
Doctors Battling Borders: How U.S. Immigration Policies Are Exacerbating the Nation's Physician Shortage

*“Non-U.S. [International Medical Graduates] play a critical role in providing healthcare to many Americans because they tend to choose primary-care specialties and work in areas of the country with higher rates of poverty; they are providing important medical services to communities in need. . . . [A]bout 20.8 million Americans live in areas where at least half of the physicians are foreign-trained.”*¹

I. INTRODUCTION

According to data published by the Association of American Medical Colleges, the United States could see an increased shortage of up to 121,300 physicians by the year 2030—a shortage that would more dramatically affect the promise of healthcare throughout the nation.² The current shortage is exacerbated by an increasing demand for physicians, stemming from both a growing and aging population, as well as the prevalence of chronic disease, expanded insurance coverage, and a recovering economy.³ To combat the shortage, hospitals and residency programs must compete on the world stage to attract international medical graduates (IMGs)—foreign students who graduated from medical schools outside of the United States and Canada—in order to meet the demand.⁴ Unfortunately, U.S. immigration policies have narrowed the doorway

1. Letter from James L. Madara, MD, Exec. Vice President, CEO, Am. Med. Ass'n, to L. Francis Cissna, Dir., U.S. Citizenship & Immigration Servs. (June 5, 2018), <https://www.aila.org/infonet/ama-letter-uscis-delays-in-h1b-visa> [<https://perma.cc/P2YJ-RU96>] [hereinafter Letter from James L. Madara to L. Francis Cissna].

2. See TIM DALL ET AL., IHS MARKIT LTD., THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS FROM 2016 TO 2030, at 35 (2018), https://www.heartland.org/_template-assets/documents/publications/aamc_2018_workforce_projections_update_april_11_2018.pdf [<https://perma.cc/3WYX-S5X8>] (detailing key findings regarding physician shortage).

3. See *id.* at 2 (describing causes of physician shortage); see also Nicole Fisher, *25% of Physicians Are Born Outside the U.S. Can Immigration Reform Fix the Shortage?*, FORBES (July 12, 2016, 9:00 AM), <https://www.forbes.com/sites/nicolefisher/2016/07/12/25-of-docs-are-born-outside-of-the-u-s-can-immigration-reform-solve-our-doc-shortage/#1a5ffcbb155f> [<https://perma.cc/3LAC-ACM9>] (explaining retiring baby boomers strain healthcare system).

4. See Letter from James L. Madara to L. Francis Cissna, *supra* note 1 (stressing teaching hospitals' reliance on IMGs). For at least one internal medicine training program, 60% of incoming medical residents are foreign students on H-1B visas. Letter from All. for Acad. Internal Med. et al. to L. Francis Cissna, Dir., U.S. Citizenship & Immigration Servs. (May 30, 2018), https://www.acponline.org/acp_policy/letters/joint_letter_to_uscis_re_h1b_visas_delays_for_imgs_2018.pdf [<https://perma.cc/YZ8V-VJVQ>]. Today, foreign-born physicians make up a little more than 25% of all doctors practicing in the United States. See Melissa Cruz, *Fewer Foreign*

for the talent the U.S. healthcare system desperately needs, as IMGs, as well as foreign-born physicians—foreign doctors who graduated from either U.S. or non-U.S. medical schools—meet a complex immigration barrier at every turn.⁵ An IMG must first complete residency training in the United States as a J-1 Exchange Visitor, then return home to fulfill a two-year foreign residency requirement for his or her J-1 visa or seek a waiver of the requirement.⁶ Finally, IMGs must usually attain an H-1B nonimmigrant visa before they can practice medicine in the United States.⁷

The United States' underserved urban and rural areas are those most negatively affected by the physician shortage.⁸ Studies have shown though, that when compared with medical graduates who are U.S. citizens, IMGs are more likely to practice in both inner cities and rural communities, and are more likely to enter essential practice areas such as primary care and family medicine.⁹ The Conrad Waiver Program (Conrad Program), a state-based program Congress implemented to provide physician resources, was implemented to assist underserved areas by granting waivers of the home residency requirement for IMGs if they were committed to work for three years in a designated "medically underserved area."¹⁰ Launched in 1994, the Conrad Program originally allowed each state's Department of Health to sponsor up to twenty IMGs each year for a waiver of

Doctors Could Spell Disaster for America's Most Underserved Communities, IMMIGR. IMPACT (Apr. 13, 2018), <http://immigrationimpact.com/2018/04/13/foreign-doctors-poor-rural-communities/> [<https://perma.cc/R64Y-37Z6>] [hereinafter Cruz, *Fewer Foreign Doctors*] (explaining U.S. healthcare system relies on highly-skilled immigrants to fill gaps).

5. See Catherine Rampell, *Path to United States Practice Is Long Slog for Foreign Doctors*, N.Y. TIMES (Aug. 11, 2013), <https://www.nytimes.com/2013/08/12/business/economy/long-slog-for-foreign-doctors-to-practice-in-us.html?smid=pl-share> [<https://perma.cc/WZH7-ZN3C>] (laying out process for IMGs). The whole process can take up to a decade for those lucky enough to make it through. See *id.*

6. See Greg Siskind & Bryant Stevenson, *Physician J-1 Waivers: A Primer*, HEALTH LAW., Aug. 2005, at 3-4 (summarizing J-1 visa uses and requirements).

7. See *id.* at 1.

8. See Susanne Klaric, Note, *The "Conrad State 30" Improvement Act: Remediating the Physician Shortage*, 18 S. CAL. REV. L. & SOC. JUST. 611, 613 (2009) (stating physician shortage most severely impacts rural areas and inner cities). Many communities in these areas have no local physicians, and residents must travel many miles for basic medical care. See *id.*; see also Fisher, *supra* note 3 (explaining IMGs essential to addressing primary care physician shortage in underserved communities).

