HOD ACTION: Council on Medical Education Report 4 adopted and the remainder of the report filed.

REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION

Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice (June 2021)
(Resolution 308-I-19)
(Reference Committee C)

EXECUTIVE SUMMARY

International medical graduates (IMGs) currently represent a quarter of the physician workforce and physicians-in-training in the United States. They have long been an integral part of the U.S. health care system, contributing substantially to primary care disciplines and providing care to underserved populations, and their foreign language proficiency can be invaluable when communicating with patients from the same country of origin. The diversity of IMGs contributes to the many ethnicities and cultures represented in the health care workforce. This diversity is likely to be a factor enhancing health outcomes, considering the equally diverse nature of the U.S. patient population. In addition, IMGs are serving on the front lines of patient care during the COVID-19 pandemic.

IMGs are subject to the same rigorous credentialing standards as any other U.S. physician, which assures the quality of the medical workforce and protects the public. That said, some licensing regulations, such as attaining source documents to verify one's medical education or other schooling, may be more challenging for IMGs than for physicians who graduated from medical schools in the U.S. Improving and streamlining licensing and credentialing policies and processes, where appropriate, can ensure that IMGs can help address health care inequities and improve health care access through service in federally designated health care shortage areas.

The goal of this report, which is in response to American Medical Association (AMA) House of Delegates (HOD) Policy D-255.978, "Study Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice," is to "study and make recommendations for the best means for evaluating, credentialing, and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA."

This report provides information on state legislatures that have begun to implement strategies to assist IMGs with credentialing, licensure, and certification requirements in order to increase access to primary care in rural and underserved areas. This report also provides information on AMA efforts to assist non-U.S. citizen IMGs, who are severely restricted as to where they can practice under the terms of their visas. This includes some physicians who could not work as a result of being furloughed when the facilities at which they were working closed.

The AMA continues to assist IMGs through its International Medical Graduates Section and advocacy efforts. New models, such as those described in this report, may enable physicians to be credentialed and licensed in a more efficient and timely manner in an effort to address national or international pandemics or medical emergencies at a state or regional level. The Council on Medical Education believes that states remain best positioned to evaluate the relative success of these programs in addressing their needs. In addition, successful efforts to reduce medical licensing barriers should be shared as best practices across states.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 04-JUNE-2021

Subject:	Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice (Resolution 308-I-19)
Presented by:	Liana Puscas, MD, MHS, Chair
Referred to:	Reference Committee C

American Medical Association (AMA) House of Delegates (HOD) Policy D-255.978, "Study Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice," asks that our AMA "study and make recommendations for the best means for evaluating, credentialing, and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA." This report is in response to that policy.

INTRODUCTION

There is a projected shortage of physicians in the United States, given the aging of the present physician and general civilian populations, as well as potential and ongoing crisis situations, such as the COVID-19 pandemic, which has spiked the need for patient care and hospital beds across the country.[1] Compared with U.S. medical school graduates, IMGs provide care to a disproportionate number of socioeconomically disadvantaged patients, and certain states and specialties disproportionately depend on these physicians. IMGs represent nearly one-quarter of the U.S. physician workforce. They often practice at institutions that are on the front line of the COVID-19 pandemic, and these physicians play a critical role in providing health care in areas of the country with higher rates of poverty and chronic disease. Appendix A displays the U.S. map indicating medically underserved areas/populations (MAU/P) and practicing IMGs by state.

The continued steady influx of immigrants from strife-torn regions of the world to the U.S. includes highly trained physicians fleeing their country because of political or religious persecution. These immigrant physicians may have beneficial skills, such as professional experience and language proficiency. However, IMGs often face licensing barriers beyond those of physicians who graduated from a U.S. medical school. IMGs often are required to repeat complete cycles of training, including medical school, residency, and subspecialty training. This report provides information on state legislatures that have begun to implement strategies to assist IMGs with credentialing, licensure, and certification requirements in order to increase access to primary care in rural and underserved areas.

This report also provides information on AMA efforts to assist non-U.S. citizen IMGs, who are severely restricted as to where they can practice under the terms of their visas. This includes some physicians who could not work as a result of being furloughed when the facilities at which they were working closed.

CREDENTIALING REQUIREMENTS

Certification by the Educational Commission for Foreign Medical Graduates (ECFMG) is the standard for evaluating the qualifications of IMGs before they enter U.S. residency and fellowship programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). ECFMG requirements include examinations in the medical sciences, evaluation of English language proficiency, and documentation of medical education credentials.[2]

Non-U.S. citizen IMGs who seek entry into U.S. graduate medical education (GME) programs must obtain a visa permitting clinical training to provide medical services. The ECFMG / Foundation for Advancement of International Medical Education and Research Exchange Visitor Sponsorship Program (EVSP) serves as the visa sponsor for approximately 12,000 IMGs at teaching hospitals in the U.S.[3-4] All non-U.S. citizen IMGs enter the U.S. in one of two broad immigration categories—either under a temporary, nonimmigrant visa or as a permanent resident. The two most common temporary, nonimmigrant classifications for IMGs are the J-1 Exchange Visitor program and the H-1B temporary worker classification. Both classifications limit a physician's duration of residence in the U.S. and impose strict controls over the range of employment authorized. In contrast, permanent residence provides a foreign national with both an unlimited duration of residence in the U.S. and authorization of full, unrestricted employment. However, the lead time required to qualify for permanent residence status is usually substantially longer than the lead time required to obtain temporary worker status.[4] Additional information about visa options for IMGs is provided in Appendix B.

