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THE ROLE OF INTERNATIONAL MEDICAL GRADUATES IN THE U.S. PHYSICIAN WORKFORCE

American College of Physicians
A Policy Monograph
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A Policy Monograph of the
American College of Physicians

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Executive Summary

International medical graduates (IMGs) serve an integral role in the delivery of health care in the United States. IMGs contribute helpful and necessary diversity to the physician workforce and help to care for an increasingly diverse patient population. IMGs also provide health care for underserved populations and are often more willing than their U.S. medical graduate (USMG) counterparts to practice in remote, rural areas. IMGs serve an indispensable role in providing primary care in many communities.

While the number of USMGs choosing to train in general internal medicine and family medicine has steadily declined, IMGs are prepared to fill these slots (1). In 2007, only 56% of the 98% filled internal medicine residency positions and only 42% of the 88% filled family medicine residency positions were filled by U.S. medical school seniors (2). Most of the remaining positions were filled by IMGs.

The American College of Physicians (ACP), the nation's largest specialty society, represents 126,000 internal medicine physicians (internists) and medical students. Our membership includes physicians, nearly 30% of whom are IMGs, who provide comprehensive primary and subspecialty care to tens of millions of patients. The College has long recognized the value of IMGs and their contributions to health care delivery in this country. More IMGs choose internal medicine than any other specialty. This policy monograph discusses the role of IMGs in the U.S. health care system, addresses the impact of physician migration, and offers recommendations to improve conditions for IMGs seeking training and practice opportunities in the United States. It also discusses the steps the nation can take to help less-developed countries improve education, training, and health care.

Recommendations of the American College of Physicians:

1. ACP recognizes the potential for "brain drain" from less-developed countries, but opposes enactment of measures that would prevent international medical graduates—who otherwise meet all U.S. immigration requirements for admittance and residency in the United States—from emigrating to the United States.
2. ACP supports streamlining the process for obtaining J-1 and H1B visas for non-U.S. citizen international medical graduates who desire postgraduate medical training and/or medical practice in the United States.
3. ACP supports the expansion of J-1 visa waiver programs, such as Conrad 30, to help alleviate physician shortages in underserved urban and rural areas. This program should also be made permanent.
4. ACP supports the exemption of physicians trained in specialties that are facing shortages in the United States from the annual H-1B visa cap.
5. ACP supports Schedule A status for physicians trained in internal medicine and other specialties that are facing shortages in the United States. Schedule A status is a designation under federal law indicating that these physicians will not adversely affect the wages and working conditions of U.S. workers similarly employed and will exempt them from the annual immigration visa (green card) cap.
6. ACP encourages collaboration between medical schools and teaching hospitals in the United States and those in less-developed countries to improve medical education and training in those countries.

7. ACP supports the development of a Global Health Corps or other entity that would facilitate opportunities for physicians and other health care providers in the United States to serve in less-developed countries.

The United States has depended on IMGs to fill gaps in care in underserved areas since the 1970s, and will probably continue to do so for some time. Recent projections by the Council on Graduate Medical Education and others estimate that the United States is facing a significant physician workforce crisis (3). While ACP has not embraced the view that there will be an overall physician shortage, the College is extremely concerned about the looming crisis in the supply of primary care physicians, including general internists. The College feels strongly that the nation needs to create a comprehensive national health care workforce policy to guide the training, supply, and distribution of health care providers. This policy should address the contributions of IMGs in meeting current needs and include them in estimating how the anticipated needs of the patient population will be met (4).

While some have called for an overall increase in medical school class size and the establishment of new medical schools (5), these efforts will take several years to affect the supply of physicians, and will do little to alleviate the shortage of primary care physicians unless they are accompanied by a corresponding increase in the number of residency positions in internal medicine, family medicine, and pediatrics. In fact, without an increase in residency positions, IMGs may be forced out of the U.S. health care system as more U.S. medical graduates will probably fill residency positions once filled by IMGs, leading to a less culturally diverse physician population.

The American College of Physicians is on a mission to fundamentally change health care delivery in the United States (6). The College strongly believes that a system organized around the relationship between primary care physicians and patients is essential to improving health care quality and efficiency in this nation and is especially concerned that the supply of well-trained general internists to meet the nation's growing health care needs will be inadequate. The College has made a series of proposals to improve the practice and payment environment for internists and has proposed steps to improve the future of internal medicine (7, 8). This policy monograph focuses on the important role of IMGs as part of the internal medicine workforce in the United States.