9. See Klaric, *supra* note 8, at 614-15 (noting more doctors specializing rather than practicing basic family medicine); Jamie Ducharme, *Trump's Immigration Policies Are Making It Harder for Foreign Doctors to Work in the U.S.—and That Could Hurt Patients*, TIME (June 8, 2018), <http://time.com/5299488/international-medical-graduates/> [<https://perma.cc/VSR4-D45A>] (highlighting doctors trained in United States tend to favor high-paying specialties).

10. See Immigration and Nationality Act of 1952 § 214(l), 8 U.S.C. § 1184(l) (2018) (setting forth waiver requirements for employment at health facilities with physician shortages); Immigration and Nationality Technical Corrections Act of 1994, Pub. L. No. 103-416, sec. 220, §§ 212(e), 214, 108 Stat. 4305, 4319-20 (codified as amended at 8 U.S.C. §§ 1182(e), 1184 (2018)) (proposing original Conrad Program); Robert D. Aronson, *The Evolution of the Conrad Waiver Program: Fourteen Years of State- and Federal-Based J-1 Waivers to Physicians* (summarizing Conrad Program began for public interest reasons), in IMMIGRATION OPTIONS FOR PHYSICIANS 63, 63 (Margaret A. Catillaz ed., 3d ed. 2009).

the two-year home residency requirement of the physician's J-1 visa.¹¹ Congress has reauthorized and extended the Conrad Program multiple times with reforms, allowing for an increase to thirty spots per state, and allotting ten waivers or "flex slots" per year for locations not designated as underserved, but that serve patients from underserved areas.¹²

Nevertheless, the Conrad Program needs to undergo reform in order to address the acute physician shortage, and the Conrad Program's supporters seek to have it extended until 2021.¹³ Legislation to reform the Conrad Program, the most recent introduced in March 2019, has been stalled, and discussion around reform is more contentious than ever due to the current national debate surrounding immigration.¹⁴ If a bill is not passed to extend the Conrad Program, the entire waiver system could break down.¹⁵

In the meantime, IMGs face formidable barriers to attaining necessary visas due to rigid immigration policies under the current administration.¹⁶ Compre-

11. See Immigration and Nationality Technical Corrections Act of 1994 §§ 212(e), 214 (outlining original Conrad Program); Aronson, *supra* note 10, at 66 (laying out provisions of original Conrad Program legislation); Rita Sostrin & Sarah Baker, *Practical Guide to Conrad Waivers: Thirty, . . . Two, One, Gone!* (discussing two-year foreign residence requirement for J-1s), in IMMIGRATION OPTIONS FOR PHYSICIANS, *supra* note 10, at 45, 45. Any IMG in J-1 status is subject to a two-year foreign residence requirement, which requires that he or she return to his or her home country for at least two years prior to being eligible to obtain other immigration benefits. See Sostrin & Baker, *supra*, at 45.

12. See Aronson, *supra* note 10, at 67-70 (describing multiple expansions to Conrad Program legislation); see also Klaric, *supra* note 8, at 626-28 (discussing legislation altering Conrad Program).

13. See Conrad State 30 and Physician Access Reauthorization Act, S. 948, 116th Cong. § 2(a) (2019) (proposing extending Conrad Program to 2021); AAMC Endorses Senate Conrad 30 Reauthorization and Dream Act, AAMC (Apr. 5, 2019), <https://www.aamc.org/advocacy-policy/washington-highlights/aamc-endorses-senate-conrad-30-reauthorization-and-dream-act> [<https://perma.cc/9KRN-RSMD>] (noting bipartisan and health professional support of reauthorization bill).

14. See *Conrad 30 Reauthorization Bill Earns Bipartisan Support*, AMA (May 18, 2017), <https://www.ama-assn.org/delivering-care/patient-support-advocacy/conrad-30-reauthorization-bill-earns-bipartisan-support> [<https://perma.cc/3GSL-LPL5>] (asserting reauthorizing Conrad Program slow to progress and contentious). Controversies that have caused worry for physicians with J-1 visas include the current administration's immigration and travel executive orders. See *id.*; see also Otieno B. Ombok & Forrest G. Read IV, *New Legislation Offered to Extend and Expand Conrad 30 Waiver Program*, NAT'L L. REV. (Apr. 23, 2019), <https://www.natlawreview.com/article/new-legislation-offered-to-extend-and-expand-conrad-30-waiver-program> [<https://perma.cc/N6X9-SP8U>] (recognizing past efforts to reauthorize Conrad Program).

15. See *Conrad 30 Reauthorization Bill Earns Bipartisan Support*, *supra* note 14 (declaring waiver process could break down). If the Conrad Program breaks down, 1,500 physician placements in underserved communities could be affected. See *id.* Continuing the Conrad Program will ensure and protect patient access to healthcare. See *AAMC Endorses Senate Conrad 30 Reauthorization and Dream Act*, *supra* note 13 (recognizing critical need for reauthorizing Conrad Program).

16. See Nelson D. Schwartz & Steve Lohr, *Companies Say Trump Is Hurting Business by Limiting Legal Immigration*, N.Y. TIMES (Sept. 2, 2018), <https://nyti.ms/2MMX7UI> [<https://perma.cc/YQ8U-T3W5>] (discussing new roadblocks limiting legal arrivals). Many businesses, including hospitals, say they are struggling to fill jobs due to the government denying more work visas, asking applicants for more information, and delaying approvals. See Cruz, *Fewer Foreign Doctors*, *supra* note 4 (noting concern about impact of Trump Administration's strict immigration policies on foreign-born physicians); Schwartz & Lohr, *supra* (noting current bureaucracy constricts flow of foreign workers into United States).

hensive immigration reform has been delayed at every pass, and changing attitudes and government policies have created an inhospitable landscape of uncertainty and hostility.¹⁷ Specifically, President Donald Trump's executive orders, "Buy American and Hire American" (BAHA Order) and the so-called "Travel Ban" (Travel Ban), have created more barriers preventing IMGs from applying the skills that are essential to maintaining and growing the U.S. healthcare system.¹⁸