Certification from the ECFMG is a requirement for medical licensing, and it is a prerequisite for taking the United States Medical Licensing Examination (USMLE) Step 3. However, state licensure requirements vary from state to state.[5] All state licensing jurisdictions require IMGs to complete at least one year of accredited U.S. or Canadian GME before licensure. However, 21 states require two years, and 27 states require three years of accredited GME.[5]

Some states issue limited, restricted licenses that allow IMGs who have not entered U.S. GME to practice in the U.S. under supervision and in specific institutions. To qualify, IMGs must have been trained in a specialty and practiced medicine abroad. After immigrating to the U.S., these physicians have been able to establish themselves in an institution, despite being ineligible for full licensure. (Refer to CME Report 2, June 2021, "Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses," for more information about states that issue restricted licenses.)

Many institutions also require that physicians be board-certified or board eligible. However, it is the policy of the American Board of Medical Specialties (ABMS) that to be eligible for certification in any specialty or subspecialty and to maintain certification a physician must: 1) complete ACGME-accredited or Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited GME; and 2) hold a full and unrestricted license to practice medicine in at least one jurisdiction in the U.S., its territories, or Canada. Some of the ABMS member boards recognize alternative pathways that may meet eligibility requirements for initial board certification for candidates who have not completed U.S. or Canadian-accredited GME.

Recognized alternative pathways for international trainees that may meet eligibility requirements include Canadian and international training. Twenty ABMS member boards accept all of a candidate's training in Canada (either accredited by the RCPSC or by another body acceptable to the board) and of these, seven further require that a candidate be certified by the RCPSC or other Canadian certifying body. Three boards will accept some of a candidate's training in Canada

(either accredited by the RCPSC or by another body acceptable to the board). Fifteen boards offer pathways for non-Canadian internationally trained physicians. Of these, nine boards offer pathways for physicians practicing in the U.S. at an ACGME-accredited institution who are faculty at an ACGME-accredited program and may have achieved a specified academic rank (from associate to full professor). Two boards will accept international training as meeting all training requirements on a case-by-case basis, and four boards will accept international training as meeting some of the training requirements on a case-by-case basis. (Refer to CME Report 2, June 2021, "Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses," for more information about board certification pathways.)

On January 26, 2021, the Federation of State Medical Boards (FSMB) and National Board of Medical Examiners (NBME), co-sponsors of the USMLE, announced the discontinuation of work to relaunch a modified Step 2 Clinical Skills examination (Step 2 CS) and henceforth the discontinuation of Step 2 CS, while continuing to seek innovative and sensible ways to assess medical licensing eligibility. ECFMG continues to oversee requirements for its certification of IMGs and announced an expansion of its pathways allowing qualified IMGs to meet the requirements for ECFMG Certification and continue to pursue U.S. graduate medical education.

AMA ADVOCACY ACTIVITIES DURING COVID-19 RELATED TO IMGS

The AMA has been especially active in its federal level advocacy efforts on behalf of IMG physicians during the COVID-19 pandemic. Some of the areas in which AMA advocacy has been most significant include visas, labor condition applications, work surrounding last year's presidential proclamations, and the HEROES Act.

Visa Processing, Allocation, and Extensions

On March 20, 2020, U.S. Citizenship and Immigration Services (USCIS) suspended premium processing for visas. As such, IMG physicians were concerned about being able to obtain visas in a timely manner. In response, on March 24, 2020, the AMA sent a letter to USCIS urging USCIS to reconsider the suspension and instead expand premium processing for H-1B visas. USCIS reopened its offices and resumed citizenship ceremonies in June 2020. Additionally, it restarted premium processing for certain visa petitions, including H-1B visas, in phases throughout June. Moreover, companies were allowed request accelerated processing for immigrant worker visas, and employers who had pending H-1B temporary worker visas could ask for their applications to be fast-tracked. Per the USCIS website, premium processing for H-1B visa holders is available.

As the severity of the COVID-19 pandemic increased, embassies and consulates around the world stopped processing visas, including J-1 physician visas. As such, J-1 physicians were concerned that they would not be able to obtain or maintain a valid visa. Additionally, due to visa restrictions, J-1 physicians were concerned about being able to continue their training during the pandemic. In response, the AMA sent a letter to the U.S. Department of State (DoS) and the U.S. Department of Homeland Security (DHS) requesting opening of visa processing at embassies and consulates for physicians joining U.S. residency programs on July 1, 2020. Additionally, the AMA requested that J-1 physicians be allowed to engage in extended training activities and asked for confirmation concerning J-1 physician redeployment to new rotations to respond to the pandemic. As a result of AMA advocacy, in concert with ECFMG, the DoS agreed to begin processing visa applications for foreign-born medical professionals and announced that J-1 physicians may consult with their program sponsor to extend their programs in the U.S. The AMA also confirmed that J-1 physicians can engage in revised clinical training rotations/assignments, in keeping with the ACGME's "Response to Pandemic Crisis."

