
REMAPPING DEBATE

Asking "Why" and "Why Not"

Recruitment of foreign physicians: a zero-sum equation?

Original Reporting | By Mike Alberti | Health care, Medicine

March 9, 2011 — The United States relies heavily on foreign physicians to supply health care to Americans, especially when it comes to providing primary care. Foreign physicians are also concentrated in underserved communities. For several decades, there have not been enough U.S. medical school graduates to fill the slots available in domestic residency programs, and those that are left over go to international medical graduates, or IMGs. In 2010, for example, [more than 20 percent](#) of graduates who were matched to first-year residency positions had graduated from foreign schools.

CONFRONTING THE DOCTOR SHORTAGE

This is the third in a series of articles that examine the intensifying shortage of doctors in the United States.

Previously in this series: [Warnings of doctor shortage go unheeded](#) and [Nurses to the rescue?](#)

With an intensification of the [U.S. doctor shortage looming](#), one suggested stopgap is to increase the U.S.'s reliance on foreign physicians. The proposal takes two basic forms. Some advocate for "passive recruitment" — a policy under which the number of funded slots at U.S. residency programs would be increased and those additional slots filled, at least in the short-term, with graduates of foreign medical schools. This increase should come hand-in-hand with the relaxation or elimination of current restrictions and bureaucratic regulations on foreign physicians, proponents argue, thereby making it easier for foreign physicians to stay and practice in the U.S. after they have completed their residency programs here.

A more radical proposal, known as "active recruitment," is to lift altogether the current requirement that any foreign physician who wishes to obtain a license to practice medicine in the U.S. complete a residency program here. Several other countries, including Canada and the United Kingdom, engage in active recruitment to address their own physician shortages, or have in the past.

The proposals raise questions about how best to deal with the fact that standards for both medical school education and residency training vary from country to country; the fact that relaxations on limitations of IMGs would not increase the number of doctors in the pipeline if the existing cap on the number of funded residencies weren't lifted; or the fact that attracting foreign doctors to the U.S. would exacerbate doctor shortages in other countries.

The proposals also have to contend with another frequently observed phenomenon: the tendency of solutions that are touted as "temporary" to harden into permanent arrangements. Would either passive or active recruitment have the perverse effect of stymieing efforts to increase the number of U.S.

medical school graduates, or mean that the “zero sum” problem of shifting doctors from other countries to the U.S. would be ignored over the long term?

Active recruitment

Currently, in order to obtain a license to practice medicine in the U.S., all foreign medical school graduates are required to complete a medical residency program of at least three years in the U.S. But Richard Cooper, former dean of the Medical College of Wisconsin, suggested that, in order to alleviate the physician shortage here, the U.S. should pursue a strategy of active recruitment of physicians abroad, in which the requirement to complete residency training in the U.S. is waived for qualified doctors.

“The United States is the only country in the world that requires foreign medical students to do their residencies here before they can practice,” he said.

“The countries that people come from are left without healthcare workers to take care of their pressing needs,” said Kate Tulenko, director of Intrahealth.

According to Ivy Lynn Bourgeault, professor of health sciences at the University of Ottawa, Canada currently allows foreign doctors to practice through two channels. One is similar to the model used in the U.S., where IMGs come to do residency training here and can thereafter be certified to practice. The other involves active recruitment by understaffed hospitals, health centers or communities of foreign physicians, who are then granted a provisional license.

The United Kingdom [aggressively pursued](#) a similar policy in the past, recruiting extensively from other Commonwealth countries like India and South Africa.

“It would be fast, almost immediate, and it would be cheap, too,” Cooper said.

Opponents, such as Edward Salsberg, director of the National Center for Workforce Analysis, which is housed in the Department of Health and Human Services, argue that the requirement that foreign graduates complete residency training in the U.S. is the foremost safeguard for ensuring quality of care.

“We have some of the highest standards in the world, and it’s in everybody’s interest that they be maintained,” he said.

But Daniel Purdom, a family practitioner in Kansas City, argued that requiring that IMGs complete medical residency programs in the U.S. is not the only way to ensure quality. One option, he said, would be for the U.S. to impose qualification requirements on individual physicians, based on competency and language tests, like Canada does (see sidebar).

Salsberg argued that this wouldn’t go far enough to ensure quality.

“In general, we don’t think that just passing a test is going to [provide] sufficient confidence of the qualifications of the individual physicians,” he said.

Another way to assure physician quality, Purdom said, would be to allow a U.S. organization — most likely the Accreditation Council for Graduate Medical Education, which is responsible for certifying U.S. programs — to certify residency programs in other countries.

“That certainly would give more comfort,” Salsberg agreed. “That would have to be looked at.”