This Note examines and analyzes prior and current immigration policies that have hindered IMGs from filling U.S. hospital positions and benefitting the U.S. healthcare system.¹⁹ Part II maps out the various immigration processes that IMGs must complete in order to enter the U.S. medical field, and reviews the history of the Conrad Program.²⁰ Part II also details previously proposed legislation for reform and discusses the current administration's policies that have blocked reform.²¹ Part III analyzes reform bills under consideration and evaluates their strengths and weaknesses, as well as outlines the negative effects of the current U.S. immigration landscape on the healthcare sector.²² Finally, Part IV advocates for policy changes that should be made in order to combat the physician shortage that the nation faces.²³

II. HISTORY

A. *Becoming a U.S. Physician: The Residency Training Program*

For an IMG, the path to obtaining medical licensure in the United States is long, costly, and confusing.²⁴ An IMG is a "physician who received a basic

17. See Susan Davis & Alan Gomez, *House GOP Opposes Senate-Passed Immigration Bill*, USA TODAY (June 27, 2013, 4:38 PM), <http://usat.ly/12os0PJ> [<https://perma.cc/X9BG-8BM7>] (summarizing recent immigration bill passed in Senate but received opposition from House of Representatives); *Why Immigration Reform Died in Congress*, NBC NEWS (July 1, 2014, 9:09 AM), <https://www.nbcnews.com/politics/first-read/why-immigration-reform-died-congress-n145276> [<https://perma.cc/E7WJ-K5EB>] (listing multiple years Congress could not pass immigration reform). Several immigration policy changes from the Trump Administration have left IMGs deterred from or unable to practice medicine in the United States. See Ducharme, *supra* note 9 (opining current administration intimidating to foreign-born physicians and hospitals).

18. See Julia Belluz & Sarah Frostenson, *How Trump's Travel Ban Threatens Health Care, in 3 Charts*, VOX (June 26, 2018, 2:45 PM), <https://www.vox.com/2017/2/1/14470746/trump-travel-ban-health-care-doctors> [<https://perma.cc/GXE8-29NK>] (detailing Travel Ban's effects on foreign-born physicians); Wendy S. Salkin, *A Quarter of the Work Force: International Medical Graduates and the Lives They Save*, HARV. L. PETRIE-FLOM CTR.: BILL OF HEALTH (May 3, 2017), <https://blogs.harvard.edu/billofhealth/2017/05/03/a-quarter-of-the-work-force-international-medical-graduates-and-the-lives-they-save/> [<https://perma.cc/DZ8G-SSCB>] (discussing concern over effects of executive orders on H-1B visas to IMGs).

19. See *infra* Part II (detailing policies hindering solving physician shortage).

20. See *infra* Sections II.A-D (summarizing visa procedures and requirements for IMGs).

21. See *infra* Section II.E (outlining reform measures and roadblocks).

22. See *infra* Part III (evaluating reforms and advocating for new measures).

23. See *infra* Part IV (summarizing need for policy changes).

24. See Rita Sostrin, *Qualifying International Medical Graduates (IMGs) for Immigration Benefits in the United States* (illustrating various pathways IMGs may take to become U.S. physicians), in IMMIGRATION OPTIONS FOR PHYSICIANS, *supra* note 10, at 309, 309; Rampell, *supra* note 5 (calling process "gantlet" for IMGs,

medical degree or qualification from a medical school located outside the United States and Canada.”²⁵ Although these IMGs may be qualified as physicians in the country from which they graduated, they must still pursue U.S. programs of Graduate Medical Education (GME), which aim to prepare physicians for practicing in the United States.²⁶ Most GME programs are overseen by accreditation boards, and include training under the direct supervision of attending physicians.²⁷ In order to enter a training program to become a clinical physician, however, the IMG must be sponsored and certified by the Educational Commission for Foreign Medical Graduates (ECFMG).²⁸

1. ECFMG Certification

The ECFMG is the sole institution that assures eligibility of training programs for IMGs in the United States and exclusively manages the J-1 Exchange Visitor Program for Alien Physicians.²⁹ The medical community created the ECFMG in 1956 to evaluate IMGs’ qualifications before they enter U.S. GME programs.³⁰ In addition, the ECFMG verifies each IMG’s medical graduation status, administers certain prerequisite exams before IMGs may enter residency training programs, and certifies requirements of non-Canadian-educated IMGs to train to

no matter how experienced or trained).

25. See NAT’L RESIDENT MATCHING PROGRAM, CHARTING OUTCOMES IN THE MATCH: INTERNATIONAL MEDICAL GRADUATES, at ii (2d ed. 2018), <http://www.nrmp.org/wp-content/uploads/2018/06/Charting-Outcomes-in-the-Match-2018-IMGs.pdf> [<https://perma.cc/PV8P-PRFQ>]. The location of a student’s medical school, not the student’s citizenship, determines whether he or she is an IMG. See *id.* U.S. citizens who graduate from international medical schools are considered “U.S. IMGs,” and non-U.S. citizens who graduate from medical schools in the United States and Canada are not considered IMGs. See *id.* This Note focuses solely on non-U.S. citizen IMGs, not U.S. IMGs. See *supra* Part I (introducing Note with focus on non-U.S. citizen IMGs).