IMG physicians were also concerned about alterations in work schedules and the visa consequences of being laid off due to the impact of the COVID-19 pandemic. To help ease these concerns, on April 14, 2020, the AMA sent a letter urging USCIS to recognize the COVID-19 pandemic as an extraordinary circumstance beyond the control of non-U.S. citizen IMG applicants or their employers. The AMA consequently asked to expedite approvals of extensions and changes of status for non-U.S. citizen IMGs practicing, or otherwise lawfully present, in the U.S. In addition, the AMA urged the Administration to extend the 60-day maximum grace period to a 180-day grace period to allow any non-U.S. citizen IMG who had been furloughed or laid off as a result of the pandemic to remain in the U.S. and find new employment. Moreover, the AMA asked USCIS to protect the spouses and dependent children of H-1B physicians by automatically granting a one-year extension of their H-4 visas. Due in part to the advocacy efforts of the AMA, USCIS announced that it is temporarily waiving certain immigration consequences for failing to meet the full-time work requirement due to quarantine, illness, travel restrictions, or other consequences of the pandemic.

Throughout the pandemic, the AMA has not lost sight of the need for long term policy change, especially change surrounding the need for an increase in visas for additional physicians. As such, on May 8, 2020, the AMA sent letters to the U.S. House of Representatives and the U.S. Senate supporting the "Healthcare Workforce Resilience Act" and urging the Congress to quickly pass the legislation so that the U.S. can recapture 15,000 unused employment-based physician immigrant visas from prior fiscal years. The bill was not enacted.

Labor Condition Applications

Labor Condition Application restrictions have made it difficult for IMGs to practice in areas where they are most needed during the pandemic. As such, on April 3, 2020, the AMA wrote a letter to then Vice President Pence and USCIS urging the Administration to permit non-citizen 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. The AMA also urged the Administration to expedite work permits and renewal applications for all IMG physicians who are beginning their residencies or fellowships or are currently in training. Due in part to the advocacy efforts of the AMA, USCIS announced that IMGs can deliver telehealth services during the current public health emergency without having to apply for a new or amended Labor Condition Application. At the time of the writing of this report, the AMA is not planning additional follow up on the Labor Condition Application.

Presidential Proclamation

As a result of the April 22, 2020 Presidential Proclamation, *Suspending Entry of Immigrants Who Present Risk to the U.S. Labor Market During the Economic Recovery Following the COVID-19 Outbreak*, the AMA sent a letter to then-Vice President Pence urging the Administration to allow IMGs with J-1, H-1B, and O-1 (individuals with extraordinary ability or achievement) visas to be exempt from any future immigration bans or limitations, so that these physicians can maintain their lawful non-immigrant status while responding to the pandemic.

On June 22, 2020, President Trump issued a Proclamation, *Suspending Entry of Aliens Who Present a Risk to the U.S. Labor Market Following the Coronavirus Outbreak*. In response to the proclamation, the DoS issued a statement that "as resources allow, embassies and consulates may continue to provide emergency and mission-critical visa services. Mission-critical immigrant visa categories include applicants who may be eligible for an exception under these presidential

proclamations, such as…certain medical professionals." As such, on June 26, 2020, the AMA sent a letter to the DHS and the DoS strongly urging the Administration to consider J-1 and H-1B IMGs and their families' entry into the U.S. to be in the national interest of the country, so that families could remain together and IMG physicians could immediately begin to provide health care services to U.S. patients. The AMA understands that every physician is mission-critical, especially at this time.

Moreover, on July 8, 2020, the AMA initiated a sign-on letter for medical specialty societies. The letter urges the DoS and DHS to issue clarifying guidance pertaining to the June 22, 2020, proclamation by directing Consular Affairs to advise embassies and consulates that H-1B physicians and their dependent family members' entry into the U.S. is in the national interest.

During his first day in office, President Biden issued a *Proclamation on Ending Discriminatory Bans on Entry to The United States* to revoke Executive Order 13780 of March 6, 2017 (Protecting the Nation From Foreign Terrorist Entry Into the United States), Proclamation 9645 of September 24, 2017 (Enhancing Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats), Proclamation 9723 of April 10, 2018 (Maintaining Enhanced Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats), and Proclamation 9983 of January 31, 2020 (Improving Enhanced Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats).

On January 25, 2021, President Biden issued a *Proclamation on the Suspension of Entry as Immigrants and Non-Immigrants of Certain Additional Persons Who Pose a Risk of Transmitting Coronavirus Disease* to further examine certain current public health precautions for international travel and take additional appropriate regulatory action, to the extent feasible and consistent with Centers for Disease Control and Prevention guidelines and applicable law.

HEROES Act

H.R. 6800, the "Health and Economic Recovery Omnibus Emergency Solutions Act" (HEROES ACT), is the U.S. House of Representatives' next proposed coronavirus relief fund package and incorporates many of the IMG advocacy requests, including authorization of the Conrad 30 Program, expedited visa processing, and employment authorization cards for IMGs. For more information, see sections 191201 and 191204 of the HEROES Act or the AMA HEROES Act Summary. The AMA has worked with members of the U.S. House of Representatives to help ensure that favorable measures for IMGs are included in this proposed legislation. At the time of the writing of this Council report, the HEROES ACT had been passed in the House and was sent to the Senate. It was assigned to the Committee on Small Business and Entrepreneurship and hearings were held but no action was taken. The Continuing Appropriations Act (H.R. 8337) was passed; however, it had very little in it concerning IMGs. The most recent stimulus bill, the American Rescue Plan, does not include anything related to IMGs.

