2024, Volume 56, Issue 10, 617-619, e-ISSN 1938-3800

Family Medicine

COMMENTARY

Supporting International Medical Graduate Workforce Integration in the 2024 US Election

Cameron J. Sabet, MA, MBA[a]; **Mohamed Khalif, MBBS**[b]; **Nguyen Quoc Hoan, DDS**[c]; **Sarah Kureshi, MD, MPH**[a]

AUTHOR AFFILIATIONS:

[a] Georgetown University Medical Center, Washington, DC

[b] Washington Academy for International Medical Graduates, SeaTac, WA

[c] School of Dentistry, Hanoi Medical University, Hanoi, Vietnam

CORRESPONDING AUTHOR:

Cameron J. Sabet, Georgetown University Medical Center, Washington, DC, sk795@georgetown.edu

HOW TO CITE: Sabet CJ, Khalif M, Hoan NQ, Kureshi S. Supporting International Medical Graduate Workforce Integration in the 2024 US Election. *Fam Med.* 2024;56(10):617-619. doi: 10.22454/FamMed.2024.706876

PUBLISHED: 16 October 2024

© Society of Teachers of Family Medicine

Over the next decade, the Association of American Medical Colleges anticipates a 124,000-person shortage in meeting population health needs.[1] This scarcity intimately impacts health equity and care access for all Americans, though the issue has received disproportionately little attention in recent election years. With an aging population and growing health care demands, the contributions of international medical graduates (IMGs) will only increase in importance. IMGs currently account for 25% of all active doctors nationwide and are covering many gaps in care access.[2] During the COVID-19 pandemic, research from Malayala and colleagues revealed that 45.6% of IMGs were supporting rural patients, with 64% of them offering services in disadvantaged communities more broadly.[3] Moreover, IMGs also serve a disproportionate role in often understaffed inner-city teaching hospitals.[4] Despite serving these indispensable roles in the health of our nation's most vulnerable communities, IMGs have historically faced barriers to workforce entry and retention, such as stringent licensing requirements, limited residency positions, visa restrictions, and lack of recognition of foreign qualifications. Indeed, some programs apply blanket filters to ban IMGs from consideration—a harmful practice that could inculcate a largely unjustified bias toward domestically trained medical graduates even as they enter the workforce.[5] The upcoming 2024 elections provide an opportunity to make the elimination of IMG workforce barriers a ballot box issue.

The US physician workforce shortage is already severely impacting access to care, especially for rural communities. More than 46 million Americans, or 15% of the population, live in rural areas, but only 10% of doctors currently practice in these regions. As the population grows and ages, more patients will be seeking care from this limited and overburdened pool of physicians. Rural hospitals already struggle to recruit enough doctors to meet local needs, with many closing for financial reasons. The worsening physician shortage threatens to compound this long-standing primary care and geographic maldistribution. While US medical schools have been increasing enrollments, these graduates will not begin independent practice for more than a decade.[6]

Due to concerns over fraudulent training programs and varying global protocols, IMGs with significant clinical experience have oftentimes been required to completely retrain in America despite prior international medical education.[7,8] However, research by Garibaldi and colleagues has revealed that IMGs score higher on the In-Training Examination of internal medicine than their US counterparts.[9] Among surgical residency applicants at East Carolina University's teaching hospital, IMGs were found to publish more often and have more degrees.[10] Moreover, a study from Norcini and colleagues demonstrated that, among 244,153 hospitalizations across Pennsylvania, patients cared for by non-US-citizen IMGs had a 9% reduction in patient mortality rates relative to US graduates.[11]

Building on these proven competencies and positive impacts of IMGs, 2024 presidential candidates can use existing state laws as a blueprint for national policy. For instance, Tennessee passed a new law (SB1451) in April 2023 allowing IMGs to obtain a temporary license to practice medicine without completing a US residency, provided they meet specific qualifications such as competency, completion of a 3-year postgraduate program abroad, and attainment of an employment offer from an accredited Tennessee health care provider, leading to a full license after 2 years of good standing. Though the state's Board of Medical Examiners elected not to provide application forms for IMGs to follow this path, if they do follow through with such a plan, these policies could help address the shortages in spans of months, not years.[12] On April 4, 2024, the Virginia Governor approved House Bill 995, which permits the Board of Medicine to issue temporary and then renewable licenses to foreign-licensed physicians to practice in underserved areas, with a path to full licensure after applicants meet specific educational criteria.[13]

Voters should raise several key IMG workforce issues with current elected officials and 2024 Presidential and Congressional candidates. First, the annual cap of Conrad-30 J-1 visa waivers should be permanently lifted.[14] This restrictive decades-old quota limits how many foreign physicians can remain in medically underserved areas after completing US residency training. While some states use all 30 of the slots allotted by the federal government, others do not—resulting in unused visas even as physician shortages grow. States should retain authority over selections, but no longer face an arbitrary ceiling clearly incongruous with national physician needs. Moreover, with 39% more positions available for the match than there are US graduates and many slots going unfilled,[15] an inefficiency in the system continues when IMGs go unmatched—including US-born applicants. A solution could be to increase awareness of the option of admitting IMGs and to lift blanket filters from primary care programs in less popular locations like rural or inner-city hospitals to minimize the number of slots going unfilled each year.

Resistance to these updates may also arise from the American Medical Association, which is largely responsible for maintaining physician incomes. Thus, the solution may come in the form of a middle ground where states can loosen restrictions but have requirements for practice in rural or other underserved areas. Additionally, the states could mandate a 10-year payback period for IMGs, and afterward these physicians could be required to find their replacement if they move.