26. See Robert D. Aronson & Michele Stelljes, *J-1 Issues Within a Graduate Medical Education (GME) Context* (describing GME programs), in IMMIGRATION OPTIONS FOR PHYSICIANS, *supra* note 10, at 5, 7. GME programs can be “based in hospitals, clinics, health care facilities, or institutions with or without medical school affiliations.” *Id.*

27. See *id.* (listing various accreditation committees and organizations). Although accreditation is voluntary, these training programs strive for accreditation to meet the professional standards of the medical community. See *id.*

28. See *id.* at 9 (listing two training program categories relevant to IMG community). If the IMG is pursuing a training program dedicated to research or teaching with only incidental patient contact, his or her immigrant process is managed directly by institutes of higher education. See *id.*

29. See *id.* (highlighting statutory history of exclusively designating ECFMG for J-1 visas). Since 1958, ECFMG has certified more than 320,000 IMGs. See *About ECFMG: Overview*, EDUC. COMMISSION FOR FOREIGN MED. GRADUATES, <https://www.ecfmg.org/about/index.html> [<https://perma.cc/ETK5-Z4S7>] (last updated Feb. 23, 2018) (summarizing ECFMG’s role in helping IMGs attain medical licensure); see also *infra* Section II.B (examining background and categories of J-1 visa).

30. See Aronson & Stelljes, *supra* note 26, at 9 (providing historical background on ECFMG). Although the ECFMG is dedicated to certifying IMGs, it is not guaranteed that every IMG will be accepted into a program, because the number of applicants surpasses the number of available placements. See EDUC. COMMISSION FOR FOREIGN MED. GRADUATES, ECFMG CERTIFICATION 2019 INFORMATION BOOKLET 4 (rev. 2018), <https://www.ecfmg.org/2019ib/2019ib.pdf> [<https://perma.cc/2TQY-SFJ6>] [hereinafter ECFMG BOOKLET] (describing ECFMG’s functions).

practice medicine in the United States.³¹

To satisfy eligibility standards for ECFMG certification, an IMG must meet several requirements, the first being the medical school requirement.³² The IMG's medical school must meet certain qualifications as defined by the ECFMG and listed in the World Directory of Medical Schools.³³ Additionally, the IMG must submit an online application for ECFMG certification attesting to his or her identity and degree.³⁴ Finally, most IMGs must pass Step 1 and Step 2 of the United States Medical Licensing Examination (USMLE), which can take years to prepare for and pass.³⁵ Once the IMG completes each of these steps, the ECFMG will issue a certificate to the IMG, allowing the IMG to begin the mandatory U.S. residency training program.³⁶

2. *The Residency Training Program*

After receiving ECFMG certification, any IMG who wants to practice medicine in the United States must complete an accredited residency training program in the United States or Canada, regardless of whether he or she previously received similar training overseas.³⁷ Depending on the area of medical specialty, these training programs take between three to eight years, and involve long hours and low pay.³⁸ In order to qualify for and enter these programs, however, the American Medical Association advises IMGs to submit a minimum of twenty-

31. See Aronson & Stelljes, *supra* note 26, at 9 (highlighting core services performed by ECFMG). The ECFMG does not certify graduates from Canadian medical schools because students who have graduated from Canadian medical schools are not considered IMGs. See ECFMG BOOKLET, *supra* note 30, at 4.

32. See ECFMG BOOKLET, *supra* note 30, at 5-7 (listing general requirements and stating medical school requirement).

33. See *id.* at 5, 62-63 (outlining medical education requirement for IMGs). To fulfill the medical school education credentialing requirements, IMGs must have received credit for at least four academic credit years, prove they received their final medical diploma, and provide their final medical school transcript. See *id.* at 6-7.

34. See *id.* at 5-6, 29 (detailing process for certification).

35. See *id.* at 6, 31-33 (explaining USMLE exam). The USMLE is a two-part exam, consisting of Step 1 and Step 2, and both parts must be completed in seven years. See *id.* Step 2 has two separately administered components: the Clinical Knowledge component, which satisfies the medical science examination requirement, and the Clinical Skills component, which satisfies the clinical skills requirement. See *id.* It took one doctor from Colombia three years to study and pass the licensing exams while working as a nanny to support herself. See Rampell, *supra* note 5 (offering real-world experiences with exam process from IMGs).

36. See Immigration and Nationality Act of 1952 § 212(j)(1)(A), 8 U.S.C. § 1182(j)(1)(A) (2018) (indicating IMGs must receive GME from medical school or affiliated hospital); ECFMG BOOKLET, *supra* note 30, at 4, 8 (describing ECFMG Certificate necessary for entering programs for GME); *Residency Program Requirements for International Medical Graduates*, AMA, <https://www.ama-assn.org/life-career/residency-program-requirements-international-medical-graduates> [<https://perma.cc/T7GE-2SSQ>] (stating residency requirement for IMGs).

37. See Rampell, *supra* note 5 (highlighting requirement still necessary for those from countries with advanced medical systems); *Residency Program Requirements for International Medical Graduates*, *supra* note 36 (indicating IMGs must complete residency training in United States or Canada).

38. See Aronson & Stelljes, *supra* note 26, at 8 (noting different program durations for different specialties); Glen Cheng, *The National Residency Exchange: A Proposal to Restore Primary Care in an Age of Microspecialization*, 38 AM. J.L. & MED. 158, 169 (2012) (addressing small stipend physicians earn during residency); Rampell, *supra* note 5 (stressing "grueling" eighty-hour workweeks in residency).

five comprehensive applications to have the chance to “match” with a desired residency program.³⁹ The National Resident Matching Program (NRMP) annually administers The Match process to link applicants and hospital residency programs—a process all U.S. and non-U.S. medical students must undergo.⁴⁰ Congress funds these residency programs, which have a limited number of slots available each year.⁴¹

IMGs face many challenges in order to be matched with a residency program, while also competing with U.S.-trained medical students as part of the overall matching process.⁴² As of 2018, the overall position “fill rate” for residencies was 96.2%, with 94.3% of graduating U.S. medical students matching compared to only 56.1% of non-U.S. IMGs matching to a residency position.⁴³ The discrepancy in figures can be attributed to IMGs demonstrating lower USMLE test scores and not ranking enough residency programs necessary for The Match process.⁴⁴ Most importantly, however, in order to be eligible for and engage in these clinical training programs, the IMG must obtain a visa.⁴⁵

