Featured Article
Immigration Options for Hiring International Physicians

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The facts are staggering. America’s physician population is aging, doctors fed up with increasing bureaucracy and liability fears are retiring early, 79 million baby boomers are heading for retirement and the country has opened just one new medical school in two decades. Add to this the fact that the U.S. population has grown by more than 30 million in those two decades and that there have been significant advances in health care treatments in recent years and you have a “perfect storm” for a massive physician shortage.

The statistics are starting to back up the fears. According to the Health Policy Institute, in 15 years the U.S. will have a physician shortage of 200,000 doctors. And the American Medical Association has recently recognized the shortage and called for Congressional action.\(^1\)

More than 30 percent of the doctors training in the U.S. today are international medical graduates (IMGs). A large number of them leave the U.S. when their programs are over, but as the demand for their services increases, more and more employers are interested in keeping them in the U.S. Recent changes in immigration law have facilitated this trend by making it considerably easier for employers to sponsor them for visas.

While the majority of these physicians come to the U.S. on visas that require them to leave the country upon completion of their residencies and fellowships, many U.S. employers take advantage of government sponsored waiver programs that allow these physicians to avoid this requirement and remain in the U.S. to work. And an increasing number of physicians in training in the U.S. are on H-1B visas and can work in positions that do not require service in underserved communities.

**IMG Myths**

Health care recruiters, practices and facilities have been slow to embrace international medical graduates over the years, but the justifications for reluctance are now largely dated or based on incorrect assumptions.

Some have questioned whether IMGs are as qualified as American doctors. But, as noted above, all IMGs train side by side with their American colleagues and must meet the same state licensing requirements. Furthermore, while all American medical school graduates land spots in training programs, U.S. training programs will only consider the very top graduates of foreign medical schools. It is not surprising that America’s top research hospitals have a disproportionate number of IMGs on their faculties given the global talent we attract for graduate medical education.

Others have questioned the communication skills of IMGs. This was a genuine problem in the past, but it is one that has largely disappeared as a result of the addition of a new exam in 1998 that puts the doctor through a series of interactions with actors portraying patients. If physicians are not clearly understandable, they do not pass. In the first year following the exam’s introduction, there was a 25 percent drop in approvals. But the numbers have risen in the years since, largely because physicians are focusing a lot more on developing these skills before coming to the U.S.

In the past, it was difficult to sponsor specialists to remain in the U.S. But in 2004, President Bush signed legislation that made it clear that specialists could be sponsored to remain in the U.S. alongside primary care doctors.\(^2\)
Many people assume that foreign physicians can only be recruited to work in underserved areas. And while most physicians will need to spend some time working in an underserved area on the path to becoming a citizen, an increasingly larger portion are coming on visas that do not have such a requirement or are able to stay based on serving populations that live in underserved areas even if they do not actually work in the underserved areas.

J-1 Visas and the Home Residency Requirement

About two-thirds of foreign-born physicians coming to train in the U.S. typically enter on what is known as a “J-1” visa. This type of visa usually requires that once a physician completes his or her medical training, he or she must return to his or her home country for two years before he or she is eligible to apply for a work visa or green card. The home residency requirement may be waived if the physician can demonstrate that the physician’s departure from the U.S. would cause an extreme hardship to a U.S. citizen or permanent resident spouse or child, that the physician would face persecution in his or her home country, or if a government agency vouches that it would be in the public interest for the physician to remain in the U.S. The last category, the Interested Government Agency (IGA) waiver, is the type most commonly used by J-1 physicians who wish to stay in the U.S. after completing their training. For purposes of a J-1 physician, an IGA can be any U.S. government entity or state health department that is willing to write a letter stating that it is in the public interest for the physician to remain in the U.S. All state health departments offer J-1 waiver programs that permit sponsorship of 30 physicians per year.

General Waiver Program Requirements

Federal waiver programs are also available. The major ones are administered by the U.S. Department of Health and Human Services (HHS), the Appalachian Regional Commission, the U.S. Department of Veterans Affairs (VA) and the Delta Regional Authority. With the exception of the VA, all of the waiver programs require a participating physician to work in a geographic area recognized by HHS as being “medically underserved.” In other words, the facility in which the physician works must be located within one of these HHS designated areas.

HHS designates underserved areas in two databases: one for health professional shortage areas (HPSAs) and the other for medically underserved areas (MUAs). A geographic area is designated as a HPSA based upon the ratio of primary care physicians to the local population. If the primary care physician to population ratio is less than one to 3,000, and if certain other factors are present, the area is designated as a HPSA. As HPSA designations change with population flows, areas are frequently re-designated over time. Different ratios may also be used if an area has a low average income or other for other special considerations. An area is designated as an MUA based upon an “index” of medical underservice. The index involves certain variables beyond the ratio of physicians to population, including infant mortality, poverty level, and age of the population. An Interested Government Agency can require that a physician practice at a facility located within an area that is designated as a HPSA, an MUA, or both.

Federal Law now permits state health agencies to designate five of their thirty physicians a year for “flexibility slots.” Flexibility slots are available for positions not in shortage areas but where physicians treat patients coming from shortage areas. Federal law also requires physicians to work 40 hours per week in a shortage area and sponsors must demonstrate that a facility or employer has been unsuccessfully recruiting to find an American physician. Finally, federal law requires as a condition of a waiver that a physician work three years in the underserved area.

