dr. SKORTON. They sure do, Congresswoman. They sure do use objective criteria. Those criteria include a whole panoply of things. Obviously, the scores on tests, obviously how the person has done in medical school, obviously the recommendations that they get. Certain specialties are extraordinarily competitive and others are less competitive. So, it's a wide variety.

I must give a public tip of the hat to those who run the residency training programs throughout the country. It's a difficult job to do. As I mentioned before, it's a negative cost center. If we were making money on it, then every hospital would want to have teaching facilities, but it's not the case. Only a minority of hospitals do this because it is complicated, it's costly, and it's draining to the system.

So, it is based on a variety of criteria. Although nothing is perfect, I have great, great confidence in the overall system. Yet, it is very important that we figure out for those who do not match what we can do to help them going forward. As I mentioned, this is a high priority for us at the AAMC, Congresswoman, and for the medical schools themselves.

Ms. GARCIA. Real quickly, because I didn't have time, Ms. Harris, we're really just focused on immigrants who have been trained here. They may be foreign-born, but they were trained in America. Do you know how many of those may have come to America through the southern border?

Ms. HARRIS. When you say through the southern border, do you mean without authorization?

Ms. GARCIA. I mean just coming through the southern border.

Ms. HARRIS. Okay.

Ms. GARCIA. I leave that up to the immigration justice to decide whether they are authorized or not. It's not my job.

Ms. HARRIS. So, very briefly, nearly all foreign-born physicians in the United States doing graduate medical education are doing so through a visa, through a visa that got stamped in their passport by the U.S. Government. The very minor exception, and I can get these numbers to you, I think the AAMC may have them as well, would be what we call DACA. So, there are some DACA medical students who I believe may have matched into GME. That would be the only, only subcategory that would not have already been vetted by the U.S. Government before they ever arrived for the purpose of graduate medical education.

Ms. GARCIA. So, none of these folks are adding to this supposed crisis at the southern border?

Ms. HARRIS. No, not at all.

Ms. SCANLON. Thank you, gentlewoman your time has expired.

Ms. GARCIA. I yield back.

Ms. SCANLON. Thank you.

Representative Jackson Lee, you are recognized 5 minutes. Representative Jackson Lee you're muted. You're recognized 5 minutes.

Ms. JACKSON LEE. Thank you very much. Thank you for this hearing. Thank you to the Witnesses. Dr. Skorton, I'm going to focus a lot of my questions on your testimony. Thank you again for leading the Nation's doctors.

Living as well in Houston and interacting with the Texas Medical Center, but also the public health system, which is Harris Health, portions of which are in my congressional district and spending a lot of time on the journey that we took with the pandemic have worked. I'm sure you're aware of Dr. Peter Hotez and the enormous work that he's been doing. I have worked with him extensively throughout a number of infectious diseases: Ebola, West Nile, et cetera, that doctors, researchers are researchers are crucial. There are individuals in the Texas Medical Center that are still attempting to get citizenship. They are either legal permanent residents, or they have the physician status, and they are not even at that point. It does cause a depression, if you will, in the level of research and the amount of expertise that we have. So, I happen to be one that believes that we can answer the points that have been made by our minority Witness. I happen to believe we can walk and chew gum at the same time. There is no doubt that medicine is international. You actually may want the expertise of international research to provide Americans with the very best medical care that they can. I think the brain drain of training foreign doctors and then losing them is also a concern. So, we must find just, like we have to regularize immigration, we must find a crucial way

to be able to address that. So, hopefully, I've laid the groundwork for a number of questions.

One, my empathy for individuals who have bought into social media, and not gotten vaccinated, and who are in the medical arena is limited at best. You might comment.

Also, I want to make sure that you give us your best answer on how we address the question from the American Medical Association's perspective on dealing with doctors, foreign doctors—I guess I just missed that exact point, if you'd like.

Then answer the question about homegrown doctors, in particular, the African-American community and the low number of doctors, and how we cannot be attacked by supporting the reality of importance of doctors who are immigrants, but also push this idea of ensuring where there are depressed areas without African-American doctors, that we can do that as well. That's why I focused on you, Doctor, and I yield to you at this time.

Dr. SKORTON. Thank you very much, Congresswoman. Very, very important questions. I'll try to be brief.

First, my colleagues at the Association of American Medical Colleges would want me, just for the record, to say that we don't represent the AMA, but the Association of American Medical Colleges. That is the medical schools teaching hospitals in academic societies.

Ms. JACKSON LEE. Thank you for clarifying that. Thank you.

Dr. SKORTON. Thank you for allowing me to.

Our failure, especially to get African-American men in medicine is one of the failures of my generation of leadership. The year that I started, my first faculty position, Congresswoman, 1979, 1980 up until last year, we didn't change the proportion of Black men in medical schools by even .1 percent. So, we have a lot of work to do. We are beginning to see some light at the end of the tunnel.

As was mentioned, I believe actually by Mr. Lynn, applications to medical schools are very high. Last year, we saw not only a great increase in applicants from the African American and Hispanic community, but increases in matriculants from both of those communities. In passing for the record, let me just say, however, that in the Native-American and Alaska Native communities, although we saw increase in applicants, we actually saw a decrease in matriculants.

Second, I would say that there are some other good ideas, especially thinking about the pathways to a medical career. I personally, having been in higher education for a long time, think that we need to start earlier in the educational pathway, perhaps as early as middle school, in helping people to dream a dream of a life in science and medicine.

Also, I wouldn't want to yield the floor without saying what a treasure to the country the Texas Medical Center is in every field of medicine and Dr. Hotez as well.

Thank you.

Ms. JACKSON LEE. Can you quickly answer the question about what we need for the immigration, the doctors who are immigrants? That's what I asked that as well.

Dr. SKORTON. Sure. There are few things, and you can get the most authoritative advice from Kristin Harris. We are very lucky

to have her as a Witness. I will just tell you that if we could have a pathway to citizenship through DACA, and if we could do something with the Conrad 30 program to increase the number of slots in that program, that would be a pretty good start. In my longer submitted testimony, Congresswoman, there are a few other areas that we think would also be helpful.

Ms. SCANLON. Thank you.

Ms. JACKSON LEE. Thank you.

Ms. SCANLON. The time of the gentlewoman has expired.

Chair Lofgren is recognized for 5 minutes to close us out.

Ms. LOFGREN. Thank you, Madam Chair. Thanks to all the Witnesses.

Just a couple of thoughts. It's a rare occasion when we have Witnesses that have actually testimony that is I'm sure offered in good faith and under oath that is factually at odds. So, I am looking forward to getting the further information from Mr. Lynn and the further analysis by Dr. Skorton so we can sort through how this divergent testimony can be reconciled. I'll just say that when that happens, we will make it part of the official record, obviously. I'm very interested in it.

One question I guess I have is whether the discrepancy relates to the nature whether it's an M.D. or a different type of degree. I hope that that can also be addressed when the analysis is made.

Ms. Harris, I heard your testimony as an expert on immigration law, talking about adjustments to the Conrad program, the per-country cap, DACA and the like. As you may know, the House recently passed the America COMPETES Act, which, among other things, would exempt immigrants who undergo U.S. medical residency and fellowship programs from the numerical limits on green cards. Wouldn't that actually be a simpler way to just deal with this whole issue?

Ms. HARRIS. Absolutely. I make reference in the written testimony at greater length. Basically, so long as technical corrections are clarified such that all those would be outside of the country limit, that would be an elegant solutions, absolutely to taking all these physicians outside of the country limit. Absolutely.

Ms. LOFGREN. I would just note that to be qualified for a green card, you need to actually prove that there is no American citizen or legal permanent resident who is able and willing to take the job that has been offered to you. So, that is the standard. Only in that case are you qualified for that visa.

I'm just interested as well, Dr. Kura, thank you for your service to your patients. One of the things I note in the immigration field is that people in underserved communities are so grateful to the physicians who come in to take care of them.

I remember, when we were pursuing adjustments to the per-country cap that I think has become politically more fraught at this point unfortunately because of actions taken by the U.S. Senate, talking to a physician from India and his wife, who was also a physician in a little town in Iowa. They practice together. They were the only doctors in that town. They were both on H–1B visas. No, he and she was exempt. The problem was, they had, looking at a 50-year wait for a visa and their children as dependents had grown up in the United States. When they reached 21, they were going

to have to return to India, even though their parents were living in this little town in Iowa. They were considering, and I think, in fact, ultimately did, leaving their patients for the sake of their children to go to Canada where they got the green card equivalent in about 5 months. Is that a phenomenon that you have seen around the country among immigrant physicians, Dr. Kura?

Dr. KURA. Thank you very much, first, for the question, Madam Lofgren. Yes, I do have one dentist who has left the country to Canada, and one rheumatologist who has left the country for Canada.

My wife is a rheumatologist in Sikeston, a small place in southeast Missouri. She is booked out for 6 months. I mean, the earliest she can see a new patient is 6 months down the road. Such is the State of affairs.

Ms. LOFGREN. Thank you, Doctor.

Dr. KURA. I'm sorry.

Ms. LOFGREN. My time is just about to be expired and I know the Chair is going to insist on it. I'll just say this, that there are a lot of things we need to do. We need to make sure that medical education isn't as expensive, crushingly expensive. We need to make sure that we have enough slots for training. Those aren't within the jurisdiction of this Subcommittee. This issue is. I think this has been an important hearing.

I yield back to Ms. Scanlon with thanks.

Ms. SCANLON. Thank you, Chair.

Without objection I would like to enter statements from the following organizations and individuals into the record. We have a letter from the International Medical Graduate Task Force to HHS,a statement from the American Medical Association, anda statement from the Educational Commission for Foreign Medical Graduates. We also have an individual statement fromDr. Jeffrey A. Singer, a Senior Fellow with the Department of Health Policy Studies at Cato.