Additional Rule Changes

In the latter part of 2020, the AMA commented on related rule changes/proposed rule changes. Information regarding these rules and comments are located in Appendix C.

IMG Resource Guide

Due to the uncertainty that IMGs are experiencing during this time, the AMA has created an IMG resource guide, "FAQs: Guidance for international medical graduates during COVID-19." This guide answers some of the most pressing questions IMGs have surrounding their ability to practice and visas. It also lists available resources for assistance.

REVISIONS TO STATE LICENSURE REQUIREMENTS DURING COVID-19

In areas where physicians were acutely needed to address the needs of the patient surges during the pandemic, state agencies created stratification processes for those non-U.S. citizen IMG physicians most easily integrated into the system. These were IMGs working under direct supervision of licensed physicians and identified on the basis of education, training, certification as a medical specialist, English proficiency, and experience in direct patient care in countries other than the U.S. For example, in 2020 the New Jersey Division of Consumer Affairs had been authorized to issue temporary state medical licenses to IMGs who are licensed and in good standing in other countries, along with other workforce measures. In January 2021, it was announced they were no longer accepting new applications and pending applications were put on hold per review of the program.[6] In New York, a March 23, 2020 executive order from Governor Cuomo allows non-US citizen IMGs who are not licensed in the state but have completed at least one year of GME in the U.S., to provide patient care in hospitals, under the supervision of a New York State-licensed and registered physician, by way of a limited permit. This order was extended until May 6, 2021.[7-8]

PROGRAMS THAT SERVE AS MODELS FOR ACCELERATED TRAINING AND CREDENTIALING

Programs such as the National Health Service (NHS) of Scotland show it is possible to retrain immigrant physicians in 18 to 24 months, and that these physicians are able to demonstrate proficiency in language, medicine, and the culture of the host country. Immigrant physicians in Scotland who have been retrained on an accelerated path and who have demonstrated proficiency in language, medicine, and Scottish culture are obligated by the NHS of Scotland to practice in the NHS specific areas of need.[9]

Similarly, the following states are studying and developing pathways for qualified IMGs to expeditiously enter practice in the U.S.

Minnesota

The Minnesota Department of Health (MDH) has supported the integration of IMGs through the state's International Medical Graduate Assistance Program.[10] As the first program of its kind in the U.S., the Minnesota Legislature established this program in 2015 to address barriers to practice and facilitate pathways for immigrant IMGs to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state. It has achieved considerable success, including forming grant agreements with nonprofits to provide career support to IMGs and working with residency directors to carve out pathways for IMGs to demonstrate the clinical expertise required to enter into residency programs. The program requires that participants be legal residents who have lived in Minnesota for at least two years, graduated from an accredited medical school outside the U.S., and are willing to practice primary care in the state's underserved communities in rural and urban areas.

In its 2018 report, the MDH reported that the program has developed a database comprised of immigrant IMG physicians in Minnesota. The program also identified barriers to residency, and it is taking steps to address those barriers with the following interventions: funding dedicated residency positions for immigrant IMGs, supporting clinical readiness assessment and preparation programs, and providing career guidance and support. The MDH report includes data on IMGs who received career guidance and support as well as those who were selected by the University of Minnesota Medical School to participate in the clinical experience component, which began in September 2017.

The MDH met with the Minnesota Board of Medical Practice and other stakeholders to study possible changes to the Medical Practice Act. The group proposed two possible strategies: an IMG Primary Care Integration License and an amendment to the Medical Practice Act, which would include an exemption for practicing primary care in a rural or underserved area. As noted in the 2018 MDH report, the creation of this alternate license would be beneficial because it would allow objectively qualified IMGs into the system quickly to address issues of health disparities and primary care shortages. It would not require additional residency positions and thus would be cost-effective. The process would require that IMGs pass all licensure exams, demonstrate previous work of at least seven years in medical practice, participate in a six-month clinical experience, and undergo an assessment. This process would culminate in a certificate allowing work under supervision.

Implementation of this proposal raised several concerns. This effort is based on identifying and securing the commitment of an accredited assessor. In addition, these IMGs would not be eligible for board certification and may encounter employment restrictions. Key stakeholders, including the Minnesota Medical Association and Minnesota Academy of Physician Assistants, have raised objections, citing concerns over a tiered licensure system and professional role confusion. The MDH continues to research possible licensure changes.[11-13]

THE CONRAD 30 J-1 VISA WAIVER

IMGs who graduate from U.S. residency and fellowship programs may be in search of hospitals and practice groups that will support them in continuing their careers in the U.S. If these physicians held a J-1 Exchange Visitor visa during their GME in the U.S., they are required to return to their home countries for a two-year period before they can continue their careers in the U.S., but this provision can be waived in specific instances. One common way to do so is through the Conrad 30 Program, whereby a hospital or health center makes an application to a state department of health, requesting that the two-year home residency requirement be waived in exchange for the physician's three years of service in a medically underserved or health professional shortage area. The program currently allows for 30 waivers per state per year. However, the details of this annual program differ by state. States collectively recruit approximately 800 to 1,000 IMGs annually through the Conrad 30 program to practice in underserved communities.[17]

A study conducted by the Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) Rural Health Research Center, University of Washington, showed that Conrad 30 program staff generally valued the J-1 visa waiver as one of several important tools for recruitment of physicians to rural and underserved communities.[17] Since at least 2013, there have been efforts to make the Conrad 30 J-1 visa waiver program for physicians permanent; as this has yet to occur, it has been necessary to reauthorize the program every year. In 2019, bill was introduced in Congress to improve and extend the program until 2021—*the Conrad State 30 and Physician Access Reauthorization Act*.[18] The bill was not enacted.

