

HOD ACTION: Council on Medical Education Report 10 adopted as amended, and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 10-A-11

Subject: Integration of IMGs Into the US Physician Workforce
(Resolution 306-A-10; Resolution 903-I-10)

Presented by: Baretta R. Casey, MD, MPH, Chair

Referred to: Reference Committee C
(Robert J. Havlik, MD, Chair)

1 Resolution 306-A-10, introduced by the AMA International Medical Graduates (IMG) Section,
2 asked our AMA to encourage state medical licensing boards to accept certification by the
3 Educational Commission for Foreign Medical Graduates (ECFMG) as primary source verification
4 of medical education credentials, and to recognize that the ECFMG certification is the primary
5 source of medical education credentials for IMGs. Based on testimony at Reference Committee C,
6 which revolved around the complexity of the issues and the need to clarify the resolution's intent,
7 the HOD referred Resolution 306 for further study with a report back at the 2011 Annual Meeting.
8

9 Resolution 903-I-10, introduced by the AMA IMG Section, asked "That our AMA seek federal
10 legislation to create a pathway for J-1 visa waiver status for IMGs who are appointed as US
11 medical school faculty members and agree to serve in that capacity for a minimum of three years of
12 full-time employment." The question was raised as to whether the J-1 visa waiver is the
13 appropriate program to achieve this goal, and the resolution was referred.
14

15 Policy D-255.981 (AMA Policy Database), asked our AMA to continue to monitor issues for IMGs
16 in the US under H status visas who are not able to complete their residency/fellowship training
17 within the H-1's six-year time limit. The Policy also calls for a follow up report to the House of
18 Delegates no later than the 2012 Annual Meeting.
19

20 THE US PHYSICIAN WORKFORCE AND IMGs
21

22 Because of the many contributions of IMGs to the US physician workforce, it is important to frame
23 these items in the context of the current and growing shortage of physicians in many states and
24 specialties/subspecialties. IMGs represent 25 percent of the physician population and in several
25 states provide more than 33% percent of health care services. IMGs also account for 27 percent of
26 the resident and fellow physicians in the US. Furthermore, IMGs play a critical role in filling gaps
27 in the US physician workforce. For example, they comprise more than 30 percent of the primary
28 care workforce in the US.
29

30 The Association of American Medical Colleges' (AAMC) Center for Workforce Studies estimates
31 that the US will face a shortage of 124,000 to 159,000 physicians by 2025. A shortage of this
32 magnitude would affect those in vulnerable and underserved populations, which includes the 20
33 percent of Americans who live in a health professional shortage area.

1 Further, the pace of the shortfall has been escalating over the past decade, with reports of current
2 physician workforce shortages since 2000 from at least 22 states, with five additional states having
3 predicted future shortages. Twenty-two specialty groups are reporting shortages now or in the very
4 near future, including gastroenterology, thoracic surgery, general surgery, generalist physicians,
5 geriatric medicine, oncology, pediatric subspecialties, public health, rheumatology, allergy and
6 immunology, child psychiatry, critical care, emergency medicine, family medicine, neurosurgery,
7 cardiology, dermatology, medical genetics, anesthesiology, endocrinology, psychiatry and
8 hospice/palliative medicine.

9 10 IMGs AND GRADUATE MEDICAL EDUCATION IN THE US

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12 In light of these current and projected shortages of physicians, the nation's medical schools have
13 responded to calls by the Council on Graduate Medical Education, AAMC, AMA, and other
14 organizations to increase class enrollments and to develop new medical schools. These efforts
15 have been successful. Unfortunately, Medicare support for graduate medical education (GME) has
16 been frozen since 1997. Without an increase in the number of available, funded residency slots, the
17 size of the US workforce will remain stagnant. In addition, thousands of eligible and qualified
18 IMGs will be unable to secure a residency position and to practice medicine in the US.

19
20 Looking at the specialty choices of IMGs over the past several years, IMGs often select
21 residency/fellowship positions in disciplines that have fallen out of favor with US-trained MDs and
22 DOs, while being displaced from the specialties that have gained in popularity with US medical
23 graduates. For example, there have been substantial increases of IMGs in primary care specialties,
24 and major decreases of IMGs in anesthesiology, pathology, psychiatry, and physical medicine and
25 rehabilitation.

26 27 J-1 VISA WAIVERS

28
29 One program that is vital for addressing physician shortages in underserved areas is the J-1 visa
30 waiver program, which allows IMGs to remain in the US after completing a residency/fellowship if
31 they have agreed to practice in a medically underserved location for at least three years.