But Salsberg pointed out that the requirements of residency programs in other countries vary substantially. Some countries from which the U.S. currently accepts physicians — particularly African countries — don’t even require residency training, he said, and others in Europe, Asia and South America require only two years.

“It isn’t necessarily in the interest of these programs to change their requirements to meet U.S. standards,” he said, which means that, before approving other programs, the U.S. would have to determine which ones come close enough to U.S. standards to qualify for certification.

Salsberg admitted that there are likely several foreign residency programs suitable for evaluation by U.S. standards, particularly in Europe, but narrowing the pool to those programs could significantly limit the numbers of new physicians that could be recruited to the U.S. through this proposal, he said.

Purdom argued that every state is already responsible for setting the standards a physician must meet to obtain a license to practice in that state.

Additionally, residency programs in many states, such as New York, already have recruitment in place programs to attract foreign medical graduates. Those programs could theoretically serve as models for hospitals and health centers that want to employ foreign physicians who have already completed residency training abroad.

THE CANADIAN MODEL

Foreign physicians actively recruited by Canadian communities or hospitals are required to complete several steps before they are deemed “practice ready.” The exact requirements vary province-to-province, but in general, applicants must first pass a series of examinations, administered by the Medical Council of Canada, designed to test their medical capability through both multiple-choice tests and clinical skills examinations that use actors playing the role of patients.

Applicants must also demonstrate their competency in English (or French, depending on the province).

If these requirements are fulfilled, applicants may be given a “conditional license” and allowed to practice under the close supervision of a licensed physician for six months to two years, depending on the province (some provinces do not grant conditional licenses at all).

Only after this period can a foreign physician that has not completed a residency program in the U.S. or Canada apply for a license to practice independently in Canada.

Salsberg, who is opposed to relying more heavily on foreign doctors, said that he didn't see recruitment being part of U.S. policy anytime soon.

"We haven't even gotten to the point where we're accrediting foreign medical schools yet," he said. Last year, the Educational Commission for Foreign Medical Graduates (ECFMG) announced that it will be 2023 before it requires all foreign physicians to graduate from a medical school that has been accredited by the Liaison Committee on Medical Education.

Passive recruitment

Much of the effort to increase the U.S. physician supply has centered on [increasing the number of medical residency positions](#) — or graduate medical education (GME) slots — that are partially funded by the government, primarily through Medicare. The number was capped at about 100,000 in 1997.

The Association of American Medical Colleges and the American Medical Association argue that the U.S. will not be able to meet its need for more physicians if the cap remains in place.

But if the cap were lifted immediately, residency programs would not find large numbers of U.S. medical school graduates ready to fill newly-created spots. Nearly all graduates of domestic medical schools are already "matched" into residency programs. Thus, unless U.S. medical school enrollments were greatly expanded — as many have [urged, so far unsuccessfully](#) — an increase in the residency cap would effectively result in residency programs turning to IMGs to fill most of the new slots.

Historically, some justification for limiting U.S. reliance on foreign medical graduates has been based on [questioning the quality of those graduates](#).

Elizabeth Garvish, an immigration attorney based in Atlanta, argued that foreign medical graduates provide at least the same level of care as U.S. trained physicians, and already have to pass several tests before they can even apply to a U.S. residency program. Those tests include an examination of clinical knowledge, a hands-on clinical skills exam, and an English-language exam.

A study by researchers at the Foundation for Advancement of International Medical Education and Research, published last year, reinforced that argument. The study found that foreign graduates perform as well as U.S. graduates, and actually perform better than American nationals who attended medical school abroad and then return to do their residency training in the U.S.

Currently, there is a high level of competition for IMGs who seek a residency slot in the U.S. Though 93 percent of U.S. medical school graduates were matched last year to first-year residency positions in the U.S., only 40 percent of IMGs were. What would happen if significantly more residency posi-