The AMA has been vocal in its support for the Conrad 30 program over the years. Recently, the AMA worked with U.S. Senator Amy Klobuchar and a bipartisan list of other U.S. Senators to show the impact of the Administration's immigration policy changes during the pandemic to IMGs, reiterating the value of the Conrad 30 program and the need for its reauthorization.

RELEVANT AMA POLICY

The AMA has extensive policy regarding the requirements to practice medicine in the United States. AMA Policy H-255.983 states that "the AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character." Policy H-275.934 (2) states, "All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine." Policy H-255.966 (1.D.) notes, "U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions." Policy H-255.985 (1) states, "Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States programs." Policy H-255.988 states that the AMA "continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs."

At the Special Meeting of the AMA House of Delegates in November 2020, Policy D-275.950 "Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association" was adopted. In part it asks that the AMA "in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency." Other related policies are shown in Appendix D.

SUMMARY AND RECOMMENDATIONS

IMGs currently represent a quarter of the physician workforce and physicians-in-training. They have long been an integral part of the U.S. health care system, contributing substantially to primary care disciplines and providing care to underserved populations. The diversity of IMGs contributes to the many ethnicities and cultures represented in the health care workforce.[19] This is likely to be a factor enhancing health outcomes, considering the equally diverse nature of the U.S. patient population. In addition, IMGs are serving on the front lines of patient care during the COVID-19 pandemic.

IMGs are subject to the same rigorous credentialing standards as any other U.S. physician, but some licensing regulations may be more challenging for IMGs than for U.S.-educated physicians. There are, however, ways to improve and streamline licensing and credentialing policies and processes to ensure that IMGs can be recruited to federally designated health care shortage areas to address health care inequities and improve health care access. The AMA continues to assist IMGs through its International Medical Graduates Section and advocacy efforts. Proposed and enacted state models, such as those described in this report, may enable physicians to be quickly credentialed and licensed in an effort to address national or international pandemics or state/

regional medical emergencies. States remain best positioned to evaluate the relative success of these programs in addressing their needs; however successful efforts to reduce medical licensing barriers should be shared among state licensing boards as best practices.

The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed:

1. That American Medical Association (AMA) Policy D-255.980 (1), "Impact of Immigration Barriers on the Nation's Health," that reads, "Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine" be reaffirmed. (Reaffirm HOD Policy)

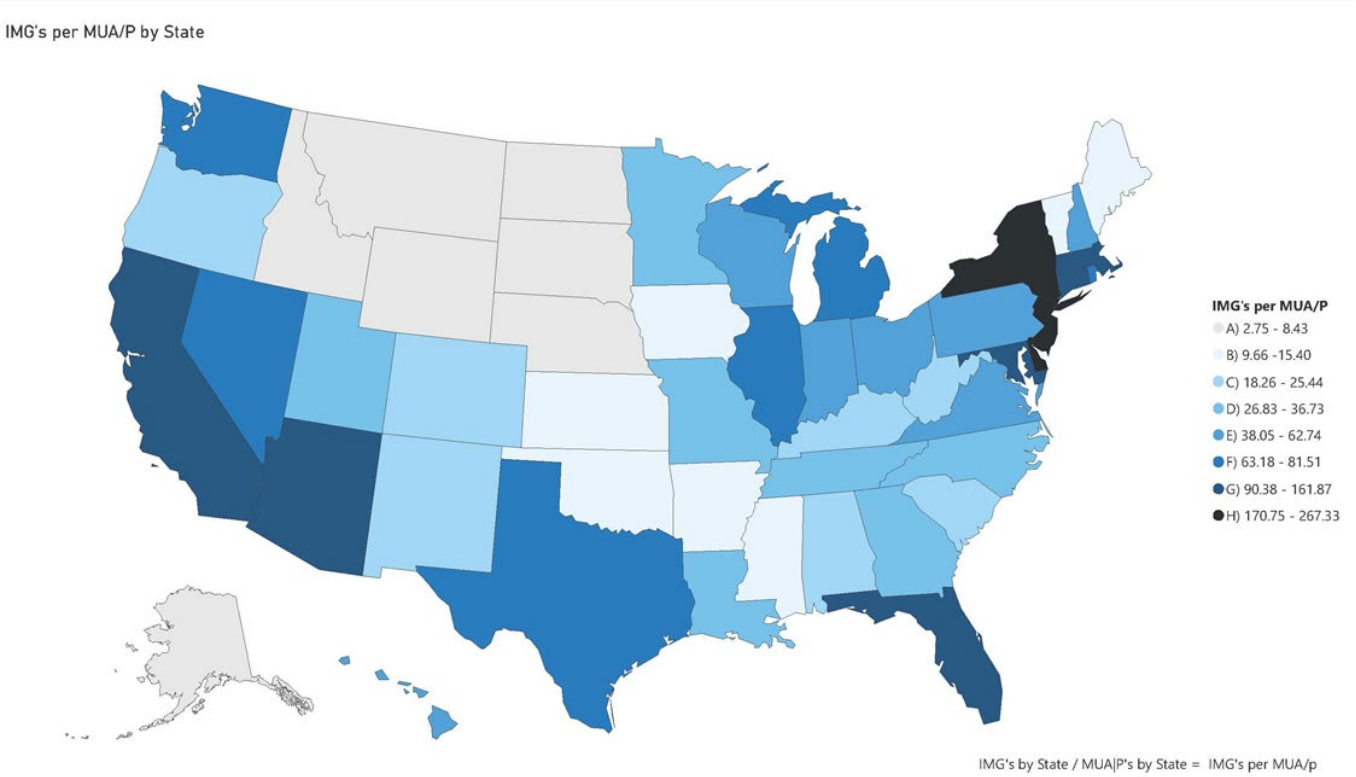
2. That our AMA encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas. (Directive to Take Action)