[The information follows:]

MS. SCANLON FOR THE RECORD

IMG TASKFORCE
INTERNATIONAL MEDICAL GRADUATE TASKFORCE

1028 Oakhaven Road Memphis,
TN 38119

April 7, 2020

VIA EMAIL

Jessica Stewart
HHS/Office of Global Affairs
Switzer Building, Room 2008 330
C Street, SW Washington, DC
20201

Michael Berry
HRSA/Bureau of Health Workforce
Parklawn Building, Room 11W-56
5600 Fishers Lane
Rockville, MD 20857

Thomas Alexander
Deputy Director of Global Affairs
HHS/Office of Global Affairs
Switzer Building, Room 2008 350
C. Street, SW Washington, DC
20201

Re: Expansion of HHS Clinical Waiver Program to Address the Covid-19 Pandemic

Dear Ms. Stewart, Mr. Berry and Mr. Alexander:

The International Medical Graduate Taskforce respectfully writes to urge the Department of Health and Human Services (HHS) to immediately exercise its existing statutory and regulatory authority to expand the physician workforce in the United States by designating the entire country as a shortage area and to accept clinical J-1 waiver applications from any physician and any facility that agrees to provide care to Medicare or Medicare-eligible patients.

The International Medical Graduate Taskforce is a nationwide coalition of professionals in medicine and law dedicated to helping Americans, especially those in rural and other physician-shortage areas, obtain the basic medical services they so desperately need and deserve. Our members work on behalf of universities, teaching hospitals, medical centers, and clinics of all sizes, and on behalf of IMG physicians seeking necessary authorizations, including J-1 waiver applications. As such, members of our organization have occupied a front row seat from which to observe the success of the Conrad State 30 Program since its inception in 1994. However, we have witnessed an increased need for medical professionals. The cap of 30 waivers per state limits many states' ability to meet the needs of underserved populations, from low-income urban communities receiving care at hospitals in our nation's poorest neighborhoods, to farming communities served by small medical practices. For this fiscal year alone, to date, 27 of the states have filled their 30 waiver spots and another 12 only have a few waiver spots available.

The HHS program has always excelled in assisting federally qualified health centers (FQHCs) to attract and retain US-trained International Medical Graduates who provide critically needed primary care services. Expanding the program to accept applications from a broader applicant pool -- and to serve a broader range of facilities -- will help address the spiraling unmet needs of medically underserved American citizens nationwide, especially during a global pandemic. Report after report has confirmed that the country is in the middle of a long-term physician shortage that is only getting worse. The projected shortage over the next few years ranges from 50,000 to 150,000 physicians making the retaining of US-trained J-1 physicians critical to the U.S. national interest.

Over 80% of foreign medical graduate physicians undertake graduate medical education in the U.S. in J-1 status. In 2000, roughly 6000 non-US citizen IMGs participated in the Main Residency Match, compared to 2020, when approximately 6,907 participated. In 2020, 4,222 non-US citizen IMG's Matched and are expected to undertake their residency programs on the J-1 visa.

In light of the pandemic and this readily available and US-trained workforce presently in the U.S., we request that HHS consider the following:

1. To accept applications from physician specialists despite the regulatory prohibition on applications from those who will not start work within one year of completing a residency program. This emergency exception to the general rule is warranted in light of the devastating shortage of physicians during the COVID-19 pandemic. In particular, we note that hospitals have identified critical care intensivists, anesthesiologists, general surgeons, orthopedic surgeons, cardiologists, and oncologists as specialties that have the skills to treat critically ill patients. News reports make clear that hospitals are receiving more critically ill patients than they can treat with the currently available physician workforce. Recent reports also indicate that efforts to "flatten the curve" are showing success, which means that the pandemic will continue to produce a steady flow of critically ill patients presumptively over a longer period of time. In addition, reports identify the likelihood that the pandemic will come in waves over time. Consequently, expeditious processing of J-1 clinical waivers from specialist physicians will likely produce additional providers who can participate in the response to the pandemic at present and in the near future as the pandemic runs its course.

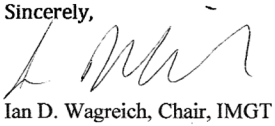
2. To designate the entire United States as an underserved area. Section 332 of the PHS Act, 42 U.S.C. 254e, provides that the Secretary of HHS shall designate HPSAs based on criteria established by regulation. HPSAs are defined in section 332 to include (1) urban and rural geographic areas with shortages of health professionals, (2) population groups with such shortages, and (3) facilities with such shortages. The language is very broad and simply says a HPSA includes any area "which the Secretary determines has a health manpower shortage." At present, the entire geographic area of the United States is underserved; and, the likelihood that the current pandemic will render physicians unable to work due to their own illness will only exacerbate the physician shortage. In fact, a number of physicians and other healthcare workers have already been infected nationwide. Given that HHS has the statutory authority to designate the entire country as a HPSA or MUA/P, we encourage the agency to exercise this authority as soon as possible.

3. To accept applications from any facility that can demonstrate a physician need. With respect to facility eligibility for an HHS clinical waiver, the regulations require the "head of the facility to "confirm the facility is located in a specific designated HPSA or MUA/P, and that it provides medical care to Medicaid or Medicare eligible patients and to the uninsured indigent" 45 C.F.R. §50.5(e)(6). Accordingly, the IMGT proposes that existing statutory and regulatory authority permits HHS to grant waivers to international medical graduates for full-time employment in any type of facility where the need for a doctor can be demonstrated. The proposed changes would comply with existing HHS regulations by requiring sliding fee scales and acceptance of Medicare and Medicaid.

An expansion of the HHS waiver program will enhance the program and maximize its use to satisfy the exigent medical needs of the country. The IMG Taskforce strongly believes implementing these important and life saving measures will help to further your mission of improving delivery of healthcare to all Americans and will complement efforts by other federal and state authorities to increase the number of physicians who may serve our country in this critical moment and into the future. We would be happy to collaborate with you on these measures should that be helpful.

Thank you for considering these suggestions. We look forward to your thoughts and would appreciate a response by April 20, 2020.

Sincerely,



Ian D. Wagreich, Chair, IMGT Liaison Committee

STATEMENT

of the

American Medical Association

to the

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

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

February 15, 2022

Division of Legislative Council

202-789-7426

Statement for the Record

of the

American Medical Association

to the

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

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

February 15, 2022

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

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

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

[1] https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage.
[2] https://www.nashp.org/states-address-provider-shortages-to-meet-the-health-care-demands-of-the-pandemic/.

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

When Congress enacted the Balanced Budget Act of 1997 it placed a limit (or cap) on the funding that Medicare would provide for GME.[3] This meant that most hospitals would receive direct medical education (DGME) funding and indirect medical education (IME) support only for the number of allopathic and osteopathic full-time equivalent (FTE) residents it had in training in 1996.[4] As U.S. medical schools have increased enrollment, residency training positions at teaching hospitals have not kept up with the larger pool of applicants, limited by the cap on Medicare support for graduate medical education. According to the Association of American Medical Colleges (AAMC), there has been a 52 percent increase in medical student enrollment since 2002,[5] but only a 17 percent increase in funded GME slots.[6] Though, for the first time since 1996, 1,000 new Medicare-supported GME positions were provided in the Consolidated Appropriations Act, 2021,[7] many more Medicare-supported GME positions are needed to alleviate the physician shortage. **Therefore, it is crucial that we invest in our country's health care infrastructure by providing additional GME slots so that more physicians can be trained, and access to care can be improved.**

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

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

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

The United States is suffering from a major physician shortage, with forecasts of a widening gap that will continue to grow over the next decade. It is projected that by 2032, there will be a 50 percent growth in the population of those ages 65 and older, compared with only a 3.5 percent growth for those ages 18 or younger.[8] Partly due to this phenomenon, by 2033 the United States will experience a shortage of between 54,100 and 139,000 physicians. This number includes a projected primary care physician shortage of between 21,400 and 55,200, as well as a shortage of non-primary care specialty physicians of between 33,700 and 86,700.[9] As such, there is a growing need for a larger physician workforce that the U.S. cannot fill on its own, in part due to the fact that the U.S. physically does not have enough people in the younger generation to care for our aging country. Furthermore, the pandemic has put an incredible strain on our health care system and this crisis has drastically exacerbated physician shortages in many rural and underserved communities across the U.S.

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[3] https://www.congress.gov/bill/105th-congress/house-bill/2015.
[4] https://www.ama-assn.org/education/improve-gme/compendium-graduate-medical-education-initiatives.
[5] https://www.aamc.org/news-insights/us-medical-school-enrollment-rises-30.
[6] https://www.ncbi.nlm.nih.gov/books/NBK248024/.
[7] https://www.congress.gov/bill/116th-congress/house-bill/133/text.
[8] https://www.aamc.org/download/472888/data/physicianworkforceissues.pdf.
[9] AAMC (2020, June) The Complexities of Supply and Demand: Projections from 2018 to 2033. Retrieved from AAMC:https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf.

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

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

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

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

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

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

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

[11] https://data.hrsa.gov/topics/health-workforce/shortage-areas.

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

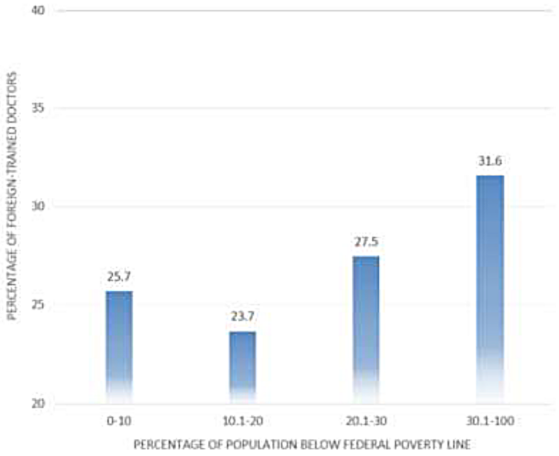
[13] The U.S. Department of Health & Human Services, Bureau of Health Workforce Health Resources and Services Administration (HRSA), Bureau of Health Workforce, Fourth Quarter of Fiscal Year 2020, Designated HPSA Quarterly Summary. Data as of September 30, 2020.