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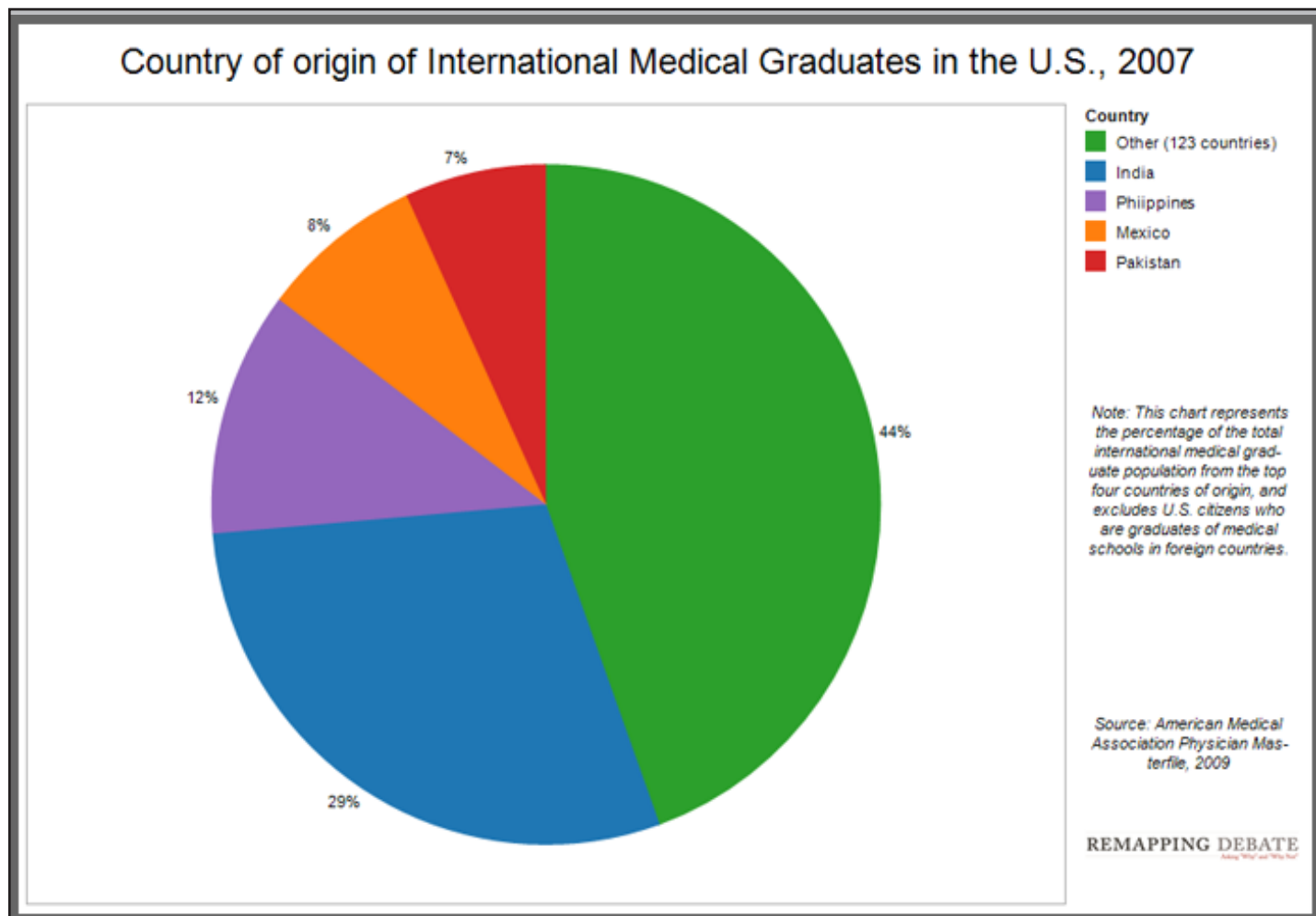
tions were created and then filled by IMGs?

Salsberg acknowledged that there would be a short-term reduction in the competitiveness of U.S. residency slots for graduates of foreign medical schools if the cap on residencies were lifted in the near future, and added: “That’s just another reason why we have to get our production up domestically.”

Brain Drain

Even if the quality of foreign physicians were ensured, Kate Tulenko, director of Intrahealth, a public health organization, argued that, when viewed internationally, physician migration is inherently a zero-sum equation.

After U.S. nationals who travel abroad to attend medical school (who are still considered international medical graduates), the largest numbers of IMGs come from India, the Philippines, Pakistan, and Mexico (see chart below). Tulenko pointed out that all of these countries have physician shortages of their own, and that the World Health Organization has classified India and Pakistan as “health work-force crisis countries.”



Many of the foreign physicians who would be recruited to work in the U.S. would likely come from these same countries, Tulenko said.

“The countries that people come from are left without healthcare workers to take care of their pressing needs,” she said, adding that recruitment of physicians by wealthy countries and recruitment of nurses by the U.S. have only exacerbated the problem.

According to GW’s Fitzhugh Mullan, reliance on foreign medical school graduates was supposed to be a temporary solution, but U.S. medical school enrollments were never increased substantially past the level they reached in the early 1980s.

Bourgeault agreed, calling reliance on foreign physicians an “ethical gray area.” The policy of recruiting nurses from abroad has also been widely critiqued on brain drain grounds. Indeed, Salsberg pointed out that last year, the U.S. signed a [“code of practice,”](#) along with 193 other countries at the World Health Assembly, in which voluntary principles for “the ethical international recruitment of health personnel” were endorsed in order to lessen recruitment from lower income countries with “fragile health systems.”

Garvish dismissed ethics-based arguments against foreign recruitment, saying that it “may be the case” that the U.S. is depriving other countries of their health workforce, “but I don’t know if the U.S. is supposed to make sure that every country out there has enough qualified doctors to care for their people. It’s a free world, and I think the U.S. needs to deal with its own issues.”