3. That our AMA encourage the Federation of State Medical Boards and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure—including successes, failures, and barriers to implementation. (Directive to Take Action)

4. That Policy D-255.978, "Study Expediting Entry of Qualified IMG Physicians to US Medical Practice," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal Note: $1,000.

Appendix A. U.S. map indicating medically underserved areas/populations (MAU/P) and practicing IMGs by state



Data sources;
Health Resources & Services Administration (HRSA), Medically Underserved Areas/Populations (MUA/P) data: 2021. Available at: https://data.hrsa.gov/maps/map-tool/. Accessed 1-14-21.
Association of American Medical Colleges (AAMC), 2019 State Physician Workforce Data Report. Available at: https://www.aamc.org/data-reports/workforce/report/state-physician-workforce-data-report. Accessed 1-12-21.

Map created with Microsoft Power BI.

Appendix B. Visa Options for Non-U.S. Citizen International Medical Graduate Physicians

Visa Option	Purpose	Requirements
J-1 Exchange Visitor program[1-2]	Intended to provide a broad range of foreign nationals with educational, employment, and training opportunities in the U.S. Allows International Medical Graduate (IMG) physicians to attend residency and fellowship programs in the U.S. *Physicians wishing to stay in the U.S. after completion of training (or applying for a Green Card), must first return to their home country for a period of two years.*	Educational Commission for Foreign Medical Graduates (ECFMG) Certification* including: 1. Passage of United States Medical Licensing Examination (USMLE) Steps 1 and 2 examinations or the Visa Qualifying Examination (VQE) prepared by the National Board of Medical Examiners, and administered by the ECFMG to establish medical competence 2. Passage of the ECFMG English language examination 3. Possession of an MD degree** from a foreign medical school listed in the International Medical Education Directory of the Foundation for Advancement of International Medical Education and Research (FAIMER®) A statement of need from the government of the country of the physician's nationality or last legal permanent residence to provide written assurance to the Secretary of Health and Human Services of the need in that country for persons with the skills the physician seeks to acquire and that the physician has filed a written assurance with the government of this country that he/she will return upon completion of the training An agreement or contract from a U.S. accredited medical school, an affiliated hospital, or a scientific institution to provide the accredited graduate medical education (GME), signed by the physician and the official responsible for the training *Upon entry to the U.S., an IMG is authorized to pursue GME training for a period of up to seven years. Each year, the training program in conjunction with the IMG must file an extension application with the ECFMG.*
J-1 Waiver[3]	Can be granted for the J-1 two-year requirement. *The most common waiver options are those granted by: 1) obtaining an official recommendation from an interested government agency in need of the physician's services, or 2) through the Conrad 30 Waiver Program offered by states in exchange for three years of service in a qualifying medically underserved area.*	Grounds under law to obtain a waiver of home residence obligation: • If the physician will suffer from persecution in his/her home country or country of last permanent residence • If fulfillment of the two-year home residence obligation will subject a U.S. citizen spouse or child to exceptional hardship • Based on a recommendation issued by a government agency interested in the physician's continued residence or employment in the U.S.
H-1B Temporary Worker classification[4]	Enables a foreign national to enter the U.S. to accept professional level employment for a period of up to six years.	A certified Labor Condition Application covering each location where the physician will perform services as required under Department of Labor regulations

	IMG physicians must have an existing job offer for full-time employment with a U.S. employer. This can be a hospital, university, clinic, a doctor's office, or an assisted living community.	Completion of a medical degree from either a U.S. based school or an acceptable school in a foreign country Possession of a full, unrestricted state medical license or the "appropriate authorization" for the position Completion of the USMLE (Steps I, II, and III) or be eligible for the limited exceptions to this requirement English language competence as established through graduation from an accredited medical school or by passing the ECFMG English language examination
O-1 Visa: Individuals with Extraordinary Ability or Achievement[5]	Option for well-established doctors who are looking to come to the U.S. to practice. *Significant amount of documentation needed to qualify*	Must demonstrate (through awards, publications, or other evidence) extraordinary accomplishments in the medical field The position for which the physician is going to work must require someone with well-above average skills and experience Abilities must be corroborated with consultation letters (detailed letters of recommendation) from other respected experts in the applicant's specific field May be exempted from the USMLE examination requirement (some state medical boards may still require USMLE passage)

*All IMGs, regardless of country of citizenship, are required to complete ECFMG Certification to be eligible for J-1 visa sponsorship for clinical GME in the U.S. The location of the medical school, not the citizenship of the physician, determines whether the graduate is an IMG. U.S. and Canadian citizens who graduate from medical schools located outside the U.S. and Canada are considered IMGs and must be certified by ECFMG.[1]

**The ECFMG Reference Guide for Medical Education Credentials lists the exact name of the final medical diploma that these applicants must have earned (and must provide).