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

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

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

Foreign-trained Doctors Serving U.S. Population by Poverty Level[16]



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

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

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

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

[15] https://www.americanimmigrationcouncil.org/sites/default/files/research/foreigntrained_doctors_are_critical_to_serving_many_us_communities.pdf.
[16] https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf.
[17] https://www.americanprogress.org/article/immigrant-doctors-can-help-lower-physician-shortages-rural-america/.

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

J-1 physicians

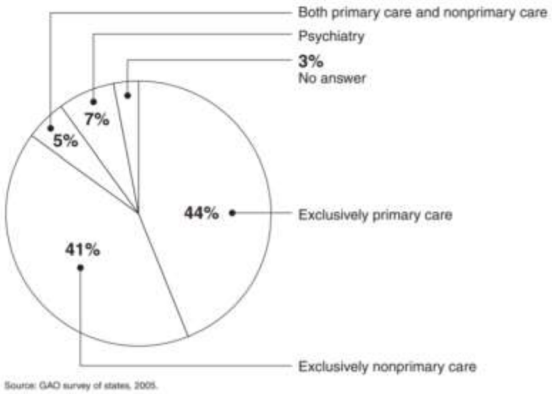
A prospective exchange visitor must be sponsored by a U.S. Department of State (DOS) designated program sponsor to be admitted to the United States in the "J" nonimmigrant category or to participate in an exchange visitor program. The DOS-designated sponsor, which for all J-1 physicians is the Educational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

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

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

Specialties Practiced by Physicians for Whom States Requested J-1 Visa Waivers, Fiscal Year 2005 [20]

[18] https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf.
[19] https://www.kunr.org/post/visa-program-enables-foreign-doctors-work-underserved-communities#stream/0.
[20] https://www.govinfo.gov/content/pkg/GAOREPORTS-GAO-06-773T/pdf/GAOREPORTS-GAO-06-773T.pdf.



Source: GAO survey of states, 2005.

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

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

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

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

H-1B physicians

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

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

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

Immigration barriers

J-1 physicians were surveyed by ECFMG in late 2019 and asked to describe challenges to their well-being. Responses were received from 7,817 physicians and showed that fluctuating immigration laws contribute to a unique set of stressors for this cohort. Further, 63 percent of male respondents reported that visa and immigration concerns were among the top issues impacting their wellness.[24] This is not surprising given the massive fluctuation in immigration laws over the past few years and the significant increase in wait time associated with many immigration forms. For example, overall U.S. Citizenship and Immigration Services (USCIS) average processing times have increased by 46 percent over the past two fiscal years and 91 percent since fiscal year 2014.[25] As such, a number of administrative changes could help to increase the number of physicians in the U.S. and decrease the stress that IMGs face when applying for visas and green cards. For example, physician J-1 visas could be granted premium processing rights or some other form of expediated processing. With the delays that were caused by COVID-19 and the difficulties that some consulates are facing, a number of J-1 physicians over the past two years have come close to, or completely missed, their residency

[21] *See* 8 U.S.C 1101(a)(15)(H)(i)(b), 1184(i).
[22] https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-who-are-international-medical-graduates-imgs-specialty-2017.
[23] *Id.*
[24] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-10-26-Duration-of-Status-Comment-Letter-FINAL.pdf.
[25] AILA Policy Brief: USCIS Processing Delays Have Reached Crisis Levels Under the Trump Administration, January 30, 2019, https://www.aila.org/infonet/aila-policy-brief-uscis-processing-delays.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

Thank you for inviting the Educational Commission for Foreign Medical Graduates (ECFMG) to provide comment to the important work of the House Judiciary Subcommittee on Immigration and Citizenship's hearing on physician immigration. As the only organization in the United States charged with both certifying the credentials of physicians who attend medical schools outside of the United States and sponsoring foreign national physicians for participation in the U.S. Department of State's BridgeUSA exchange visitor program, ECFMG is uniquely qualified to comment on the contributions of international medical graduates (IMGs) to U.S. health care.

ECFMG, a non-governmental, tax exempt entity, was formed over seventy years ago to be the only organization to certify physicians who graduated from medical schools outside of the United States and Canada and aim to engage in supervised patient care in the United States. Through its many programs and services, ECFMG presently serves as a world leader in promoting quality health care globally — serving physicians, members of the medical education and regulatory communities, health care consumers, and those researching issues in medical education and health workforce planning. Furthermore, ECFMG serves as the primary source for physician immigration data in the United States. Through its many programs and services, ECFMG does the following:

- Certifies the readiness of IMGs for entry into graduate medical education and health care systems in the United States through an evaluation of their qualifications.
- Identifies the needs of IMGs to become acculturated into U.S. health care.
- Verifies credentials and provides other services to health care professionals worldwide.
- Expands knowledge about international medical education programs and their graduates by gathering data, conducting research, and disseminating the findings.
- Facilitates the entry of foreign national physicians to the United States on J-1 visas.

ECFMG certification remains the standard by which IMGs are vetted. In administering its certification program, ECFMG is guided by three mindful principles:

- To assure the U.S. public that those IMG's who are involved in supervised patient care are appropriately certified and hold credentials that have been primary source verified;
- To assure residency program directors there is an adequate pool of qualified IMG applicants;
- To facilitate, and not impede, IMGs seeking professional career advancement.

Currently, all U.S. states require IMGs to hold ECFMG certification and to have one to three years of training before being eligible for an unrestricted medical license. While not an ECFMG regulation, our organization supports these requirements, because the residency training outside of the United States is very heterogenous and frequently not regulated. In order to engage in required U.S. training, each foreign national physician is selected through a highly competitive matching program and has their eligibility status verified by ECFMG prior to being selected.

Ensuring that physicians are qualified and able to enter the United States and complete training is essential to both U.S. and global health care. Key points related to physician

immigration include:

- The United States remains the premier country for the training of physicians

- The United States is suffering from a physician shortage with forecasts of a widening gap that will continue to grow over the next decade. The Association of American Medical Colleges (AAMC) predicts that, by 2033, the United States will experience a shortage of between 54,100 and 139,000 physicians. This number includes a projected primary care physician shortage of between 21,400 and 55,200 as well as a shortage of non-primary care specialty physicians of between 33,700 and 86,700.[1] With more than 40 percent of international medical graduates working in primary care, the US needs to continue to maintain policies that encourage foreign national physicians to come to the United States for training.

- Physician immigration is a matter of national security. Foreign national physicians provide important patient care in medically underserved areas of the United States.

- Any review of physician immigration must consider the burden of United States Customs and Immigration Enforcement (USCIS) processing times. Overall USCIS average processing times have increased by 46 percent over the past two fiscal years and 91 percent since fiscal year 2014. This directly impacts physician immigration in the United States.

- More than 900,000 Americans have died from COVID-19 and infections continue to touch all parts of American life. States with the highest numbers of foreign national physicians are those hardest hit by COVID-19, including New York, Michigan, Texas, Pennsylvania, Massachusetts, and Florida. Ensuring an uninterrupted frontline health care workforce is critically important.

ECFMG urges policymakers to consider the impacts that foreign national physicians have on patient care in the United States and carefully evaluate their contributions to U.S. health care. As the leading experts on the credentialing and visa sponsorship of foreign national physicians, ECFMG remains available to advise policy makers on this important public diplomacy matter.

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

February 15, 2022

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully submitted,

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

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

That concludes today's hearing. I'd like to, once again, thank our panel of witnesses for participating in this hearing.

Without objection, all Members will have 5 legislative days to submit additional written questions for the Witnesses or additional materials for the record.

Without objection, the hearing is adjourned. Thank you.

[Whereupon, at 3:50 p.m., the Subcommittee was adjourned.]

APPENDIX

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

February 17, 2022

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

The Honorable Joe Neguse
Vice Chair
Subcommittee on Immigration and Citizenship,
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

Dear Chair Lofgren and Vice Chair Neguse:

On behalf of the American Academy of Family Physicians (AAFP) and the 133,500 family physicians and medical students we represent, I applaud the committee for its continued focus on strengthening the health care workforce. I write in response to the hearing: "Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Health Care System" to share the family physician perspective and the AAFP's policy recommendations for ensuring that we have a robust primary care workforce to address our nation's current and future health care needs.

Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. As such, the AAFP has long been concerned about the shortage of primary care physicians in the U.S., particularly the supply of family physicians, who provide comprehensive, longitudinal primary care services for patients across the lifespan, including chronic disease management, treatment of acute illnesses, and preventive care. It is projected that we will face a shortage of up to 48,000 primary care physicians by 2034.[1]

Family physicians are acutely aware of the current shortage of primary care physicians across the country and the important role International Medical Graduates (IMGs) play in addressing this shortage. In fact, nearly 21 million Americans live in areas of the U.S. where foreign-trained physicians account for at least half of all physicians.[2] The COVID-19 pandemic has also highlighted the urgency of building and financing a robust, well-trained, and accessible primary care system in our country. The AAFP urges the committee to consider the following recommendations.

Role of IMGs in Addressing Health Equity
IMGs play a vital role in caring for some of the most vulnerable populations in the U.S. IMGs make up more than 22 percent of active family physicians, and they are more likely to practice in rural, low socio-economic status, and non-white communities.[3, 4] In fact, IMGs are twice as likely to practice in health professional shortage areas.[5] By increasing the number of visas available to IMGs these vulnerable populations will be better served and the overall health care system will be bolstered. **We urge Congress to pass the *Health Care Workforce Resilience Act* (H.R. 2255) to recapture 15,000 unused employment-based physician immigrant visas from prior years to enable physicians to have the support they need and our patients to have the care they deserve.**

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The lack of a diverse physician workforce has significant implications for public health. Physicians who understand their patients' languages and understand the larger context of culture, gender, religious beliefs, sexual orientation, and socioeconomic conditions are better equipped to address the needs of specific populations and the health disparities among them. Several studies show that racial, ethnic and gender diversity among physicians promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.[6, 7] Data shows that IMGs add significantly to the diversity of the physician population. Among IMGs with Education Commission for Foreign Medical Graduates certification, all races and ethnicities are substantially represented and, as a group, the percentage who are people of color is much higher than that of U.S. medical graduates.[8] Therefore, IMGs help to diversify the physician workforce, decrease health disparities, and improve health outcomes. **We urge Congress to continue consider IMGs as an important way to diversify the physician population to meet the growing needs of our diverse patient population.**

Conrad 30 Waiver Program Reauthorization
Currently, resident physicians from other countries working in the U.S. on J-1 visa waivers are required to return to their home country after their residency has ended for two years before they can apply for another visa or green card. The Conrad 30 Waiver Program allows these physicians to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years.