Background

International Medical Graduates in the United States

An International Medical Graduate is an individual who has graduated from a medical school outside of the United States or Canada. An IMG must have had at least four credit years in attendance at a medical school that is listed in the International Medical Education Directory (IMED) of the Foundation for Advancement of International Medical Education and Research (FAIMER). The Educational Commission for Foreign Medical Graduates (ECFMG) assesses the readiness of IMGs to enter residency or fellowship programs in the United States that are accredited by the Accreditation Council for Graduate Medical Education (ACGME) through its program of certification.

IMGs account for almost one quarter of the nation's active physicians. Eighty percent of IMGs are involved in patient care and 16% are involved in academics. Thirty percent of IMGs are internists, representing 36% of total physicians in internal medicine. IMGs are most heavily concentrated in New York, California, Florida, New Jersey, and Illinois. The top five countries of medical education for IMG physicians are India, Philippines, Mexico, Pakistan, and the Dominican Republic (9).

Visa and Immigration Options for International Medical Graduates

IMGs who seek entry into U.S. Graduate Medical Education (GME) programs must obtain a visa that permits clinical training to provide medical services. Most IMGs who are not U.S. citizens or permanent residents enter the U.S. on a J-1 Exchange Visitor visa or an H-1B visa.

J-1 Exchange Visitor Program

The most common visa used to participate in U.S. graduate medical education programs is the J-1 visa, sponsored by the Educational Commission on Foreign Medical Graduates. An IMG may apply for a J-1 visa after passing Step 1 and Step 2 of the United States Medical Licensing Examination (USMLE), obtaining a valid ECFMG Certificate at the time they begin training, holding a contract or an official letter of offer for a position in an accredited program of graduate medical education or training that is affiliated with a medical school, and providing a statement of need from the Ministry of Health of the country of last legal permanent residence. Upon completion of training, an IMG must either return to his or her home country for a period of 2 years or obtain a waiver of this obligation before being eligible to return to the United States. In academic year 2004-2005, more than 6100 IMGs with J-1 visas participated in U.S. graduate medical education programs (10).

Under some circumstances, the 2-year home residence requirement of the J-1 visa program can be waived. Rarely, the 2-year residency requirement is waived if the applicant can demonstrate that he or she will be persecuted in his or her home country or if fulfillment of the residency requirement would bring significant hardship to the applicant's spouse and/or children who are U.S. citizens or permanent residents. More commonly, applicants find an Interested Governmental Agency (IGA) to sponsor their waiver in exchange for agreeing to practice in an underserved area for at least 3 years.

State departments of public health have become the primary source of J-1 visa waivers through the Conrad-30 Program, which allows sponsorship of up to 30 J-1 visa waivers per year. In 2005, these waivers accounted for more than 90% of J-1 visa waiver requests (10). Other agencies that sponsor J-1 visa waivers include the Appalachian Regional Commission (ARC), Delta Regional Authority (DRA), Department of Health and Human Services (DHHS), and Department of Veterans Affairs (VA). The U.S. Department of Agriculture (USDA) previously sponsored waivers for physicians who agreed to serve in a rural Health Professions Shortage Area (HPSA), but terminated its involvement in sponsoring waivers in 2002 citing difficulty in addressing security considerations after the events of September 11, 2001.

Temporary Worker H-1B

The H-1B visa is for temporary workers in specialty occupations holding professional-level degrees, including graduates of foreign medical schools. Unlike the J-1 visa, the H-1B visa does not have a 2-year home residence requirement and allows a foreign national to remain in the United States for professional-level employment for up to 6 years.

The current annual cap on the H-1B category is 65,000, with an additional 20,000 H-1B visas for foreign workers with a Master's or higher level degree from a U.S. academic institution. Obtaining an H-1B visa has become increasingly difficult as the number of applicants in this category has increased considerably. In addition, the number of visas granted to computer-related occupations is significantly higher than those granted to medical occupations. For example, in fiscal year 2005, 45.3% of H-1B visas were granted to computer-related occupations, while 6.2% were awarded to occupations in medicine and health (11).

In April 2007, the U.S. Citizenship and Immigration Services (USCIS) announced that it had received over 150,000 H-1B petitions for fiscal year 2008 within the first 2 days of the petition acceptance period, closed the petition period early, and used a random selection process to fill the 65,000 slots (12). This was distressing to many IMGs who had secured positions in the United States as some were unable to submit petitions within the first 2 days of the petition period, and those who had were forced to rely on the computer-generated random selection process.