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2. Exchange Visitor Program. U.S. Department of State. Available at: https://j1visa.state.gov/programs (Accessed 7-16-20).
3. Waiver of the Exchange Visitor Two-Year Home-Country Physical Presence Requirement. U.S. Department of State-Bureau of Consular Affairs. Available at: https://travel.state.gov/content/travel/en/us-visas/study/exchange/waiver-of-the-exchange-visitor.html (Accessed 7-20-20).
4. H-1B Specialty Occupations, DOD Cooperative Research and Development Project Workers, and Fashion Models. U.S. Citizenship and Immigration Services. Available at: https://www.uscis.gov/working-united-states/temporary-workers/h-1b-specialty-occupations-dod-cooperative-research-and-development-project-workers-and-fashion-models (Accessed 7-16-20).
5. O-1 Visa: Individuals with Extraordinary Ability or Achievement. U.S. Citizenship and Immigration Services. Available at: https://www.uscis.gov/working-united-states/temporary-workers/o-1-visa-individuals-extraordinary-ability-or-achievement (Accessed 7-20-20).

Appendix C. Rule Changes/ Proposed Rule Changes

J-1's

- In October 2020, the U.S. Department of Homeland Security (DHS) released a proposed rule titled "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media." The proposed administrative change to eliminate "duration of status" as an authorized period of stay would significantly disrupt the medical specialty and subspecialty training of thousands of foreign national physicians in the United States in J-1 visa status, which in turn will have severe implications for patient care.
- DHS is proposing to eliminate the duration of status in favor of only admitting J-1 physicians until the program end date noted in their Form I-20 or DS-2019, not to exceed four years, unless they are subject to a more limited two-year admission, plus a period of 30 days following their program end date. Individuals who need time beyond their period of admission would have to timely file a complete extension of stay (EOS) with U.S. Citizenship and Immigration Services (USCIS) before their prior admission expires. As such, under the proposed rule, J-1 physicians applying for EOS would need to file a Form I-539 with the required fee, provide biometrics, and possibly undergo an interview. While the rule provides an admission period of two to four years, this timeframe will not be applicable to J-1 physicians because they are required to undergo an annual application process.
    - On October 23, 2020, the AMA commented on a DHS proposed rule concerning "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media."
    - The AMA urged DHS to withdraw the proposed rule as it relates to J-1 IMGs.
    - The AMA signed onto two letters, one that was circulated around the Hill and one that was submitted as a formal comment that asked that IMGs be exempt from the proposed rule.
    - The AMA spearheaded a letter that was sent by Representatives Brad Schneider (D-IL), Abby Finkenauer (D-IA), and David McKinley (R-WV) to the Department of Homeland Security (DHS) in opposition to the regulatory changes to duration of status for J-1 physicians. The letter also opposes the regulation because it will disrupt the Conrad 30 Program. The letter was co-signed by 36 bipartisan members of Congress and sent to DHS' Legislative Affairs Department.

H-1B's

- The AMA drafted a letter in opposition to the interim final rule "Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States." In the letter the AMA strongly urged the U.S. Department of Labor (DOL) to rescind the Interim Final Rule (IFR), effective October 8, 2020. If rescission is not possible, we urged the DOL to exempt physicians from the IFR. Additionally, the AMA strongly urged the DOL to continue to approve, and DHS to annually accept, without reservation, the wage data from the Association of American Medical Colleges (AAMC) Survey of Resident/Fellow Stipends and Benefits Report for our foreign medical residents.
    - Currently, the Immigration and Nationality Act (INA) requires employers attempting to hire H-1B physicians to pay the greater of "the actual wage level paid by the employer to all other individuals with similar experience and qualifications for the specific employment in question," or "the prevailing wage level for the occupational classification in the area of employment." Without providing evidence-based reasoning, this rule increased wage levels. Specifically,