Many communities, including rural and low-income urban districts, have problems meeting their patient care needs and depend on the physicians in this program to provide health care services. Over the last 15 years, the program has brought more than 15,000 foreign physicians to underserved and rural communities. With communities across the country facing physician shortages, the Conrad 30 Waiver Program ensures that physicians who are often educated and trained in the U.S. can continue to provide care for patients during the COVID-19 crisis and beyond**. We urge Congress to pass the *Conrad State 30 & Physician Access Act* (H.R. 3541 / S. 1810) to provide needed stability for the Conrad 30 Waiver Program.**

Thank you in advance for consideration of our recommendations. The AAFP looks forward to working with the committee to develop and implement policies to strengthen the primary care workforce. Should you have any questions, please contact John Aguilar, Manager of Legislative Affairs at jaguilar@aafp.org.

Sincerely,

Ada D. Stewart, MD

Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians

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[1] IHS Markit Ltd. *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034*. Washington, DC: AAMC; 2021.
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February 17, 2022

The Honorable Zoe Lofgren
Subcommittee on Immigration and Citizenship
House Committee on the Judiciary
Washington, DC 20515

The Honorable Tom McClintock
Subcommittee on Immigration and Citizenship
House Committee on the Judiciary
Washington, DC 20515

Statement for the Record on "Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System"

Dear Chair Lofgren and Ranking Member McClintock:

The American Academy of Neurology (AAN), the world's largest association of neurologists representing over 38,000 professionals, is strongly committed to improving the care and outcomes of persons with neurologic illness in a cost-effective manner. One in six people lives with a brain or nervous system condition, including Alzheimer's disease, Parkinson's disease, stroke, epilepsy, traumatic brain injury, ALS, multiple sclerosis, and headache.

The AAN thanks the House Committee on the Judiciary Subcommittee on Immigration and Citizenship for hosting the upcoming hearing titled "Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System." The AAN strongly supports strengthening the health care workforce by utilizing the skills of immigrant physicians who completed their training in the United States to assist in the growing shortage.

The United States is facing a shortage of between 54,100 and 139,000 physicians by 2034 that will likely be exacerbated by rising rates of physician burnout and early retirement due to the COVID-19 pandemic.[1] Now, more than ever, it is critical that we ensure our nation's health care workforce can meet the needs of the American people. Additionally, as the significant impacts of Long COVID for millions of Americans are emerging, having a sufficient workforce to address the additional demand for neurologic care is critical. According to a recent study, one-third of patients diagnosed with COVID-19 may develop psychiatric or neurologic disorders within six months, including depression, anxiety, strokes, and dementia.[2] That same study found that among COVID-19 patients admitted to an intensive care unit (ICU),

[1] https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mounting-physician-shortage

[2] https://journals.lww.com/neurotodayonline/Fulltext/2021/06030/6_Months_After_COVID_19_Infection,_1_in_3_Develop.4.aspx

the incidence of developing a psychiatric or neurologic disorder increased to 46%. Given the magnitude of COVID-19 cases across the US, the impact of neurologic symptoms is likely enormous, making the need for neurologists ever-growing.

Furthermore, the population of the United States is also expected to grow by 10.6% by 2034, with a 42.4% increase of individuals aged 65 years and older, and a 74% increase of individuals aged 75 years and older. As life expectancy continues to rise, more Americans will develop chronic neurologic conditions such as Parkinson's disease, dementia, and Alzheimer's disease, which require specialized care.

The Conrad State 30 and Physician Access Reauthorization Act

International medical graduates (IMGs) are an important part of the US neurology workforce, with 31.5% of active neurologists being IMGs. However non-US IMG resident physicians training in the US on J-1 visas are required to return to their home country for two years after their residency has ended before they can apply for a work visa or green card. The Conrad 30 program provides 30 waivers per state to allow these physicians to remain in the US without having to return home for two years if they agree to practice in a medically underserved area for three years. With communities across the country facing physician shortages, the Conrad 30 program helps physicians who are educated and trained in the US continue to care for patients. We encourage the Subcommittee to advance **The Conrad State 30 and Physician Access Reauthorization Act (S. 1810/ H.R. 3541)**, which would reauthorize the Conrad 30 program for an additional three years, as well as make several key improvements to the program, including creating a process to gradually increase the number of waivers while requiring additional employment protections.

Healthcare Workforce Resilience Act

The AAN also encourages the Subcommittee to review the **Healthcare Workforce Resilience Act (S. 1024/ H.R. 2255)**, a bill that would reallocate 15,000 visas for foreign-born physicians and 25,000 visas for foreign-born nurses to practice in the United States. The Healthcare Workforce Resilience Act would provide much-needed stability to foreign-born physicians already practicing in the United States who are stymied by the green card backlog due to per country caps. According to one AAN member from India who has worked in an underserved area of Tennessee, based on "current wait times, it may take several decades for me to get a green card. Due to my visa status, me and my family face significant uncertainties regarding work and life in America." These qualified health professionals, including neurologists, will help fill shortages as our nation's health systems continue their "all hands-on deck" response to COVID-19. In addition, these highly trained medical professionals will provide life-saving care in many of our nation's underserved communities.

In conclusion, the AAN thanks you for your leadership on these important issues. If you have any questions or require additional information, please do not hesitate to contact Derek Brandt, Director of Congressional Affairs at *dbrandt@aan.com* or Fred Essis, Congressional Affairs Manager at *fessis@aan.com*. We look forward to working with you as we all strive to improve access to timely care for all Americans with neurologic conditions.

Sincerely,

Orly Avitzur MD

Orly Avitzur, MD, MBA, FAAN
President, American Academy of Neurology

February 18, 2022

The Honorable Zoe Lofgren
Chair
House Committee on Judiciary
Subcommittee on Immigration
and Citizenship
Washington, D.C. 20515

The Honorable Tom McClintock
Ranking Member
House Committee on Judiciary
Subcommittee on Immigration
and Citizenship
Washington, D.C. 20515

Dear Chair Lofgren and Ranking Member McClintock:

On behalf of the Healthcare Leadership Council (HLC), we thank you for holding a hearing on, "Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System."

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, homecare providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

As you know, the COVID-19 pandemic has exacerbated the ongoing shortage of healthcare workers in America, leaving many healthcare facilities short staffed even as the number of COVID-19 cases decrease. In addition, the United States faces a physician shortage of up to nearly 124,000 physicians by 2034, including shortfalls in both primary and specialty care.[1] This shortfall could disproportionately affect rural and underserved communities. The 46 million Americans who live in rural areas often have trouble accessing care due to a shortage of healthcare workers and long distances to healthcare services that can be made more challenging by difficult terrain and severe weather. As a result, rural residents overall suffer poorer health outcomes and are at greater risk of dying from heart disease, cancer, unintentional injuries, chronic lower respiratory disease, and stroke than their urban counterparts. Without congressional action, workforce shortages are likely to worsen and, consequently, the state of health for people across America may worsen as well.

As Congress looks further into supporting the healthcare workforce and the role of immigrant physicians in the healthcare system, HLC encourages Congress to support the passage of

[1] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034, Association of American Medical Colleges (June 2021) https://www.aamc.org/media/54681/download?attachment

H.R. 2255/S. 1024, the "Healthcare Workforce Resilience Act" to provide green cards or permanent residency to foreign medical professionals such as immigrant nurses and physicians. Under the bill, U.S. Citizenship and Immigration Services would recapture up to 25,000 immigrant visas for nurses and 15,000 immigrant visas for physicians which will help strengthen health systems' capacity as we continue to combat the pandemic, the growing opioid crisis, and other significant health challenges. In addition, HLC believes it is imperative to support immigration policies that enable the entry of qualified medical professionals into the United States and encourages Congress to take the following actions to strengthen the healthcare workforce during and beyond the COVID-19 pandemic.

- Enable swift allowance of temporary visas for nurses, physicians, pharmacists, and other healthcare professionals (especially those who have already completed clearances) during a period of workforce shortages.
- Direct the Department of Homeland Security to take the following actions to increase the supply of physicians during the national emergency:
    - Temporarily suspend the enforcement of the two-year home residency requirement for any J-1 medical resident or fellow who is willing to work full time in a Health Professional Shortage Area or Medically Underserved Areas and Populations (MUA/Ps) or in a medical field that is directly treating COVID-19 patients or assisting in the battle against COVID-19. This should not be restricted to just the Conrad 30 Waiver program. There are many other Interested Government Agency Waivers including Appalachian Regional Commission, Delta Regional Authority VA Waivers, and Health and Human Services Waivers.
    - Temporarily exempt from the annual H-1B cap any physician, or healthcare worker (as long as they are H-1B classifiable positions) involved in direct patient care.
    - Extend the status and work authorization of any H-1B physician beyond the normal six-year limit if they are filling an unmet workforce need.
    - Require U.S. Citizenship and Immigration Services to reinstate premium processing for any H-1B filed for a physician, physician assistant, registered nurse, nurse practitioner, and any other critical healthcare professional who is filling a need in an underserved area.
    - Immediately grant Employment Authorization Document (EAD) approval to any physician or healthcare worker whose EAD card is about to expire, or whose application for renewal is pending or grant work authorization based on a Receipt Notice of an I-765 Application.
    - Temporarily suspend the Visa Screen Certificate or equivalent requirement for healthcare professionals in light of the shortage of qualified medical personnel available to practice in the United States.