Immigrant Visas

IMGs may qualify for an immigrant visa (also known as a green card), which permits a foreign citizen to remain permanently in the United States if they are an immediate relative of a U.S. citizen or lawful permanent resident, an employee of a sponsoring employer or prospective employer, or a "diversity immigrant" under a visa lottery program.

Legislation to Exempt International Medical Graduates from H-1B Visa Cap

The Securing Knowledge, Innovation, and Leadership (SKIL) Act of 2007 (S. 1083/H.R. 1930) was introduced by Senator John Cornyn (TX) and Representative John B. Shadegg (AZ) in April 2007. The legislation would exempt from the annual H-1B (specialty occupation) visa cap professionals who have 1) earned a master's or higher degree from an accredited U.S. university; or 2) been awarded a medical specialty certification based on postdoctoral training and experience in the United States. It would also increase the annual H-1B cap, with a 20% increase for the following year if the previous year's quota is reached.

The legislation would also exempt from worldwide immigration caps professionals who 1) have earned a master's or higher degree from an accredited U.S. university; 2) have been awarded medical specialty certification based on postdoctoral training and experience in the United States; 3) will work in shortage occupations; 4) or have earned a master's degree or higher in science, technology, engineering, or math and have been working in a related field in the United States during the 3-year period preceding his or her immigrant visa application.

Contributions of International Medical Graduates

IMGs are an important source of primary care physicians in rural and underserved areas. About one quarter of community health centers rely on IMGs to fill physician vacancies (13). It has also been estimated that if all IMGs currently in primary care practice were removed, "one out of every five 'adequately served' nonmetropolitan counties would become underserved and the percentage of rural counties with physician shortages would rise to 44.4%" (14).

Critical access hospitals (CAH) in the United States rely heavily on IMGs, 60% of whom are internists. Over 50% of the nation's CAHs have or have had at least one IMG on the medical staff. IMGs make up more than half of the medical staff at 16% of CAHs. In addition, 62% of CAHs located in "persistent poverty" rural counties rely on one or more IMGs compared with 42% of rural counties that do not have a "persistent poverty" classification (15).

A study in New York State revealed that the percentage of J-1 visa waiver IMGs planning to practice in shortage areas was triple that of U.S. medical graduates (16). While there is some debate about how long IMGs actually stay in underserved areas, new IMGs often serve in underserved communities for at least 3 years while they fulfill various visa-waiver program requirements. Many leave after their service commitment, but that is consistent with USMGs who participate in the National Health Service Corps. J-1 visa waiver physicians are currently providing care to over 4 million people living in underserved areas of rural America (17).

Given the overall disparity in the racial and ethnic makeup of the physician population relative to the U.S. population, IMGs can help to alleviate cultural and language barriers in a multiethnic and increasingly diverse population. In general, foreign-born IMGs are attracted to areas of the country where the ethnic composition of the population matches their own ethnicity, suggesting an opportunity to increase access to care for underserved minorities. IMGs from Hispanic countries are significantly more likely to practice in areas with high proportions of Hispanics than in areas with low proportions of Hispanics. Asian IMGs are also attracted to areas with high proportions of Asians (18).

Impact of Medical Migration

There has been significant debate about the negative impact of medical migration or "brain drain." According to the World Health Organization (WHO), workers tend to go where the working conditions are best. While income is an important motivation for migration, other reasons include better working conditions, more job satisfaction, and better career opportunities. In some countries, women are not encouraged or allowed to become physicians, so migration is their only choice. Other considerations include security risks and poor HIV treatment and prevention resources for health workers. In addition, many countries do not have the facilities or technology at home to allow physicians to apply the training they receive in the United States.

Nonetheless, 57 countries, mostly in Africa and Asia, face a severe health workforce crisis. The WHO estimates that approximately 2.3 million health service providers and 1.9 million management support workers are needed to fill the gap. Sub-Saharan Africa faces the greatest health workforce challenges. Although it has 11% of the world's population and 24% of the global burden of disease, it has only 3% of the world's health workers (19). When considerable numbers of health professionals leave these countries, the loss of the workers to a wealthier country in light of the cost of their education has a significant financial impact. At the other end of the spectrum, many countries, including Russia, the Caribbean, India, and Philippines, have for-profit schools whose sole purpose is to train doctors for emigration around the world. These schools not only attract local students but a large number of international students. The rapid growth of medical schools in India, particularly private for-profit schools, is testament to the high interest in emigration (23).