39. See *Residency Program Requirements for International Medical Graduates*, *supra* note 36 (discussing application process and requirements). Applicants for residency programs should highlight their unique qualifications, write a personal statement, and submit a strong letter of recommendation. *See id.* Once applications are submitted, interviews are conducted, and then applicants rank their preferred programs. *See The Match: Getting into a Residency Program*, AM. ACAD. FAM. PHYSICIANS, <https://www.aafp.org/medical-school-residency/residency/match.html> [<https://perma.cc/QAA4-CSVV>] (outlining residency matching process). A computer algorithm then matches students to residency programs that have chosen them—a process called “The Match.” *See id.*

40. See Cheng, *supra* note 38, at 181-82 (describing The Match process); *Residency Program Requirements for International Medical Graduates*, *supra* note 36 (indicating applicants must register with NRMP to match with programs); see also NAT’L RESIDENT MATCHING PROGRAM, RESULTS AND DATA: 2018 MAIN RESIDENCY MATCH, at v (2018), <http://www.nrmp.org/wp-content/uploads/2018/04/Main-Match-Result-and-Data-2018.pdf> [<https://perma.cc/SJV4-RC92>] (summarizing NRMP’s history and function). The Match process fills post-graduate training positions, and all students pursuing a residency position should enroll in The Match. *See The Match: Getting into a Residency Program*, *supra* note 39.

41. See Richard Dowse, Article, *Wasting Talent: How the US Is Losing Revenue and Skills of Immigrant Workers*, CREIGHTON INT’L & COMP. L.J., Dec. 2017, at 54, 59 (observing Congress has not added more residency spots, to detriment of IMGs); Rampell, *supra* note 5 (recognizing Congress froze residency funding in 1997).

42. See Dowse, *supra* note 41, at 59 (stressing significance of cultural and language barriers to residency programs); see also Ankur Kalra & Kunal Suri, *Alienated*, 316 JAMA 2191, 2191 (2016) (commenting on difficulties of acceptance into residencies); Rampell, *supra* note 5 (declaring winning residency spot “biggest challenge” for IMGs).

43. See NAT’L RESIDENT MATCHING PROGRAM, *supra* note 40, at 1 (summarizing data from 2018 Match results). In the last five years, an average of 42.1% of IMGs matched successfully, compared with 93.9% of U.S. medical school graduates. *See Rampell*, *supra* note 5.

44. See CHARTING OUTCOMES IN THE MATCH: INTERNATIONAL MEDICAL GRADUATES, *supra* note 25, at iii (summarizing general observations of IMGs successful in matching to preferred specialties); Rampell, *supra* note 5 (offering one IMG’s story, blaming low test scores for failure to match for three years).

45. See Aronson & Stelljes, *supra* note 26, at 8-9 (listing various types of visas for IMGs engaged in GME program); *Residency Program Requirements for International Medical Graduates*, *supra* note 36 (indicating IMGs must receive visa to apply for residency program).

B. Entering the United States: The J-1 Exchange Visitor Program

1. History of the J-1 Visa

The most common visa path for IMGs is the J-1 nonimmigrant visa, also known as the Exchange Visitor Program.⁴⁶ The earliest roots of the Exchange Visitor Program date back to 1948, when Congress enacted the Smith-Mundt Act.⁴⁷ The purpose of the Exchange Visitor Program within the Smith-Mundt Act was to “promote mutual understanding” between the American people and people of other countries.⁴⁸ Four years later, the Immigration and Nationality Act (INA) replaced the Smith-Mundt Act, incorporating and amending the Exchange Visitor language.⁴⁹ It was not until 1961, however, when Congress passed the Fulbright-Hays Act, that the J-1 visa was created as a distinct category under the INA.⁵⁰

Significantly, foreign physicians were not specifically mentioned in the J-1 visa provision of the INA until Congress enacted the Health Professions Educational Assistance Act of 1976 (HPEAA), which imposed new requirements for IMGs.⁵¹ As it stands today, the J-1 visa allows foreign nationals to temporarily visit the United States as Exchange Visitors who will receive medical training or

46. See Skyler G. Cruz, Note, *Have Foreign Physicians Been Misdiagnosed? A Closer Look at the J-1 Visa*, 2 LOY. U. CHI. INT'L L. REV. 295, 300-01 (2005) [hereinafter Cruz, *Closer Look*] (noting J-1 category predominant visa method). An IMG may also qualify for an L, O, or H-1B visa, but these visas are not as commonly used. See *id.* at 301; see also ECFMG BOOKLET, *supra* note 30, at 82 (discussing J-1 visa option to participate in clinical training programs).

47. See Robert D. Aronson & Dinesh P. Shenoy, *From Draconian to Protean: Home Residence Obligations for Physicians Under INA § 212(e)* (summarizing early beginnings of Exchange Visitor Program), in IMMIGRATION OPTIONS FOR PHYSICIANS, *supra* note 10, at 17, 18; Cruz, *Closer Look*, *supra* note 46, at 295-98 (detailing legislative history).

48. See Aronson & Shenoy, *supra* note 47, at 18 (highlighting purpose of Smith-Mundt Act). This Act was an initiative to work with foreign elites to create more positive exposure and to correct misunderstandings about the United States. See *id.* Also underlying the program was a requirement that Exchange Visitors—nonimmigrants entering the United States under the Exchange Visitor Program—return home to share their experiences in the United States. See Cruz, *Closer Look*, *supra* note 46, at 295-96 (acknowledging Congress's sentiment at time).

49. See Aronson & Shenoy, *supra* note 47, at 18 (noting Exchange Visitors designated nonimmigrants in INA). The INA amendment restricted Exchange Visitors from applying for any visa prior to returning home first. See Cruz, *Closer Look*, *supra* note 46, at 296.