Thank you again for your efforts to increase the supply of physicians by addressing immigration challenges. HLC looks forward to continuing to collaborate with you on this important issue. If you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435 or dwitchey@hlc.org.

Sincerely,

Mary R. Grealy
President

Statement for the Record by Upwardly Global

"Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System"

House Judiciary Subcommittee on Immigration and Citizenship

February 16, 2022

Upwardly Global is the first and longest-serving organization focused on advancing the meaningful inclusion of immigrants and refugees who have international credentials into the U.S. workforce. Upwardly Global has offices in four major cities and works with thousands of job seekers across the country every year to support their full inclusion in the U.S. workforce, and to share our learnings broadly to promote positive systems change. Our work with immigrant and refugee medical professionals guides this statement.

We commend the Judiciary Committee for holding a hearing on this critical subject. There is currently a critical shortage in the number of physicians available in hospitals around the country, largely exacerbated by the COVID-19 pandemic. By the year 2033, it is projected that the United States will be 139,000 physicians short of the needed amount. There is particularly a need to meet healthcare demands in underserved communities, including immigrant communities and other communities of color. Under COVID-19, hospitalization rates amongst Black and Hispanic communities across the U.S. were at least double the national average, and death amongst the older Black and Hispanic population were two times as high as the non-Hispanic white population.

While the demand for physicians is high, the United States does have the resources to meet this need, in the form of work-authorized immigrant and refugee professionals who are in the U.S. but have been trained abroad. **There are 2.3 million recently-arrived, college-educated immigrant and refugee professionals in the U.S. today with degrees in high-demand fields like technology, administration, healthcare, and other skilled professions; 165,000 are internationally-trained medical professionals who are unemployed or severely underemployed.**

We are underutilizing this talent.

Most of these medical professionals are sidelined due to licensing rules that fail to recognize their expertise and require costly and time-consuming examinations and residencies. Upwardly

Global has worked to address these limitations and provide support for medical professional through two avenues:

1. Encourage Establishment of Paid Internship and Returnship Programs
Together with New York-Presbyterian, one of the largest academic medical centers in the country, Upwardly Global has co-designed and launched a paid, mid-career internship program to on-ramp internationally-trained immigrants into open roles in the healthcare sector. The model addresses staffing needs with a new, diverse pool of talent; equips our medical system to have a greater, more equitable impact on health access and outcomes in under-served communities; and offers alternative career pathways for immigrants with international credentials and experience.

2. Highlight and Encourage Improved State Licensing Laws
Upwardly Global is also working with legislators, regulators, healthcare providers and grassroots and national organizations in several states, including Washington and Illinois, to make it easier for immigrants and refugees eager to share their talents and skills. Recently, this has taken the form of urging states to ease restrictions and allow internationally-trained medics to serve during the COVID-19 pandemic. Licensing reform should be supported in tandem with critical local actors and hospitals.

3. Fund community based organizations that support training, relicensing and connections to employers.
There are Offices of New Americans in many cities around the country that should be funded with the mandate to support immigrants and refugees who come to the U.S. with international healthcare credentials. We are working with ONA in New York State on their Pathways program in a direct service and capacity building role – a model program to this end. Critical federal agencies should also direct funding to this group of largely invisibilized immigrants and refugees. We are working with the Office of Refugee Resettlement right now to support Afghans with international credentials – an example of targeted focus.

Although these initiatives have significantly improved opportunities for immigrant and refugee medical professionals and have helped to ease the burden on the healthcare system in certain states, more work can and needs to be done on the federal level. By taking these critical steps, we can ensure that thousands of immigrant and refugee physicians are able to contribute their skills and talents while simultaneously addressing the physician shortage in underserved communities and across the United States.

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American College of Physicians
Leading Internal Medicine, Improving Lives

American College of Physicians Statement
House Committee on the Judiciary, Subcommittee on Immigration and Citizenship
"Is There a Doctor in the House?
The Role of Immigrant Physicians in the U.S. Healthcare System"
February 15, 2022

On behalf of the American College of Physicians, we appreciate the opportunity to share our statement to the House Committee on the Judiciary, Subcommittee on Immigration and Citizenship concerning the recent hearing on the role of immigrant physicians in the U.S. health care system. We thank Subcommittee Chair Lofgren and Ranking Member McClintock for hosting this hearing to examine how international medical graduates (IMGs) can reduce the shortage of physicians in this country and expand access to care for our patients who reside in underserved areas. We urge Congress to enact the following measures outlined in this statement to expand the immigrant physician workforce especially during this pandemic as their role is even more important to care for the hundreds of thousands of patients battling COVID-19.

The American College of Physicians (ACP) is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions like diabetes, heart disease and asthma.

IMGs are currently serving on the frontlines of the U.S. health care system, both under J-1 training and H-1B work visas and in other forms. These physicians serve an integral role in the delivery of health care in the United States. IMGs help to meet a critical workforce need by providing health care for underserved populations in the United States. They are often more willing than their U.S. medical graduate counterparts to practice in remote, rural areas and in poor underserved urban areas. In addition, adherence to care improves when patients experience greater comfort and higher levels of patient satisfaction with care from physicians "who look like them." This element of diversity to the physician workforce is helpful and necessary to the health care for an increasingly diverse patient population.

The COVID-19 global pandemic continues to take a toll on virtually all aspects of the U.S. economy and health care system, including physicians. Internal medicine specialists, in

particular, have been and continue to be on the frontlines of patient care during the pandemic. Many physicians were asked to come out of retirement to provide care, and there continues to be an increasing reliance on medical graduates, both U.S. and international, to serve on the frontlines in this fight against COVID-19 and deliver primary care.

According to the Association of American Medical Colleges (AAMC), before the Coronavirus crisis, estimates were that there would be a shortage of 17,800 to 48,000 primary care physicians by 2034. A report by the National Academy of Sciences, Engineering and Medicine calls on policymakers to increase our investment in primary care as evidence shows that it is critical for achieving health care's quadruple aim (enhancing patient experience, improving population, reducing costs, and improving the health care team experience). Now, with the closure of many physician practices and near-retirement physicians not returning to the workforce due to COVID-19, it is even more imperative to assist those clinicians serving on the frontlines by adopting the following measures to expand the role of IMGs in the physician workforce.

Approve The Conrad State 30 and Physician Access Reauthorization Act
We support legislation to expand access to care in underserved areas of this country through the **Conrad State 30 and Physician Access Reauthorization Act (H.R. 3541, S. 1810).** This bipartisan legislation would extend the authorization for the program for three years and would simplify the process for obtaining a visa, enhance important workplace protections for physicians, and increase the number of waivers available to states beyond the current allotment of thirty waivers, if certain requirements are met. We also appreciate that the bill would allow spouses of doctors in this program to work in the United States. **We urge Congress to approve the Conrad State 30 and Physician Reauthorization Act without delay to expand access to care for our patients who reside in underserved areas.**

The College has long recognized the value of IMGs and their contributions to health care delivery in this country. Under current law, foreign doctors on J-1 educational visas must return to their home country upon completing medical residency and wait two years before they can apply for a new visa or green card. Many IMGs provide care in medically underserved areas by participating in J-1 visa waiver programs, including the Conrad 30 waiver program that allows J-1 foreign medical graduates (FMGs) trained in the United States to remain in the country after completing their residency if they practice in an underserved area for three years. We support the reauthorization of this program without delay, and also believe that it should be made permanent to give physicians with J-1 visas certainty that they may continue to practice in underserved areas. We urge Congress to consider the permanent reauthorization of the Conrad 30 J-1 visa waiver program in the context of broader immigration reform consistent with our immigration policies as well as those set forth in our National Immigration Policy and Access to Health Care policy paper.

Enact The Healthcare Workforce Resilience Act
We support bipartisan legislation, the Health Care Workforce Resilience Act (H.R. 2255, S. 1024) that would recapture 40,000 unused visas and use them to provide additional green cards to 15,000 physicians and 25,000 professional nurses. The visas, which would not count

towards the annual limit and would be recaptured from a pool of over 200,000 employment-based visas left unused between 1992 and 2020, would provide a pathway to employment-based green cards and quickly address one of the health care system's most pressing needs.

By recapturing a limited number of unused visas from prior years and allocating them to doctors and nurses, the Healthcare Workforce Resilience Act offers the advantage of not only addressing the physician shortage that existed before the pandemic but recognizing that the shortages are growing more severe as the need for clinicians becomes greater with each passing day. It is an extremely timely response to the continued risk imposed by the COVID-19 pandemic.

We remain concerned that many internal medicine physicians who are working in this country with approved temporary immigration status are facing delays in obtaining their employment green cards, due to a backlog in the green-card approval process. Physicians with temporary immigration status may face limitations in the number of hours they can work and treat patients at a time when their help is needed to care for patients with COVID-19.

Support the Dream and Promise Act

ACP remains supportive of the Deferred Action for Childhood Arrivals (DACA) program that grants protections from deportation for undocumented individuals who were brought to the United States when they were children if they meet certain residency requirements. Without the protections granted by DACA, we remain greatly concerned about the possible future deportation of undocumented medical students, residents, fellows, practicing physicians, and others who came to the United States through no fault of their own.

We are pleased that the Biden Administration has issued a proposed rule that strengthens the Deferred Action for Childhood Arrivals (DACA) program to ensure that undocumented children in this program will not be a priority for deportation. We remain concerned that the Department of Homeland Security proposed rule, if finalized, could be overturned by future Administrations. **That is why we support the Dream and Promise Act of 2021, H.R. 6, which would provide a pathway to U.S. citizenship for undocumented individuals, who were brought to the United States when they were only children.** Without the full protections afforded to them by the Dream and Promise Act, these students and physicians could potentially be forced to discontinue their studies or their medical practice and may be deported. We are especially troubled by the plight of these individuals because they are needed in the medical field to treat an increasingly racially and ethnically diverse patient population and have the background to fulfill the cultural, informational, and linguistic needs of patients. We urge the Senate to approve this legislation so that it may be sent to the President and signed into law.