Some have cited the remittance (the money that migrants earn working abroad that they send back to their home country) and the increased opportunities for clinical and educational collaboration that are established as a result of emigration as evidence of a "brain gain." In many countries, remittance is a crucial source of foreign exchange. In 2004, global remittances to developing countries reached \$160 billion, almost equal to foreign direct investment flows to developing countries in the same year, estimated at \$166 billion (20). In fact, in Mexico annual remittances have reached \$20 billion annually, and are second only to petroleum as a generator of national wealth (21). A study focusing on physicians from the Philippines practicing overseas estimated that remittances were large enough to compensate for the economic losses associated with their emigration (22). A 2006 article in *Globalization and Health* postured that Malawi could also benefit from the export of health professionals provided the state could be compensated for the cost of training health professionals who have emigrated (21).

Many global workforce experts believe that countries that recruit the most IMGs—the United States, Canada, United Kingdom, and Australia—have long-standing patterns of underinvestment in medical education, and advocate for these countries to become more self-sufficient by adopting education policies with a goal of training a physician workforce close to the size of the demand for physicians in practice in their countries (23). While self-sufficiency is ideal, and the United States must take steps to increase the number of U.S. medical graduates, it can also be argued that in a global economy, there must be freedom of movement among workers, especially for highly trained professionals. However, in some cases, particularly in sub-Saharan Africa, migration of physicians can have a significant negative impact on health care delivery and access. The College cautions that the nation should not rely on IMGs alone to solve the shortage of physicians in the United States and that balance must be achieved between respecting the freedom of IMGs to migrate and fulfilling the needs of both home and host countries.

Legislation That Addresses "Brain Drain"

The Global Health Corps Act of 2005 was introduced by Senator Bill Frist in the 109th Congress. It has not been reintroduced in the 110th Congress. The legislation would establish an Office of the Global Health Corp within the Department of Health and Human Services to assist in improving the health, welfare, and development of communities in foreign countries and regions through provision of health care personnel, items, and related services.

The purpose of the Global Health Corps is to 1) improve the health, welfare, and development of communities in select foreign countries and regions; 2) advance U.S. public diplomacy in such locations; and 3) provide individuals in the United States with the opportunity to serve such communities by providing a broad range of needed health care and related services.

The African Health Capacity Investment Act of 2007 (H.R. 3812/S. 805) was introduced by Representative Barbara Lee and Senator Richard Durbin in October 2007. The legislation would assist countries in sub-Saharan Africa in the effort to achieve internationally recognized goals in the treatment and prevention of HIV/AIDS and other major diseases and the reduction of maternal and child mortality by improving human health care capacity and improving retention of medical health professionals in sub-Saharan Africa.

Recommendations of the ACP

- 1. ACP recognizes the potential for "brain drain" from less-developed countries, but opposes enactment of measures that would prevent international medical graduates—who otherwise meet all U.S. immigration requirements for admittance and residency in the United States—from emigrating to the United States.**

Developed nations have a responsibility to address issues of "brain drain" by providing resources to less-developed countries so that they can educate, train, and retain medical personnel and ensure adequate health care delivery to their citizens. However, just like any other profession in the world, physician migration should be seen as a part of the broader global migration of skilled labor, and IMGs should not be prevented from migrating as long as there are opportunities for training and/or practice in other countries. In fact, the annual number of IMGs admitted to the United States for residency training can serve as an important national workforce safety valve that would allow relatively rapid expansion of the number of IMGs admitted during times of U.S. physician shortages and contraction of the supply during times of surplus. However, the College cautions that the nation should not rely on IMGs alone to solve the shortage of physicians in the United States.

An argument can also be made that home countries can benefit from IMG emigration through remittance, transfer of skills, and possible investment upon a migrant's return. For example, the information technology (IT) and engineering migrations that have occurred since the early 1960s have allowed for the big boom in the Internet and technology sectors. This boom eventually led to a global IT boom in developing countries, such as China and India.

2. ACP supports streamlining the process for obtaining J-1 and H1B visas for non-U.S. citizen international medical graduates who desire postgraduate medical training and/or medical practice in the United States.

The more stringent visa and security procedures implemented since September 11, 2001, have resulted in denials and delays of visas to many IMGs seeking to come to the U.S. for ECFMG certification and residency training (24). This disrupts residency programs, and program directors may avoid accepting IMGs for this reason. Internal medicine residency programs across the nation have faced situations in which a matched intern cannot start training due to unavailability or delays in procurement of H-1B visas (24).