50. See Immigration and Nationality Act of 1952 § 101(a)(15)(J), 8 U.S.C. § 1101(a)(15)(J) (2018) (setting forth J-1 visa category and requirements); Mutual Educational and Cultural Exchange Act of 1961 (Fulbright-Hays Act), Pub. L. No. 87-256, sec. 109(b), § 101(a)(15)(J), 75 Stat. 527, 534-35 (codified as amended at 8 U.S.C. § 1101(a)(15)(J) (2018)) (adding J visa section to INA); 22 C.F.R. § 62.1(b) (2018) (discussing purpose of Exchange Visitor Program); Cruz, *Closer Look*, *supra* note 46, at 297 (noting Fulbright-Hays Act replaced Smith-Mundt Act and created J visa category).

51. See Health Professions Educational Assistance Act of 1976, Pub. L. No. 94-484, sec. 601, §§ 101, 212, 90 Stat. 2243, 2300-02 (codified as amended at 8 U.S.C. §§ 1101, 1182 (2018)) (amending INA and adding new requirements for IMGs); Aronson & Shenoy, *supra* note 47, at 20-21 (listing new requirements and referring to HPEAA's restricting legislation); see also Cruz, *Closer Look*, *supra* note 46, at 298 (maintaining HPEAA forced IMGs to begin using J-1 visa).

who will be involved in medical internships offered by sponsors.⁵² The DOS controls the Exchange Visitor Program through the Bureau of Educational and Cultural Affairs.⁵³

2. *The J-1 Visa Adjudication Process*

IMGs who wish to enter the United States for the purpose of completing residency training are part of the “Alien Physician Program” subcategory of the J-1 visa, created for the purpose of GME and managed by the ECFMG.⁵⁴ The ECFMG sponsors the IMG for a J-1 visa and issues a DS-2019 Certificate of Eligibility, which allows the IMG to apply for a J-1 visa.⁵⁵ All Exchange Visitors, including IMGs, need the DS-2019 form, which identifies the IMG’s sponsor and describes the program the IMG is participating in.⁵⁶ The IMG also must obtain a “Statement of Need” from his or her home country’s Ministry of Health.⁵⁷

Once the IMG has met the preliminary requirements, the IMG must demonstrate to the consular officer at the visa interview evidence of his or her nonimmigrant intent, the purpose of the intended travel, and an ability to pay all travel costs.⁵⁸ If the IMG successfully receives the J-1 visa, the IMG will be admitted

52. See Immigration and Nationality Act of 1952 § 101(a)(15)(J) (defining J-1 visa). The INA defines a person under the J-1 visa category as a “bona fide” student, trainee, teacher, or professor coming to the United States temporarily to participate in a specifically designated program, such as to receive GME or training. *Id.* The Department of State (DOS) designates sponsors who must approve the training or internship program. See 1 DARYL BUFFENSTEIN ET AL., BUSINESS IMMIGRATION: LAW & PRACTICE 838 (2d ed. 2017) (summarizing J-1 visa category); Aronson & Stelljes, *supra* note 26, at 9 (recognizing fourteen J-1 Exchange Visitor categories currently exist).

53. See Aronson & Stelljes, *supra* note 26, at 9 (discussing DOS’s role in J-1 program); Programs, EXCHANGE VISITOR PROGRAM, <https://j1visa.state.gov/programs> [<https://perma.cc/V5XF-KXEW>] (listing opportunities for J-1 visa candidates).

54. See 22 C.F.R. § 62.4(h)(1) (2018) (defining alien physician); Aronson & Stelljes, *supra* note 26, at 9 (noting HPEAA gave ECFMG exclusive designation to administer J-1 Alien Physician Program).

55. See BUFFENSTEIN ET AL., *supra* note 52, at 838 (summarizing J-1 sponsor requirements). As the visa sponsor, the ECFMG processes applications for physicians and their eligible dependents, ensuring both the physician and the host training program meet all federal requirements. See ECFMG BOOKLET, *supra* note 30, at 82; see also Physician Program, EXCHANGE VISITOR PROGRAM, <https://j1visa.state.gov/programs/physician/> [<https://perma.cc/KRG8-N6XE>] (listing all requirements for Alien Physician Program).

56. See About DS-2019, EXCHANGE VISITOR PROGRAM, <https://j1visa.state.gov/participants/how-to-apply/about-ds-2019/> [<https://perma.cc/XV3Q-KSB7>] (describing Form DS-2019’s purpose and function). The Form DS-2019 allows Exchange Visitors to seek an interview at a U.S. consulate to obtain their J-1 visa, which is only given at the discretion of the consular officer reviewing their application. See *id.*

57. See Aronson & Stelljes, *supra* note 26, at 10 (describing home country concurrence statement). The Statement of Need letter is proof of a shortage of trained physicians in the specialty that the IMG is training in, and assures that the IMG will return home after the training. See *id.*; see also Kalra & Suri, *supra* note 42, at 2191.

58. See 9 U.S. DEP’T OF STATE, FOREIGN AFFAIRS MANUAL § 403.2-3 (2018) (detailing components of visa application at consulate); RICHARD A. BOSWELL, ESSENTIALS OF IMMIGRATION LAW 112 (4th ed. 2016) (outlining visa application and admission procedure). All nonimmigrants must overcome a heavy burden of showing nonimmigrant (non-permanent) intent, as the INA presumes that all persons entering the United States wish to remain permanently. See BOSWELL, *supra*, at 109-10. The “dual intent” doctrine, in which an individual could

for the duration of the training program, but must renew his or her sponsorship annually.⁵⁹

3. *The Foreign Residence Requirement*

The Exchange Visitor Program was intended to foster international exchange, not immigration, and therefore IMGs must return home at the end of the residency training program.⁶⁰ This “two-year foreign residence requirement” applies to certain Exchange Visitors, and specifically to all IMGs receiving clinical GME under the J-1 visa.⁶¹ This key provision requires “alien physicians” to return to their home country or country of last residence for a period of two years before they can apply for certain types of temporary status, or for permanent status, in the United States.⁶² The two-year foreign residence requirement for certain J-1 visa holders is the only provision in immigration laws that mandates nonimmigrants reside abroad for a fixed time period before returning to the United States.⁶³