Also, more residency training positions are urgently required to accommodate US and international medical graduates. The 1997 Balanced Budget Act capped Medicare graduate medical education funding, constraining teaching hospitals' ability to expand residency programs.[16] With medical schools recently increasing enrollments, demand for residencies now more than ever outstrips supply, making competition fiercer for these limited seats. In the 2023 Main Residency Match, the number of unmatched IMG applicants approached an all-time high. Lifting the cap on residency positions would allow teaching institutions flexibility to train more physicians to care for their specific populations.

In addition, pathways should be expanded for IMGs to more easily transition from temporary work visas to legal permanent residency and ultimately naturalized US citizenship. These doctors often spend years on restrictive or temporary visas providing care in high-need areas.[3] After this service, those wishing to remain permanently and continue serving their adopted hometowns should have that option. Facilitating longevity and stability in the physician workforce through more inclusive immigration policies will strengthen continuity of care.

Reshaping the discourse surrounding the perception of IMGs would also be beneficial. Even simplistic rhetoric framing IMGs as taking spots from US medical graduates is counterproductive. This zero-sum portrayal obscures the fact that IMGs predominantly serve in areas like inner-city or rural communities alongside specialties like internal medicine or pediatrics—care settings that are often underfilled by their domestically trained colleagues.[3,15] All qualified medical students, whether from domestic or international medical schools, should have opportunities to receive high-quality postgraduate training in the United States. Moreover, some IMGs can serve alternative clinical roles such as ultrasound technicians and interpreters—offering an alternative pathway for them that does not necessitate repeating residency but includes a level of supervision.[7]

These are simply initial suggestions. Voters should actively engage candidates on other IMG workforce barriers. Physicians who are excited to dedicate their careers to caring for Americans should not be caught in endless immigration limbo, burdened by visa fees higher than their salaries, or live in constant fear of being forced to leave the country.

In this upcoming election cycle, voters must demand federal action on IMG workforce barriers to address America's health care workforce shortage. Physician workforce modernization, lifting residency caps and providing visas for doctors to serve in underserved areas, should be central to this discussion. As our population ages and care needs grow, integrating qualified IMGs into our health care system will become increasingly critical. Despite potential debates on implementation details, leaders across the political spectrum should unite behind policies that encourage dedicated physicians to serve where they are needed most. By facilitating the entry of skilled doctors committed to caring for the underserved, we leverage the expertise of foreign-trained physicians to build a more equitable health system for both millions of Americans and the people who care for them.

REFERENCES

1. Berg S. Reduce physician burnout now-or face rising doctor shortages. *American Medical Association.* 2023. https://www.ama-assn.org/practice-management/physician-health/reduce-physician-burnout-now-or-face-rising-doctor-shortages

2. Vasireddy D, Malayala SV, Atluri P, Gupta D. Pediatric care struggles of US trained international medical graduate pediatricians in COVID-19 pandemic. *J Clin Med Res.* 2021;13(1):20-25.
3. Malayala S, Adhikari R, Vasireddy D, Atluri P, Bali A. Medically underserved areas and international medical graduates (IMGs) in the United States: challenges during the COVID-19 era. *J Community Hosp Intern Med Perspect.* 2021;11(4):457-463.
4. Parsi K. International medical graduates and global migration of physicians: fairness, equity, and justice. *Medscape J Med.* 2008;10(12):284.
5. H-255. Filtering international medical graduates during residency or fellowship applications. *American Medical Association.* 2023. https://policysearch.ama-assn.org/policyfinder/detail/H-255.963?uri=/AMADoc/HOD.xml-H-255.963.xml
6. Tello C, Goode CA. Factors and barriers that influence the matriculation of underrepresented students in medicine. *Front Psychol.* 2023;14:1141045.
7. Macaskill A, Stecklow S, Miglani S. Special report: why India's medical schools are plagued with fraud. *Reuters.* 2015. https://www.reuters.com/article/world/special-report-why-indias-medical-schools-are-plagued-with-fraud-idUSKBN0OW1NM/
8. Porter JL, Townley T, Huggett K, Warrier R. An acculturization curriculum: orienting international medical graduates to an internal medicine residency program. *Teach Learn Med.* 2008;20(1):37-43.
9. Garibaldi RA, Subhiyah R, Moore ME, Waxman H. The in-training examination in internal medicine: an analysis of resident performance over time. *Ann Intern Med.* 2002;137(6):505-510.
10. Schenarts PJ, Love KM, Agle SC, Haisch CE. Comparison of surgical residency applicants from U.S. medical schools with U.S.-born and foreign-born international medical school graduates. *J Surg Educ.* 2008;65(6):406-412.
11. Norcini JJ, Boulet JR, Dauphinee WD, Opalek A, Krantz ID, St A. Evaluating the quality of care provided by graduates of international medical schools. *Health Aff (Millwood).* 2010;29(8):468.
12. Clark C. Tennessee Medical Board Refuses to Enforce New IMG Law. *Medpage Today.* 2024. https://www.medpagetoday.com/special-reports/exclusives/111837
13. Board of Medicine. Temporary licensure of physicians licensed in a foreign country. LIS, 2024 session. *Virginia's Legislative Information System.* 2024. https://lis.virginia.gov/cgi-bin/legp604.exe?241+sum+HB995.
14. US Citizenship and Immigration Services. Conrad 30 Waiver Program. *USCIS.* 2020. https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program
15. NRMP. Match data. *National Resident Matching Program.* 2024. https://www.nrmp.org/match-data.
16. Schneider A. Overview of Medicaid provisions in the Balanced Budget Act of 1997, PL 105-33. *Center on Budget and Policy Priorities.* 1997. https://www.cbpp.org/sites/default/files/archive/908mcaid.htm