Conclusion

As we enter our third year of the global COVID-19 pandemic, it is clear that we can no longer afford to wait to enact the reforms outlined in this statement to reduce the physician workforce shortage and expand access to care in this country. We appreciate the efforts of this Committee to address these reform issues during this hearing and we look forward to working

with you to move these measures forward so that they may be signed into law. If you have any questions regarding this statement please do not hesitate to contact our Senior Associate for Legislative Affairs Brian Buckley at bbuckley@acponline.org.

A statement from the Physicians for American Healthcare Access (PAHA), which includes nearly 1,000 international medical graduates (IMGs) in over 40 states, submitted by the Honorable Zoe Lofgren, Chair of the Subcommittee on Immigration and Citizenship from the State of California for the record is available at:

https://www.dropbox.com/s/54ru48nzgnfutsb/Lofren-PAHA-907pgs.pdf?dl=0].

Association of American Medical Colleges (AAMC)
Supplemental Statement for the Record
before the
House Committee on the Judiciary, Subcommittee on Immigration and Citizenship
hearing, titled
"Is There a Doctor in the House?
The Role of Immigrant Physicians in the U.S. Healthcare System"
February 15, 2022

Thank you for the opportunity to provide supplemental information and context regarding U.S. graduate medical education (GME), commonly known as "medical residency" training. During the hearing, there was significant and broad bipartisan support for increasing GME. The AAMC endorses the Resident Physician Shortage Reduction Act of 2021 (H.R. 2256, S. 834), which would add 14,000 Medicare-supported GME positions over seven years to address projected physician workforce shortages.

In addition to testimony submitted by AAMC President and CEO David J. Skorton, MD, for the Feb. 15 hearing on the importance of physicians from other countries to the U.S. health care system,[1] the AAMC provides the following supplemental information to clarify relevant GME data and issues raised during the hearing.

"Qualified" vs. Accepted Candidates

To be eligible for medical residency, all applicants must meet the same minimum requirements, including graduating from an accredited medical school and passing Steps 1 and 2 of the U.S. Medical Licensing Exam (USMLE). Graduates of international medical schools must also be certified by the Educational Commission for Foreign Medical Graduates (ECFMG). In addition to these minimum requirements, U.S. medical residency program directors conduct a highly competitive selection process to determine who are most likely to succeed in their residency program and ultimately provide the highest-quality patient care.

While the vast majority of U.S. medical school graduates are able to secure medical residency positions,[2] for applicants who are unable to secure a residency position, there can be numerous contributing factors, including not being competitive in their first-choice specialty; USMLE scores; poor interviewing or interpersonal skills; not applying to, interviewing for, or ranking

[1] https://docs.house.gov/meetings/JU/JU01/20220215/114411/HHRG-117-JU01-Wstate-SkortonD-20220215.pdf
[2] More than 99% of all U.S. MD school graduates enter residency or enter full-time practice in the United States within six years after graduation. (Sondheimer HM, Xierali IM, Young GH, Nivet MA. Placement of US Medical School Graduates Into Graduate Medical Education, 2005 Through 2015. JAMA. 2015;314(22):2409–2410. doi:10.1001/jama.2015.15702)

enough programs; concerns raised in the Medical Student Performance Evaluation (also known as the "Dean's Letter"); professionalism concerns; or school reputation.[3,4]

The AAMC provides regularly updated resources, tools, effective practices, and other materials to support students, medical school advisors, and program directors in the residency selection process.[5] U.S. medical schools also assist unmatched students with residency application guidance, finding residency vacancies, and in pursuing master's degree programs or additional research and clinical experiences to enhance their competitiveness for future residency applications.

"Matched" vs. Securing a Residency Position

Most medical school graduates seek residency positions through the National Residency Matching Program (NRMP) or "the Match." [6] However, it is important to recognize that there are additional subsequent opportunities to secure a residency position, including the NRMP's Supplemental Offer and Acceptance Program (SOAP) and individual applications for vacancies after SOAP. In 2021, an additional 1,773 applicants accepted residency positions during SOAP.[7] As such, examining only Match data is an incomplete picture.

The NRMP reports to the AAMC that after the 2021 SOAP, 672 U.S. MD seniors were left without a residency position. These applicants often apply again in future years with new Match strategies, specialty choices, and education or training that increases their competitiveness. Research has shown that more than 99% of all U.S. MD school graduates enter residency or enter full-time practice in the United States within six years after graduation.[8] The American Association of Colleges of Osteopathic Medicine (AACOM) reports similar results for graduates of U.S. DO schools, including a total placement rate of 99% for U.S. DO seniors seeking GME by June 30, 2021.[9]

"No Rank List"

The NRMP also reports separately the number of applicants who do not submit a "rank order list" of their preferred residency programs, which is necessary to obtain a residency in the Match. These individuals are eligible for the SOAP and may secure a residency position later. Further,

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[3] Sondheimer HM. Graduating US Medical Students Who Do Not Obtain a PGY-1 Training Position. JAMA. 2010;304(11):1168–1169. doi:10.1001/jama.2010.1316

[4] Bumsted, Tracy MD, MPH; Schneider, Benjamin N. MD; Deiorio, Nicole M. MD Considerations for Medical Students and Advisors After an Unsuccessful Match, Academic Medicine: July 2017 - Volume 92 - Issue 7 - p 918-922 doi: 10.1097/ACM.0000000000001672

[5] AAMC, https://www.aamc.org/collaborative-transformation-transition-residency

[6] Medical school graduates also use the Military Match and specialty-specific "early" matching programs. https://www.nrmp.org/residency-applicants/get-ready-for-the-match/early-matches/

[7] NRMP, https://www.nrmp.org/wp-content/uploads/2021/08/MRM-Results_and-Data_2021.pdf (p. 45)

[8] Sondheimer HM, Xierali IM, Young GH, Nivet MA. Placement of US Medical School Graduates Into Graduate Medical Education, 2005 Through 2015. JAMA. 2015;314(22):2409–2410. doi:10.1001/jama.2015.15702

[9] AACOM, https://www.aacom.org/docs/default-source/grad-medical-education/do-match-report-2021-full-report-final.pdf?sfvrsn=e4e00797_0

they may strategically and purposefully not submit a rank order list in order to be automatically eligible for SOAP, which is only open to unmatched or partially unmatched applicants.

U.S. Medical Schools vs. International Medical Schools

Despite recent 35% growth in U.S. medical school enrollment, some U.S. citizens or legal permanent residents attend international medical schools. In contrast to high Match rates of students from U.S. MD and DO schools, medical students who attend international medical schools have historically been less competitive in the Match as a cohort. While imperfect, pre-SOAP data can be used for comparison purposes. In 2021, 92.8% (19,866) of U.S. MD seniors and 89.1% (7,101) of U.S. DO seniors obtained a residency position through the Match. Comparatively, in 2021, 54.8% (4,356) of non-U.S. graduates of international medical schools and 59.5% (3,152) of U.S.-citizen graduates of international medical schools obtained a residency position through the Match.[10]

In 2021, U.S. MD seniors accepted 48% (846 of 1,773) of the total positions filled during SOAP. U.S. DO seniors accepted 27% (484 of 1,773) of the total positions filled. International medical school graduates, as a group, accepted 18% (313 of 1,773) total positions filled during SOAP.[11]

Retention of Physicians from Other Countries

As of Dec. 31, 2020, approximately 11,602 (8%) of medical residents in U.S. medical residency programs were on nonimmigrant visas, and an additional 29,132 (20%) were identified as not being native U.S. citizens — including 12,180 (8.4%) naturalized citizens and 6,683 (4.6%) legal permanent residents.[12] Comparatively, AAMC analysis of American Medical Association 2020 physician practice data indicates that approximately 23% of active physicians practicing in the U.S. identified as foreign born. These data suggest that relatively comparable percentages of medical residents remain in the U.S. as active physicians after training. Failure to retain medical residents on nonimmigrant visas after training may be due to immigration barriers previously discussed in testimony, including the J-1 visa home-return requirement, H-1B visa caps, and green card backlogs.[13]

While nationwide data on State Conrad 30 J-1 visa waiver program retention is not available, a 2016 report by the WWAMI Rural Health Research Center at the University of Washington found the following:

> Not all programs tracked successful completion of the three-year service obligation, but estimates from those that did ranged from 70% in Wisconsin to more than 90% in other states. Thirteen states had collected data on physician retention in shortage areas beyond the initial 3-year obligation period. Most of the programs' retention data consisted of exit surveys on physicians' intent to remain in the community. Estimates from a handful of

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[10] NRMP, https://www.nrmp.org/wp-content/uploads/2021/08/MRM-Results_and-Data_2021.pdf (p.14)
[11] NRMP, https://www.nrmp.org/wp-content/uploads/2021/08/MRM-Results_and-Data_2021.pdf (p. 45)
[12] Brotherton SE, Etzel SI. Graduate Medical Education, 2020-2021. JAMA. 2021;326(11):1088–1110. doi:10.1001/jama.2021.13501
[13] https://docs.house.gov/meetings/JU/JU01/20220215/114411/HHRG-117-JU01-Wstate-SkortonD-20220215.pdf

states providing statistics were that 55-80% of physicians intended to remain in their communities upon completion of obligated service.

In some states, staff were able to track providers from a few months to ten years after service and, in one state, until providers left the state. Findings on retention after obligated service were as follows:

- In one state, 76% of physicians were in the same community for at least a few months post obligation.
- In another state, 40% of physicians remained at their original location 1 to 5 years post-obligation, dropping to 4% 5 to 10 years post-obligation.
- A study in Nebraska, looking back over a 10-year period from 2001 through 2010, found that 39% of physicians remained at their original location.
- In Wisconsin, a survey of rural employers that had hired waivered physicians from 1996 through 2002 found that just over 40% of physicians remained with the same employer after five years, and just over 30% after seven years. It was not known, however, if physicians who left their original employer were still in the community or not.
- In Washington state, physicians with J-1 visa waivers from 1995 through 2003 had remained with their employers for a median time of 23 months post-obligation, for up to 10 years afterward, and in underserved communities (whether with the original employer or not) a median of 26 months post-obligation.[14]

The AAMC is deeply committed to improving the transition from medical school to residency — from the beginning of a student's specialty research and selection process through the completion of residency and on to clinical practice. Supporting the well-being, training, professional development, and equitable treatment of all medical students and residents is critical to the health of the nation.