The home residence obligation originated under the Smith-Mundt Act, which required Exchange Visitors to leave the United States, but did not require a set

simultaneously have an intent to remain temporarily while still wishing in the future to be a permanent resident, is recognized for a few visa categories, but not the J-1 visa. *See id.* at 111-12. Evidence to support nonimmigrant intent includes evidence of employment, binding familial ties, or that someone is covering the cost of travel if the applicant does not demonstrate enough funds. *See Exchange Visitor Visa*, TRAVEL.STATE.GOV, <https://travel.state.gov/content/travel/en/us-visas/study/exchange.html> [<https://perma.cc/QA6R-34KX>] (informing applicants of necessary documentation and qualifications for Exchange Visitor visa application); *see also Cruz, Closer Look*, *supra* note 46, at 299 (stating J-1 visa threshold requirements).

59. *See Aronson & Stelljes, supra* note 26, at 10 (explaining duration limits consistent with residency program requirements); *see also Cruz, Closer Look, supra* note 46, at 301 (recognizing J-1 visa holder must renew sponsorship annually through ECFMG). Generally, the J-1 visa is limited to no more than seven years. *See Aronson & Stelljes, supra* note 26, at 10; *see also Kalra & Suri, supra* note 42, at 2191 (declaring annual renewal process “cumbersome and tedious”).

60. *See Aronson & Stelljes, supra* note 26, at 9, 10 (introducing two-year home country presence requirement). The J-1 IMG sponsored by the ECFMG is subject to this requirement from the point of admission or change of nonimmigrant status. *See id.* at 10.

61. *See Immigration and Nationality Act of 1952* § 212(e), 8 U.S.C. § 1182(e) (2018) (setting forth current foreign residence requirement). The foreign residence requirement applies to Exchange Visitors in programs financed by the U.S. government or their own foreign government, nationals or residents of countries designated as requiring services of persons with specialized knowledge or skill, and those in GME programs. *See id.*; *see also David Ware, J-1 Physician Exchange Visitors and the Two-Year Foreign Residence Requirement: To What Country Must One Return?* (discussing difference between clinical “alien physician” and “research scholar” foreign physicians), in *IMMIGRATION OPTIONS FOR PHYSICIANS, supra* note 10, at 143, 143. IMGs engaged in non-clinical activities such as research or teaching under a J-1 visa are not subject to the two-year foreign residence requirement. *See Ware, supra*, at 143.

62. *See Immigration and Nationality Act of 1952* § 212(e) (stating mandatory two-year residence abroad). Generally, IMGs must return to the country that issued their Statement of Need letter. *See Ware, supra* note 61, at 144-45. European Union (EU) residents must return to the specific country that the requirement is attached to, and not the EU in general. *See id.* at 146. Individuals who are subject to the requirement may also apply for a waiver of the requirement. *See id.*; *see also infra* Section II.D (discussing waivers).

63. *See 1 IMMIGR. L. SERV. 2D* § 5:96, Westlaw (database updated Nov. 2019) (summarizing foreign residence requirement). A determination of whether a foreign national is subject to the two-year requirement is not made until that person pursues permanent residence or temporary work through another visa category. *See id.*

time period to remain abroad.⁶⁴ It was not until Congress amended INA section 212(e) in 1970 that the two-year requirement took shape, but at that point it did not yet apply to IMGs.⁶⁵ Through the 1970s, IMGs had many pathways to enter the United States for GME besides through the J-1 program—until a growing IMG presence in the country triggered fears about the quality of medical care, and about IMGs taking jobs from U.S. medical school graduates.⁶⁶ When passing the HPEAA, Congress declared there was no longer a physician shortage, closed the door on other visa pathways for all foreign-born physicians, and made IMGs involved in GME subject to the two-year foreign residence requirement.⁶⁷

C. *The Physician Shortage: How We Got Here*

In the 1970s, Congress felt that IMGs were not a desirable or necessary form of manpower to solve deficiencies in the physician workforce, but instead that they deteriorated the quality of care.⁶⁸ Such sentiments still persist, along with feelings that recruiting IMGs to work in the United States contributes to a “brain drain,” or the idea that underserved countries are losing their own highly-trained medical professionals due to this recruitment, worsening those countries’ healthcare problems.⁶⁹ Studies have shown, however, that IMGs deliver care

64. See Aronson & Shenoy, *supra* note 47, at 18 (discussing origin of foreign residence requirement). Under the Smith-Mundt Act, Exchange Visitors only had to depart the United States briefly, and then could immediately reenter on another visa status. See *supra* note 48 and accompanying text (highlighting purpose of Smith-Mundt Act).

65. See Aronson & Shenoy, *supra* note 47, at 18-19 (noting foreign residence requirement only applied to two scenarios at time). The two situations that the residence requirement applied to were when the Exchange Visitor’s program was funded by the United States or the foreigner’s government and when the foreign national was a national or resident of a country that was designated as requiring people engaged in a certain skill set. See *id.* at 19; see also Ware, *supra* note 61, at 145 (indicating Congress narrowed “country of return” language over time).