In addition, numerous ACP members have shared their experiences of random selection for securing H-1B visas despite completion of training in the United States and compliance with visa restrictions. Every effort should be made to avoid unnecessary delays and uncertainty affecting the timely entry of IMGs who have been accepted to postgraduate training programs or offered positions to practice in the United States. At the same time, the United States has a legitimate public interest in conducting more careful reviews of applications for visas from foreign nationals who may pose a legitimate security threat based on specific and credible evidence, and IMGs cannot be automatically assumed, by virtue of being physicians, to be exempt from such scrutiny. The goal should be to reach an appropriate balance that does not subject IMGs to unnecessary delays in the absence of specific and credible evidence that they may pose a security threat to the United States.

3. ACP supports the expansion of J-1 visa waiver programs, such as Conrad 30, to help alleviate physician shortages in underserved urban and rural areas. This program should also be made permanent.

A 2006 Government Accountability Office (GAO) study revealed that J-1 visa waivers remain a major means of placing physicians in underserved areas of the United States. In fact, the number of physicians practicing in underserved areas through the use of J-1 visa waivers was roughly 1.5 times the number of physicians practicing through National Health Service Corps programs. Over half of these J-1 visa waiver physicians practiced internal medicine (10).

The Physicians for Underserved Areas Act (H.R. 4997), which was signed into law in December 2006, extended the Conrad 30 J-1 waiver program to June 1, 2008. No changes were made to the program, which allows states to sponsor up to 30 physicians per year to work in areas that are medically underserved. A 2006 GAO study revealed that one quarter of states requested the maximum of 30 waivers in 2005 and 13% indicated that this limit was inadequate. ACP supports the expansion of the Conrad 30 program and making the program permanent.

4. ACP supports the exemption of physicians trained in specialties that are facing shortages in the United States from the annual H-1B visa cap.

The H-1B visa was created for specialty occupations in categories of employment that have been determined to be in short supply. The information technology sector has sponsored a disproportionate number of H-1B visas over the past several years. There have been occasions when IMGs have secured

positions in the United States but have been unable to procure the necessary H-1B visa. Given the continuing shortage of physicians in medically underserved areas and that IMGs continue to be willing to fill these roles, every effort should be made to accommodate hospitals that have established a shortage of medical staff to receive H-1B visa designation by supplying these visas to eligible IMGs who have passed the necessary clearances and fulfilled the required criteria. Exemption of the annual H-1B visa cap for physicians trained in specialties facing shortages in the United States, including internal medicine, is one way to ensure that areas facing shortages are able to recruit physicians in a timely manner. The exemption of visa caps for physicians would also prevent IMGs from being subjected to the random selection process once they have secured positions.

5. ACP supports Schedule A status for physicians trained in internal medicine and other specialties that are facing shortages in the United States. Schedule A status is a designation under federal law indicating that these physicians will not adversely affect the wages and working conditions of U.S. workers similarly employed and will exempt them from the annual immigration visa (green card) cap.

Schedule A is a list of occupations for which the U.S. Department of Labor has determined that there is an insufficient number of U.S. workers who are able, willing, qualified, and available. Occupations included on Schedule A must establish that the employment of foreign workers in such occupations will not adversely affect the wages and working conditions of similarly employed U.S. workers. The advantage of being on Schedule A is that foreign workers can obtain an immigration visa without first having to go through the labor certification process. Currently, the only occupations that are explicitly listed on Schedule A are professional nurses and physical therapists. "Shortage-area specialist physician" had previously been listed on Schedule A, but was taken off the list in 1987 (25). Given the current physician workforce crisis, the College supports reinstating Schedule A status for general internal medicine and other medical specialties facing shortages.

6. ACP encourages collaboration between medical schools and teaching hospitals in the United States and those in less-developed countries to improve medical education and training in those countries.

Improving medical education in developing countries is essential to reversing brain drain. Initiatives, such as the University of California San Francisco's (UCSF) Global Health Sciences Program, which is in the process of building several training and research programs to assist developing countries, should serve as models for other academic centers. UCSF's Sandwich Certificate Program allows trainees who have completed the initial part of their medical training in their native country to come to UCSF for 1 to 2 years of advanced training and return home to receive their degrees. UCSF has also developed a program that offers short-term training for international scholars by providing faculty and advanced researchers in developing countries the opportunity to work with their UCSF counterparts in mastering new techniques and identifying potential collaborations (26).