Thank you again for the opportunity to provide this supplemental statement. For additional information, please contact Matthew Shick, JD, AAMC Senior Director, Government Relations, at <mshick@aamc.org>.

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[14] Patterson DG, Keppel G, Skillman SM. Conrad 30 Waivers for Physicians on J-1 Visas: State Policies, Practices, and Perspectives. Final Report #157. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, Mar 2016.

Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System

Subcommittee on Immigration and Citizenship Hearing

February 15, 2022

Rep. Brad Schneider
Statement for the Record

The COVID-19 pandemic stretched our healthcare system thin—in some places to near the breaking point— exposing and exacerbating vulnerabilities in the system that existed before 2020. One area with particularly devastating impact was the daunting shortage of doctors in communities across the country. Consequently, we witnessed significant disparities in who received timely access to care, especially critical care. In particular, Americans living in rural communities were seven times more likely than those living in urban areas to report difficulties accessing the health care they need.

I have always worked to ensure that health care is a right in this country for every American, not just a privilege for the fortunate. We can't achieve that goal if people are not able to find doctors they trust, when they need care, close to their home. Yet, it is estimated that the United States could face a shortage of as many as 120,000 physicians by 2030. Closing this gap is essential.

As discussed in this hearing, the Conrad State 30 program has been instrumental in helping to reduce the physician shortage. Since 1994, this program has brought thousands of foreign physicians, trained in the United States, to rural, inner city, and other medically underserved communities. Under current law, foreign medical students trained in the U.S. are required to return to their home country for two years after completing their residency. Under Conrad 30, however, these highly skilled physicians can remain in the country in exchange for three years of service in an underserved area. Indicative of the wide-spread benefits of the program, Congress has reauthorized Conrad 30 several times, and every state makes use of the program for the benefit of their communities.

For the past several years, the Conrad State 30 program has been routinely authorized through appropriations legislation, limited to one year at a time. The uncertainty around short-term annual reauthorizations reduces the full effect of the program. That is why I introduced the Conrad State 30 & Physician Access Act (H.R. 35410), bipartisan legislation that would both extend the Conrad State 30 Waiver program and expand on its proven success.

My bill achieves four important objectives.

(1) It extends authorization of the program for three years.

(2) It improves the process for obtaining a visa and bolsters important workplace protections for recipients.

(3) It provides a path to increase the number of waivers available to states.

(4) The bill also allows the spouses of doctors to work in the United States, providing these physicians the needed stability to remain here and working in underserved communities.

As the pandemic hopefully wanes, the time to act is now. We can't afford to continue allowing the disparities in access to qualified, capable physicians.

I thank Chairwoman Lofgren for holding this important hearing and I look forward to bringing my legislation to the floor. We must continue working together to tackle the physician shortage and ensure that all Americans, regardless of their zip code, get the medical care they need.

Progressives for Immigration Reform Doctors without Jobs

March 4, 2022

Is There a Doctor in the House?
The Role of Immigrant Physicians in the U.S. Healthcare System
February 15, 2022
House Judiciary Subcommittee on Immigration & Citizenship
Supplemental Statement for the Record

Thank you again for affording Doctors without Jobs the opportunity to provide additional information on the number of U.S. citizens and lawful permanent residents who graduate from medical schools here in the U.S. and abroad and do not "match" for residency programs at U.S. teaching hospitals. This is, of course, a travesty that can be easily rectified by prioritizing these U.S. citizens and lawful permanent residents over physicians from other countries for taxpayer-funded residencies.

As requested by the Subcommittee on Immigration and Citizenship, Doctors without Jobs is providing information for the record that explains how we arrived at the number of unmatched U.S. citizen and lawful permanent resident doctors. In addition, I am prepared to challenge the percentage of doctors who graduate from U.S. medical colleges and eventually "match" as presented by Dr. David J. Skorton, President and CEO of the Association of American Medical Colleges.

Dr. Skorton stated that 99 percent of U.S. medical graduates match after six years. This is accurate, but only due to a limited scope. It would appear that Dr. Skorton's number was reached using data sourced from a research letter titled, *Placement of US Medical School Graduates Into Graduate Medical Education, 2005 Through 2015*, published in JAMA on December 8, 2015. It would further appear he chose a range of dates (2008 - 2015) to fit his narrative. Simply stated, the data was biased and not intended for a comprehensive review of unmatched physicians. A better portrayal of the numbers can be found on page 10 of the National Residency Matching Program data[1] which is summarized in the tables below. The data shows the number of unmatched over the past five years was 59,036 applicants, and an overall match rate for 2021 was 73.3 percent.

In addition, Dr. Skorton's data only included graduates of U.S. medical schools; it did not include U.S. citizens and lawful permanent residents who graduated from international medical schools. U.S. citizen graduates of international medical schools are not only well trained, but they, along with U.S. medical school graduates, outnumber foreign trained physicians applying for family medicine residency programs – one of our most critical needs.[2]

Furthermore, it would appear Dr. Skorton's numbers did not include what the National Residency Matching Program (NRMP) considers "non-active" applicants. Non-active applicants pay to apply to residency programs but are unsuccessful in receiving an interview at a residency program. This is due to the large number of applicants for the available positions. Without an interview, they cannot submit a rank order list (ROL). The ROL is where the applicant lists the programs, in order of preference, which they would be willing to attend. Despite this, they are considered qualified to enter residency and have to rely on a limited number of SOAP positions or must reapply the following year.

As Table 1 indicates, more than 7,409 U.S. citizens and lawful permanent residents did not match for a residency in 2021. Only a small fraction of these matched into a residency program through the Supplemental Offer Acceptance Program (SOAP) after the initial match. In 2021, there were 1,815 post graduate year one positions available in the SOAP and a total of 14,115 eligible applicants (this number includes U.S. and foreign trained doctors who did not match from the current year).

We would be happy to sit with Dr. Skorton or his designees to discuss our numbers as well as the importance of prioritizing U.S. citizens and lawful permanent residents during The Match and SOAP.

Best regards,

Kevin Lynn
Executive Director
Progressives for Immigration Reform

Co-Founder
Doctors without Jobs

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Table 1
Source: NRMP

Number Unmatched	2021	2020	2019	2018	2017	2016	2015	
Active Unmatched from US Medical Schools	3410	2983	2898	2773	2511	2486	2561	
Non-active Unmatched from US Medical Schools	445	418	448	468	511	526	463	
Active Unmatched US Citizens from Non-US Medical Schools	2143	2013	2083	2175	2292	2454	2354	
Non-active Unmatched US Citizens from Non-US Medical Schools	1411	1156	1355	1342	1486	1391	1212	
Active Unmatched Non-US Citizens from Non-US Medical Schools	3587	2685	2841	3105	3470	3691	3725	
Non-active Unmatched Non-US Citizens from Non-US Medical Schools	2026	1369	1701	1866	2065	1869	1796	Unmatched in the last 5 years
Total number of applicants not able to enter residency	13022	10624	11326	11729	12335	12417	12111	
Total number of US applicants not able to enter residency	7409	6570	6784	6758	6800	6857	6590	

Unmatched Percentage							
Unmatched from US Medical Schools	13	12	12	12	12	12	12
Unmatched US Citizens from Non-US Medical Schools	48	46	49	50	53	52	52
Unmatched Non-US Citizens from Non-US Medical Schools	52	45	49	51	55	55	55

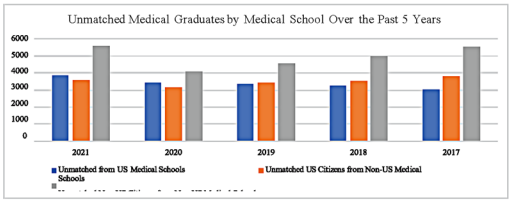
Total number of unmatched in the last 5 years	
Unmatched from US Medical Schools	16865
Unmatched US Citizens from Non-US Medical Schools	17456
Unmatched Non-US Citizens from Non-US Medical Schools	24715
	59036

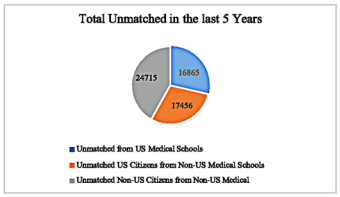
*Unmatched from US Medical School= Seniors and Prior graduates of US allopathic and osteopathic schools
*Active= Submitted a rank order list to the National Residency Matching Program
*Non-active = Couldn't submit a rank list due to no interviews

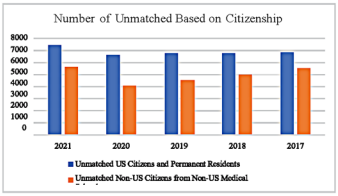
Number Unmatched	2021	2020	2019	2018	2017	2016	2015
Unmatched from US Medical Schools	3855	3401	3346	3241	3022	3012	3024
Unmatched US Citizens from Non-US Medical Schools	3554	3169	3438	3517	3778	3845	3566
Unmatched Non-US Citizens from Non-US Medical Schools	5613	4054	4542	4971	5535	5560	5521

Number Unmatched	2021	2020	2019	2018	2017	2016	2015
Unmatched US Citizens and Permanent Residents	7409	6570	6784	6758	6800	6857	6590
Unmatched Non-US Citizens from Non-US Medical Schools	5613	4054	4542	4971	5535	5560	5521

Table 2
Source: NRMP







Footnotes:

[1] National Residency Matching Program data, Advance Data Tables, 2021 Main Residency Match https://www.nrmp.org/wp-content/uploads/2021/08/Advance-Data-Tables-2021_Final.pdf

[2] The American Academy of Family Physicians Results for Family Medicine 2021 https://www.aafp.org/dam/AAFP/documents/medical_education_residency/the_match/2021-Match-Results-for-Family-Medicine.pdf

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CONGRESSWOMAN SHEILA JACKSON LEE OF TEXAS

BEFORE THE COMMITTEE ON THE JUDICIARY SUBCOMMITTEE ON IMMIGRATION AND CITIZENSHIP

ZOOM VIRTUAL HEARING STATEMENT "IS THERE A DOCTOR IN THE HOUSE? THE ROLE OF IMMIGRANT PHYSICIANS IN THE U.S. HEALTHCARE SYSTEM"

TUESDAY, FEBRUARY 15, 2022
2:00 P.M. (EST)
CISCO WEBEX

- Thank you, Chairwoman Lofgren and Ranking Member McClintock, for convening this hearing on the "Role of Immigrant Physicians in the U.S. Healthcare System."