Appalachian Regional Commission

The Appalachian Regional Commission (ARC) is a joint federal-state program dedicated to improving the quality of life for people living in the Appalachia region of the U.S. To obtain a waiver from ARC, the waiver request must be co-sponsored by a state within the ARC region (covering parts of Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina,
Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia) and must include a written recommendation by the governor of the state.

ARC requires the physician requesting a waiver to agree to provide primary medical care for three years and for at least 40 hours per week at a Medicare and Medicaid certified hospital or primary health care clinic that (1) accepts medically indigent patients, (2) is located within an area designated as a HPSA and (3) is within a state within ARC. Additionally, the facility must have attempted to recruit a U.S. physician for the position within the six months preceding the waiver request. The physician must be licensed by the state where he or she will practice, and must have completed a residency in family practice, general pediatrics, obstetrics, general internal medicine, psychiatry, or general surgery.

Each of the 12 ARC states may have its own rules that supplement the ARC requirements. An individual state’s rules can include variations of the definition of “primary care,” preclusion of sponsorship for physicians with fellowship training, restrictions on the nature of the employer and acceptance of indigent patients, site pre-approval, state affidavits of compliance, and periodic reporting to state authorities.

Delta Regional Authority

The Delta Regional Authority (DRA) is another joint federal-state program that serves a 240-county/parish area in an eight state region, comprising parts of Mississippi, Louisiana, Alabama, Arkansas, Tennessee, Kentucky, Missouri, and Illinois. The DRA program is available to both primary care and specialist physicians.

The facility at which the physician will work must be located within a HPSA or MUA within the DRA’s jurisdiction, and the facility must have made efforts to recruit a U.S. physician within the six months preceding the waiver request. The physician must agree to provide primary medical care for three years and for at least 40 hours a week at a Medicare and Medicaid certified hospital or primary health care clinic that also accepts medically indigent patients. Additionally, the physician must be eligible to be licensed by the state where he or she will practice.

Department of Veterans Affairs

The VA will sponsor a foreign medical graduate only when it is clearly within the interest of the agency and its programs. The VA will approve a waiver only if the loss of the physician’s services would necessitate a discontinuance of a VA program or a major phase of a program, and if the VA’s recruitment efforts have failed to produce a qualified U.S. physician. The VA facility that would benefit from the physician’s work sends a waiver request to the appropriate VA Regional Director, detailing the physician’s qualifications, necessity, and documenting U.S. physician recruiting efforts. The VA waiver program does not require that positions be in a medically underserved area.

Conrad State 30 Programs

Since 1994, state health departments have been able to act as an IGA to sponsor waivers of the two-year residence requirement for J-1 physicians. In 2002, Congress extended the program and allowed each state to recommend up to 30 waivers a year. For this reason, this waiver program is also known as the “State 30” program.

While exact requirements vary from state program to state program, some elements are the same for each state. The State 30 regulations require the physician’s employment location to be in a HPSA or MUA, and the contract must be for a minimum of three years at forty hours per week. States are free to define the term “primary care,” to determine the acceptability of subspecialties, to include additional contract terms, and to determine the level and type of prior recruitment required. Most states will now sponsor specialists in addition to primary care physicians.
Recent Congressional action allows each state to have the flexibility to use five waivers per year for applicants taking jobs outside of a HPSA or MUA if the state can demonstrate that the physician will actually be serving people who live in shortage areas. Several states have now begun accepting such applications.

**H-1B Visas for Residents and Fellows**

In recent years, an increasingly large number of graduate medical trainees have been entering on H-1B visas rather than J-1 visas. The key benefit to entering on this status is that a physician need not work in an HHS-designated shortage area in order to remain in the U.S. after completing his or her programs.

There are a few drawbacks to the H1-B visa category. For one, physicians must have completed USMLE Step 3 before entering the U.S. rather than completing that part in the U.S. after starting a training program. Second, while physicians are generally exempt from a tight quota in the H-1B category while they are in training, they are usually subject to the H-1B cap when they get their first job after training. In 2007, for example, the quota for H-1B visas was so oversubscribed that United States Citizenship and Immigration Services had received more than twice as many applications as visa numbers available within a few hours of the quota opening for the entire year. Even if a doctor was lucky enough to get a visa, it was hard for him or her to avoid a gap of several months between the end of the training program and the start date on his or her visa. J-1 doctors going to work in underserved areas are generally exempt from such quotas.

**Conclusion**

Given the fact that more than a quarter of the physicians in training in the U.S. are IMGs and given the extremely strong job outlook for American physicians, employers will likely find recruiting American physicians to be a tougher challenge than in past years and will have to consider IMG doctors.

Greg Siskind is a founding partner of Siskind Susser Bland, one of the nation’s largest immigration practices. He writes several books including the annually published J-1 Visa Guidebook and the American Bar Association’s Lawyers Guide to Marketing on the Internet. In 1994, he created www.visalaw.com, the first and one of the most popular immigration law firm websites in the world. He also blogs on health care immigration at www.visalaw.com/IMG/resources.html. Greg was the first immigration lawyer ever photographed for the cover of the ABA Journal and was recently named by Chambers as one of the country’s top 25 immigration lawyers.


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4 See id.