the entry level wage (Level 1) was increased from representing the 17th wage percentile or higher than 17 percent of all wages for that specific position in that Metropolitan Statistical Area, to representing the 45th percentile. Subsequently, Level 2 (qualified) was increased from the 34th percentile to the 62nd percentile, Level 3 (experienced) from the 50th percentile to the 78th percentile, and Level 4 (fully competent) from the 67th percentile to the 95th percentile.
    - Recently ruled to be in violation of the Administrative Procedure Act by a District Court.
    - Implementation date has been delayed. Comment period has been reopened until April 21, 2021. Rescindment of rule also under consideration.
- The AMA commented on proposed rule "Modification of Registration Requirement for Petitioners Seeking To File Cap-Subject H-1B Petitions."
    - DHS proposed to amend its regulations governing the process by which U.S. Citizenship and Immigration Services (USCIS) selects H-1B registrations for filing of H-1B cap-subject petitions (or H-1B petitions for any year in which the registration requirement will be suspended), by generally first selecting registrations based on the highest Occupational Employment Statistics (OES) prevailing wage level that the proffered wage equals or exceeds for the relevant Standard Occupational Classification (SOC) code and area(s) of intended employment.
    - On December 2, 2020, the AMA submitted comments strongly opposing the DHS proposed rule "Modification of Registration Requirement for Petitioners Seeking To File Cap-Subject H-1B Petitions." This proposed rule seeks to abruptly and unnecessarily change the selection process for H-1B cap-subject petitions by prioritizing registrants based on the highest prevailing wage or highest proffered wage. In our comments, we acknowledge that it is false to assume that higher skilled workers are always paid a higher wage and thus, this conclusion made by DHS devalues physicians practicing in medically underserved areas. AMA strongly urged DHS to withdraw the proposed rule, but if withdrawal is not possible, DHS was urged to exempt physicians from this provision.
    - It was scheduled to go into effect March 9, 2021 but has been delayed until December 31, 2021
- The AMA commented on proposed rule "Strengthening the H-1B Nonimmigrant Visa Classification Program."
    - DHS is proposing to revise the regulatory definition of and standards for a "specialty occupation."
    - On December 4, 2020, the AMA submitted comments. The United States District Court of the Northern District of California ruled on December 1, 2020 that the IFR is in violation of the Administrative Procedures Act. For the reasons stated in the court's ruling, we agree. The AMA strongly urges DHS to rescind the IFR. If this, or a similar rule is implemented in the future, DHS was urged to exempt physicians.

Appendix D: Relevant Policy

D-255.978, Study Expediting Entry of Qualified IMG Physicians to US Medical Practice
Our AMA will study and make recommendations for the best means for evaluating, credentialing and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA.
(Res. 308, I-19)

H-255.983, Graduates of Non-United States Medical Schools
The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character.
(Sub. Res. 45, A-88 Reaffirmed by Res. 311, A-96 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CME Rep. 1, I-03 Reaffirmed: CME Rep. 7, A-04 Reaffirmed: Sub. Res. 314, A-04 Reaffirmed: CME Rep. 11, A-10 Reaffirmed: BOT Rep. 25, A-15)

H-275.934, Alternatives to the Federation of State Medical Boards Recommendations on Licensure
Our AMA adopts the following principles:(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.
(CME Rep. 8, A-99 Reaffirmed: CME Rep. 4, I-01 Reaffirmed: CME Rep. 2, A-11 Modified: CME Rep. 2, A-12)

H-255.966, Abolish Discrimination in Licensure of IMGs
Medical Licensure of International Medical Graduates

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.
3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
(BOT Rep. 25, A-15)

H-255.985, Graduates of Foreign Health Professional Schools
(1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices.
(BOT Rep. NN, A-87 Reaffirmed: Sunset Report, I-97 Reaffirmed: Res. 320 and Res. 305, A-03 Reaffirmed: CME Rep. 1, I-03 Reaffirmed: CME Rep. 2, A-13)

H-255.988, AMA Principles on International Medical Graduates
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.

4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
(BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17 Reaffirmation: A-19)

D-275.989, Credentialing Issues
1. Our AMA shall: (A) continue to encourage the Federation of State Medical Boards (FSMB) and its licensing jurisdictions to widely disseminate information about the Federation Credentials Verification Service; and (B) encourage the FSMB and the Educational Commission for Foreign Medical Graduates to work together to develop a system for the prompt and reliable verification of the medical education credentials of international medical graduates and to serve as a repository and a body for primary source verification of credentials.
2. Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG's international medical education credentials.
(CME Rep. 3, A-02 Appended: CME Rep. 10, A-11)

D-255.991, Visa Complications for IMGs in GME
1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.

4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.
(Res. 844, I-03 Reaffirmation A-09 Reaffirmation I-10 Appended: CME Rep. 10, A-11 Appended: Res. 323, A-12 Reaffirmation: A-19)

D-255.985, Conrad 30 - J-1 Visa Waivers
1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.
(Res. 233, A-06 Appended: CME Rep. 10, A-11 Appended: Res. 303, A-11 Reaffirmation I-11 Modified: BOT Rep. 5, I-12 Appended: BOT Rep. 27, A-13 Reaffirmation A-14)

D-255.980, Impact of Immigration Barriers on the Nation's Health
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
(Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18 Reaffirmation: A-19)

H-200.972, Primary Care Physicians in Underserved Areas
1. Our AMA should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
(a) Encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.
(b) Encourage the affiliation of these family health clinics with local medical schools and teaching hospitals.
(c) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.
(d) Encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence.
(e) Urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations.
(f) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations.
(g) Urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
2. Our AMA supports efforts to: (a) expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and (b) increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.
(CMS Rep. I-93-2 Reaffirmation A-01 Reaffirmation I-03 Modified: CME Rep. 13, A-06 Reaffirmed: CMS Rep. 01, A-16 Modified: CME Rep. 04, I-18 Appended: Res. 206, I-19)

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