Tulenko, however, argued that the reliance on foreign medical graduates is so unethical that the U.S. should dramatically increase medical school enrollments before adding any new residency positions.

Cooper acknowledged that, because of these ethical issues, foreign recruitment of physicians would not be a good long-term strategy, and should only be employed in the short-term as the U.S. simultaneously ramps up its education and training capacity.

Medical school enrollments have increased somewhat in recent years in an attempt to address the physician shortage, but they are relatively minor increases in relation to the projected need. In 2006, the Association of American Medical Colleges (AAMC) called for a 30 percent increase in enrollment by 2015 – or 5,000 new M.D. students annually. Between 2006 and 2010, enrollment increased by only 7.5 percent. At that rate, medical school enrollments will fall far short of the AAMC’s goal.

A dramatic increase in the number of medical schools — an increase that would allow both new and existing residency slots to be filled by U.S. medical graduates — would not be unprecedented, however. As Remapping Debate recently reported, in the 1960s and ‘70s, enrollment at U.S. medical schools more than doubled in response to projections of a physician shortage. This expansion was largely due to funding from the 1963 Health Professions Education Assistance Act, which provided grants for the construction of new facilities and the expansion of existing schools.

Aren't these some of the "good jobs" the U.S. economy needs?

To Edward Salsberg of the Health Resources and Services Administration, proposals to rely more heavily on foreign physicians to meet U.S. healthcare needs seem ironic when viewed in the context of the current labor market.

"There are a lot of people out of work right now, and these are really wonderful careers that pay well and provide opportunities to help others," he said. "Plus, these are jobs that Americans want. We have to ensure that there is adequate educational capacity for them."

Rebecca Givan, assistant professor at Cornell's School of Industrial Labor Relations, agreed, and added that "The government could be much more active" in providing that educational capacity.

"It isn't so much a matter of capacity, as a matter of political priorities," she said.

Givan advocates a multi-prong approach, in which the government would adopt policies to recruit and educate Americans who want to become physicians, and then to retain them once they do.

To attract more people into medicine, she said, the U.S. could adopt policies that increase medical training in preparatory school, and possibly even change some of the requirements for admission into medical school to emphasize different skills sets and areas of study, like liberal arts or the humanities. In order to retain physicians, Givan believes that pay for primary care doctors should be increased, and, if possible, workload should be decreased.

Gary Fields, another labor economist at Cornell, took the argument a step further.

"When looking at the issue globally," he said, "I think the best policy would be to increase the number of highly qualified, well-trained doctors in the U.S., while simultaneously using our immigration policies to allow foreign doctors to receive high quality training here and then return to their countries to deliver care to those populations."

The U.S. currently grants many graduates of foreign medical schools a J-1 visa, which allows them to do medical residency training in the U.S., but then requires them to return to their home country for at least two years before applying to become a permanent U.S. resident. Through various government programs, however, that requirement is often waived, and foreign physicians are usually allowed to practice in the U.S. after completing their medical residencies.

If domestic medical school enrollment were increased to reduce U.S. dependency on foreign doctors, Fields said, "We could then use our immigration policy to address the global health workforce crisis."

Additionally, Tulenko said, “There is already a surplus of qualified applicants [from the U.S], who are going to medical schools abroad, mostly in the Caribbean.”

A substitute for long-term policy?

Some worry that increasing the reliance on foreign medical graduates would distract from the pressing need to increase domestic medical school enrollment. Fitzhugh Mullan, a professor of health policy at George Washington University, [has argued](#) that, without IMGs, the U.S. would already have faced a substantial physician shortage.

The U.S.’s reliance on foreign physicians exemplifies the fact that short-term policy to address immediate needs can often end up becoming long-term policy, and even substitute for a more comprehensive approach.

When the number of residency programs in the U.S. was increased in the 1960’s and ‘70s, the number of foreign medical graduates skyrocketed, despite the large increase in domestic medical school enrollment. But medical school enrollment flattened out in the 1980s, despite calls for decreasing the reliance on foreign physicians.

According to Mullan, reliance on foreign medical school graduates was supposed to be a temporary solution, but U.S. medical school enrollments were never increased substantially past the level they reached in the early 1980s and, in effect, reliance on foreign medical graduates has become long-term policy.

Bourgeault said that further increasing U.S. reliance on foreign physicians now has the same risk.

“I think it’s a short-term ‘solution,’” she said, qualifying the word solution because she was not sure that it really solved more problems than it caused. She argued that, with the political will, a wealthy country like the U.S. should be able to train enough of its own physicians to meet its needs.

This content originally appeared at <http://remappingdebate.org/article/recruitment-foreign-physicians-zero-sum-equation>