Another valuable initiative is the International Fellowship in Medical Education Program developed by the Foundation for Advancement of International Medical Education and Research, a nonprofit foundation of the ECFMG. The fellowships are designed to provide medical faculty from abroad with educational opportunities tailored to their home country's needs. The maximum length of each fellowship is 1 year, ensuring that participants return to their home countries (27).

Through the Penn-Botswana Program, a partnership between the University of Pennsylvania School of Medicine and the Botswana government, Penn physicians have helped develop and implement the Botswana national HIV treatment and prevention programs and to assist in the training of local providers on the management of HIV infected patients. Penn is also now helping the University of Botswana to form a new medical school that will enroll its first undergraduate class in January 2008 (28).

7. ACP supports the development of a Global Health Corps or other entity that would facilitate opportunities for physicians and other health care providers in the United States to serve in less-developed countries.

American physicians have long volunteered to provide education, training, and care to those in less-developed countries through a variety of organizations. The College supports these activities, and many ACP members volunteer their time to such efforts annually. The creation of a government entity, such as the Global Health Corp proposed in legislation in the 109th Congress, that would fund and organize efforts to assist less-developed countries in improving health care would help enhance the efforts of volunteer physicians and other medical personnel and provide more opportunities for those interested in volunteering their services.

Conclusion

IMGs have made numerous contributions to the delivery of health care in the United States. They have and will continue to have a particularly important role in the internal medicine workforce. With an increasingly diverse ethnic and racial patient population in the United States, the physician population must become equally diverse in order to provide culturally competent care. IMGs contribute greatly to the diversity of the U.S. physician workforce. The College supports measures to improve conditions for those IMGs seeking to train and/or practice in the United States.

US and IMG Physician Population Overview

Number of Physician in US	902,053
Number of IMG Physicians	228,665 (from 127 countries)
% of IMG Physician in US	25.3%
% of IMG in Residency Programs	28.2%
% of IMGs in Primary Care	37.6%
% of USMGs in Primary Care	31.9%
% of IMGs in Patient Care	80.1%
% of IMG in Academics	16.2%

Source: Physicians Characteristics and Distribution in the U.S. 2007 edition; AMA, Chicago, IL. International Medical Graduates by Specialty*

Percentage of the IMG population within each specialty

Internal Medicine	36%	55,467
Anesthesiology	29%	11,757
Psychiatry	31.4%	13,080
Pediatrics	28%	20,180
Family Medicine	17.8%	21,669
Obstetrics/Gynecology	17.8%	7,589
Radiology	18.8%	1,53
General Surgery	20%	7,97

Source: Physicians Characteristics and Distribution in the U.S. 2007 edition; AMA, Chicago, IL.

•These data exclude residents and students

Top ten countries of medical education for IMG physicians

1	India	19.9%	47,581
2	Philippines	8.7%	20,861
3	Mexico	5.8%	13,929
4	Pakistan	4.8%	11,330
5	Dominican Republic	3.3%	7,892
6	Russia	2.5%	6,039
7	Grenada	2.4%	5,708
8	Egypt	2.2%	5,202
9	Korea	2.1%	4,982
10	Italy	2.1%	4,741

Source: 2007 AMA Masterfile

Top 20 US states IMGs practice - number of IMG practicing physicians in state
(% of state physician workforce)

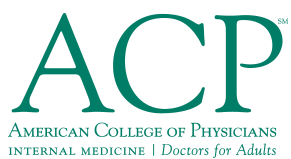
1	New York	34,455	41.9%
2	California	24,510	22.7%
3	Florida	18,861	36%
4	New Jersey	13,339	44.8%
5	Illinois	13,101	34%
6	Texas	12,729	23.8%
7	Pennsylvania	10,528	25.5%
8	Ohio	9,672	29%
9	Michigan	9,227	33.8%
10	Maryland	6,929	27.1%
11	Massachusetts	6,807	26.7%
12	Virginia	4,786	20.8%
13	Georgia	4,226	19%
14	Connecticut	4,104	28.8%
15	Indiana	3,081	20.6%
16	North Carolina	3,061	12.4%
17	Missouri	3,382	22%
18	Wisconsin	2,872	18.1%
19	Arizona	3,032	20.6%
20	Tennessee	2,827	16.3%

Source: Physicians Characteristics and Distribution in the U.S., 2007 edition. Chicago, IL.; AMA Press.

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