32
33 The H1-B employer-sponsored visa, however, limits IMGs to six years of residency/fellowship
34 training. With training in some fields as long as eight years in length, some IMGs have been
35 denied visa extensions and were unable to complete their residency education. These denials were
36 the impetus for CME Report 11-A-10. Since that time, however, no additional visa denials have
37 been brought to the attention of the AMA IMG Section.

38
39 Academic medicine shares some of the same workforce concerns noted above. Many IMGs are
40 well-qualified for medical school faculty positions but cannot accept these appointments because
41 J-1 visa waivers are available only to clinicians, not faculty. As medical school class sizes
42 continue to increase, and as more new medical schools are developed, IMGs could significantly
43 contribute to helping educate the physician workforce of tomorrow, as called for by Resolution
44 903-I-10. With respect to the medical workforce shortages in specific states and specialties, as
45 noted above, it would be wise to tie any expansion of J-1 waivers to these needs. This would be an
46 extension of the Conrad State 30 J-1 Visa Waiver Program, which authorizes state health agencies
47 to place physicians in federally designated underserved areas where it is difficult to recruit and
48 retain physicians. Existing AMA policy supports permanent reauthorization of the program and its
49 expansion from 30 to 50 positions per state.

1 REDUCING THE ADMINISTRATIVE BURDEN ON IMGs

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3 Resolution 306-A-10 called for the AMA to encourage state medical licensing boards to accept
4 ECFMG certification as primary source verification of medical education credentials, and to
5 recognize that the standard ECFMG certificate is proof of medical education credentials verified
6 from primary sources for all IMGs. Currently, IMGs who wish to enter an ACGME-accredited
7 residency or fellowship program in the US must obtain ECFMG certification prior to program
8 entry. Since the ECFMG issues the standard ECFMG certificate to applicants who meet all of the
9 examination and medical education credential requirements, this organization would be the
10 appropriate entity to be recognized as the source for primary source verification of an IMG's
11 medical education credentials. State licensing boards could then accept ECFMG certification in
12 lieu of requiring IMGs to submit original documentation again. Taking this action would
13 significantly reduce a duplicative and onerous administrative burden on IMGs as well as licensing
14 boards, hospitals, employers, and payers, and would facilitate IMGs' ability to obtain licensure and
15 begin providing health care services.

16
17 The Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards
18 (FSMB) also ensures primary source verification of IMGs' medical education credentials. The
19 majority of state licensing boards accept FCVS verification of credentials for the purpose of
20 medical licensure. The ECFMG and FSMB's FCVS have an agreement to cooperate in the
21 primary source verification of the medical education credentials of IMGs. Under the terms of the
22 agreement, since September 2004, the ECFMG has used a mutually acceptable process to obtain
23 primary source verification of the medical diploma and final medical school transcript of IMG's
24 applying for ECFMG certification. If those applicants apply to the FCVS, the ECFMG is able to
25 provide verification of their credentials immediately to FCVS, eliminating the time involved in
26 obtaining primary source verification from foreign medical schools as part of the licensure process.
27 If an applicant's medical education credentials were not verified using the mutually acceptable
28 process, the ECFMG obtains primary source verification of the credentials for the FCVS. In either
29 event, IMGs should check with their state medical board to make sure they meet the board's
30 requirements first and foremost.

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32 RECOMMENDATIONS

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34 For the past 75 years, international medical graduates have made a consistent and significant
35 contribution to American medicine and helped our nation meet its need for health care services.
36 Ensuring that IMGs can continue to play a key role in our country is especially timely as
37 predictions of physician workforce shortages grow more critical. Working for more appropriate,
38 evidence-based changes in state and national regulations and programs can help IMGs as well as
39 our nation's citizens.

40
41 The Council on Medical Education therefore recommends that the following recommendations be
42 adopted in lieu of Resolution 306-A-10 and Resolution 903-I-10 and that the remainder of the
43 report be filed.

- 44
45 1. That our American Medical Association (AMA) International Medical Graduates Section
46 continue to monitor any H-1B visa denials as they relate to IMGs' inability to complete
47 accredited GME programs. (Directive to Take Action)

- 1 2. That our AMA revise HOD Policy D-255.985 to include a new third resolved: “Advocate
2 for expansion of the J-1 Visa waiver program to allow IMGs to serve on the faculty of
3 medical schools and residency programs in geographic areas or specialties with workforce
4 shortages.” (Amend HOD Policy)
5
- 6 3. That our AMA encourage state medical licensing boards, the Federation of State Medical
7 Boards, and other credentialing entities to accept the Educational Commission for Foreign
8 Medical Graduates certification as proof of primary source verification of an IMG’s
9 international medical education credentials. (Directive to Take Action)
10
- 11 4. That Policy D-255.981 be rescinded, having been accomplished by preparation of this
12 report. (Rescind HOD Policy)

Fiscal Note: \$1,000 for staff time.