- Let me welcome our witness:

Majority Witnesses

1. David J. Skorton, M.D., *President and CEO*

Association of American Medical Colleges (AAMC)

2. Raghuveer Kura, M.D., FASN, FNKF
   Interventional Nephrologist, Poplar Bluff Regional Medical Center

3. Kristen Harris, Esq.
   Harris Immigration Law, LLC

Minority Witness

4. Kevin Lynn,
   Co-Founder of Doctors Without Jobs
   Executive Director of Progressives for Immigration Reform

- Thank you for your participation and I look forward to hearing your perspective on the role of immigrant physicians in providing general and specialized health care in the United States and on how our current immigration laws impact recruitment and retention of physicians.

- Madam Chairwoman, on Day One of the Biden Administration, the President released his vision for immigration reform, which unlike the cruel and mean-spirited policies of his predecessor, does call for separating children from their parents or putting babies in cages or diverting money from military families to build a wall to deter imaginary caravans of bad hombres.

- Instead, the President's U.S. Citizenship Act of 2021 includes a path to citizenship for the 11 million undocumented individuals in the United States, reforms to the family- and employment-based immigration systems, and provisions to facilitate immigrant integration, protect workers from exploitation and to improve border technology and infrastructure.

- Ensuring a path to earned citizenship is a non-negotiable principle for me and the *sine qua non* of meaningful immigration reform legislation.

- Indeed, providing a path to earned access to citizenship has been a central feature of every comprehensive immigration reform bill I

have co-sponsored or sponsored in the Congress since 2007 when I served as Ranking Member of this Subcommittee on Immigration and introduced the *"Save America Comprehensive Immigration Reform Act, (H.R. 1525),"* which I reintroduced in each succeeding Congress.

- Passing comprehensive and humane immigration reform is long overdue and would have a positive, life-changing impact on the nation's healthcare system.

- Communities in the United States have long struggled to access high quality healthcare as a result of a lack of available physicians.

- According to the U.S. Department of Health and Human Services, there are 7,613 Primary Health Professional Shortage Areas (HPSAs) in the United States, comprising a population of over 86,000,000 people – roughly 26 percent of the United States population.

- This physician shortage has had a disproportionate impact on rural and medically underserved areas.

- This physician shortage would be markedly worse were it not for immigrants having long comprised a large percentage of the physician workforce.

- Foreign nationals make up approximately 25 percent of the population of those who have obtained graduate medical education in the United States, meaning that there are approximately 200,000 foreign medical graduates currently working as physicians in the United States.

- Because of our antiquated immigration laws, the demand of the healthcare system for more physicians far outstrips the available supply, harming all consumers and patients but especially those residing in rural or economically disadvantaged areas.

- The United States has struggled to recruit physicians to rural and medically underserved areas for many years, as the number of

medical students from rural areas has declined and the cost of medical school has increased.

- The Association of American Medical Colleges (AAMC) predicts that by 2034, the number of individuals in the United States who are over age 65 will grow by over 40 percent, while the current shortage of physicians could increase by as much as 625 percent.

- The coronavirus pandemic worsened such projections, as a myriad of physicians died from the virus, changed careers, or retired due to exhaustion and burn out.

- International medical graduates have been on the front lines—while they comprise 25 percent of practicing physicians in the United States, as of November 2020, they accounted for 45 percent of physician deaths due to COVID-19.

- Safety net hospitals—those hospitals that provide medical care regardless of the patient's ability to pay—in both rural and urban areas have been hit particularly hard by the pandemic, with financial problems leading to the closure of hospitals and the creation of health care deserts in some of the most medically underserved parts of the country.

- Congress created numerous provisions specifically dealing with immigration pathways for physicians, from nonimmigrant (temporary) training to permanent residency but has not updated the basic structure of these laws since the 1990's.

- The primary temporary visa pathways for physicians are the J-1 visa and the H-1B visa.

- Approximately 80 percent of foreign medical graduates undergo their residency and/or fellowship training in J-1 status, which is a nonimmigrant status that allows foreign nationals who demonstrate nonimmigrant intent to temporarily come to the United States for training or other purposes.

- Under current law, J-1 medical trainees must return to their home country for a minimum of two years following the completion of

their training program.

- Physicians may obtain a waiver of the J-1 requirement to return home for two years (a "J-1 waiver") under certain conditions designed to encourage such physicians to work in rural and medically underserved areas.

- Physicians can pursue this type of J-1 waiver through either an Interested Government Agency ("IGA"), or through a state department of health participating in the Conrad State 30 waiver program ("Conrad Waiver"), which Congress enacted in 1994 with the Conrad State Waiver program, allowing each state or territory to seek up to 20 physicians to work in underserved areas; this number was increased to 30 in 2003.

- The other type of non-immigrant visa is the H-1B visa, which entities seeking to hire physicians to work in the United States temporarily generally use to petition for such workers.

- The H-1B visa is available to foreign nationals who will work in a "specialty occupation," a position that requires the "theoretical and practical application of a body of highly specialized knowledge" and the attainment of at least a bachelor's degree, or the equivalent, in the specific specialty.

- There are 65,000 H-1B visas available each year, with an additional 20,000 available to individuals who obtained a master's degree or higher from a U.S. institution of higher education.

- The number of available visa is dwarfed by the number of requests to sponsor H-1B workers (308,613 in 2021) received by U.S. Citizenship and Immigration Services requests from 37,000 prospective employers.

- Entities seeking to hire physicians to remain permanently in the United States may sponsor them for lawful permanent resident (LPR) status, also known as an "immigrant visa" or a "green card."

- While there is a dedicated program solely for physicians, it is limited to physicians working in shortage areas and veteran's facilities.

- As such, physicians often attempt to utilize the standard green card pathways available to high skilled immigrants.

- Each fiscal year, a maximum of 140,000 immigrant visas may be issued to employment-based (EB) immigrants.

- In addition, INA § 202(a) limits the number of visas that can be made available each fiscal year to natives of any single foreign state or dependent area to 7 percent and 2 percent, respectively.

- Employment-based visas are allocated in accordance with the following "preference categories":

    1. EB-1—Priority Workers: 40,040
        - Extraordinary Ability Aliens
        - Outstanding Professors and Researchers
        - Multinational Executives and Managers

    2. EB-2—Advanced Degree Professionals, Exceptional Ability Aliens: 40,040
    3. EB-3—Skilled Workers, Professionals, Other Workers: 40,040
    4. EB-4—Special Immigrants: 9,940
    5. EB-5—Employment Creation: 9,940

- While physicians are eligible for a variety of visa categories available to only the highest skilled and most valuable individuals, the two most common paths to permanent residency for physicians are through the PERM Labor Certification process ("PERM") or the Physician National Interest Waiver petition (PNIW), both of which fall within the EB-2 category.

- The PERM process starts with the employer filing an application for permanent labor certification through the Department of Labor's PERM system.

- During the labor certification process, the employer tests the labor market by recruiting for the position that the foreign national would otherwise fill.

- If the employer cannot identify a U.S. worker who is qualified, willing, and able to fill the position, the labor certification can be certified and the employer can proceed to the next step—filing a Form I-140 immigrant visa petition (green card application) with USCIS.23

- As another incentive to encourage physicians to work in medically underserved areas, Congress created the PNIW in 1999.

- The PNIW waives the labor certification requirement and allows physicians to self-sponsor for permanent residency.

- With a PNIW, the physician must agree to work for a minimum of 40 hours per week in a medically underserved area for a total of five years, inclusive of the three year J-1 waiver commitment (if applicable).

- To obtain a PNIW, the IGA or state health agency that oversees the state in which the physician will work must agree that the physician's work is in the national interest.

- Madam Chair, an estimated 1 million foreign workers and their family members have an approved employment-based petition and are waiting for a numerically limited immigrant visa.

- About 16,000 of those waiting are physicians.

- As a result of the per-country limitations, this backlog disproportionately impacts countries with higher populations and thus, higher demand for immigrant visas—particularly India and China.

- Without changes, the EB-2 backlog will more than double in size by FY 2031.

- The population of the United States is aging – increasing demand for high quality medical care.

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patients 65 and up, but by 2034, that population will demand 42 percent of physicians.

- Madam Chairwoman, the population of the United States is aging – increasing demand for high quality medical care.

- Presently, 34 percent of the demand for physicians comes from patients 65 and up, but by 2034, that population will demand 42 percent of physicians.

- With foreign physicians serving as the majority of geriatric physicians in this country, recruitment and retention of such physicians is now more important than ever.

- This is particularly true in rural areas, which have higher rates of death, disability, and chronic disease, in part due to a lack of access to physicians.

- If people living in rural and medically underserved areas sought medical care at the same rate of those who do not have barriers to their ability to access healthcare, those areas would need an additional 102,400 to 180,400 physicians to meet demand.

- Additionally, a large number of physicians are nearing retirement age – over two of every five physicians in the United States will be 65 or older within the next ten years.

- Finally, the ongoing COVID-19 pandemic is likely to accelerate physicians' retirement timelines, exacerbating this problem, as the prevalence of long-COVID as well as the after-effects of delayed medical procedures and check-ins may have an outsized impact on the future demand for health care in the United States.

- I look forward to discussing these important issues with our witnesses.

- Thank you. I yield back my time.