66. See Aronson & Shenoy, *supra* note 47, at 19 (addressing restrictions later put in place against IMGs). Previously, IMGs could have entered a GME program under H-1, H-2, H-3, or immigrant visas. See *id.* When the foreign-born physician population in the United States grew to 63,000, or 20% of the physician workforce, changes in legislation began to occur. See *id.*

67. See Health Professions Educational Assistance Act of 1976, Pub. L. No. 94-484, sec. 601(c)-(d), § 212(e), (j)(1), 90 Stat. 2243, 2301-02 (codified as amended at 8 U.S.C. § 1182(e), (j)(1) (2018)) (amending foreign residence requirement in INA); Aronson & Shenoy, *supra* note 47, at 19 (noting HPEAA principal legislation controlling IMGs). Congress’s goal in passing the HPEAA was to improve “the availability of high quality health care to all Americans[,]” particularly in the primary care field and medically underserved communities, which were suffering a shortage. See § 2(a)(1), 90 Stat. at 2243 (establishing Congress’s findings and declarations of policy); Aronson & Shenoy, *supra* note 47, at 19 (elaborating on congressional goals). Congress felt the solution to the primary care shortage was to incentivize U.S.-trained physicians to practice in those areas, because there were enough domestic physicians to fill staffing levels. Aronson & Shenoy, *supra* note 47, at 19.

68. See Aronson & Shenoy, *supra* note 47, at 21 (indicating Congress’s feelings toward IMGs in 1970s). Congress blamed immigration laws and an increase in the number of residency spots for the unnecessary increase of IMGs in the United States. See *id.* at 20.

69. See Aronson & Stelljes, *supra* note 26, at 6 (discussing controversies over GME programs); Stephanie Gunselman, Note, *The Conrad “State-30” Program: A Temporary Relief to the U.S. Shortage of Physicians or a Contributor to the Brain Drain?*, 5 J. HEALTH & BIOMEDICAL L. 91, 112-13 (2009) (arguing unethical to recruit IMGs from developing countries); see also Saeid B. Amini, *Discrimination of International Medical Graduate*

comparable to U.S.-trained physicians, and are not a threat to global healthcare, as once commonly thought.⁷⁰

In fact, IMGs have alleviated the physician shortage and contributed to meeting the needs of underserved populations across the United States.⁷¹ This is especially true in the field of primary care.⁷² The physician shortage most disproportionately affects patients living in rural areas, where 20% of the entire U.S. population resides, but only 9% of physicians provide care.⁷³ Physicians in general tend to turn away from working in rural and underserved areas because these primary care positions tend to present heavy workloads, lower salaries, and other lifestyle concerns.⁷⁴ While U.S.-trained physicians are choosing more profitable

Physicians by Managed Care Organizations: Impact, Law and Remedy, 2 DEPAUL J. HEALTH CARE L. 461, 479 (1999) (noting longstanding history of United States discriminating against IMGs).

70. See Joseph Nwadiuko et al., *International Medical Graduates—A Critical Component of the Global Health Workforce*, 319 JAMA 765, 765 (2018) (opining tight restrictions on physician migration unnecessary to improve global care). Studies have shown IMGs return to their home countries, donate to charity efforts for their countries, and participate in programs that incentivize practice in home countries, thereby refuting any concern for a brain drain. See *id.* at 765-66; Szilvia Altorjai & Jeanne Batalova, *Immigrant Health-Care Workers in the United States*, MIGRATION POL'Y INST. (June 28, 2017), <https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states> [<https://perma.cc/X9EB-R5NK>] (observing about 93% of foreign-born physicians report English proficiency); see also Yusuke Tsugawa et al., *Quality of Care Delivered by General Internists in US Hospitals Who Graduated from Foreign Versus US Medical Schools: Observational Study*, BMJ, Feb. 3, 2017, at 1, 5, <https://www.bmj.com/content/bmj/356/bmj.j273.full.pdf> [<https://perma.cc/NR38-RZY9>] (finding no evidence of worse patient outcomes for IMGs over U.S. medical graduates). Among Medicare beneficiaries admitted to a hospital, thirty-day mortality rates were lower for IMGs than U.S. medical graduates, even though IMGs tend to treat patients with lower incomes and more chronic conditions. See Tsugawa et al., *supra* at 1, 3-4.

71. See *supra* notes 2-4 and accompanying text (discussing physician shortage in United States); see also Fisher, *supra* note 3 (indicating foreign-born physicians well-positioned to fill gaps in healthcare labor force). One Pennsylvania hospital depends on two Jordanian physicians to keep its obstetrics unit open. See Miriam Jordan, *Rural Areas Brace for a Shortage of Doctors Due to Visa Policy*, N.Y. TIMES (Mar. 18, 2017), <https://nyti.ms/2nDiabR> [<https://perma.cc/A6YD-3FAE>]; see also Letter from All. for Acad. Internal Med. et al. to L. Francis Cissna, *supra* note 4 (stressing teaching hospitals rely on IMGs to provide care); Letter from James L. Madara to L. Francis Cissna, *supra* note 1 (emphasizing IMGs' critical role in providing healthcare).

72. See ESTHER HING & SUSAN LIN, NAT'L CTR. FOR HEALTH STAT., *ROLE OF INTERNATIONAL MEDICAL GRADUATES PROVIDING OFFICE-BASED MEDICAL CARE: UNITED STATES, 2005-2006*, at 1, 4 (2009), <https://www.cdc.gov/nchs/data/databriefs/db13.pdf> [<https://perma.cc/64UX-2J7E>] (confirming IMGs contribute to U.S. healthcare, especially in primary care shortage areas). In 2018, primary care specialties offered a record-high number of residency positions, and IMGs filled the majority of them. See NAT'L RESIDENT MATCHING PROGRAM, *supra* note 40, at 21 tbl.3. For example, only 42.4% of internal medicine positions were filled by U.S. medical graduates—the lowest on record—and 44.9% of family medicine positions were filled by U.S. medical graduates. See *id.*

73. See Gunselman, *supra* note 69, at 95 (declaring vulnerable populations have limited access to much-needed healthcare). In Mississippi, there are only fifty primary care physicians for every 100,000 people. See *id.*; Jennifer Lorio, Article, *Physician Reimbursement, Impending Shortages, and Healthcare Reform*, ANNALS OF HEALTH L.: ADVANCE DIRECTIVE, Fall 2011, at 11, 12-15, <https://www.luc.edu/media/lucedu/law/centers/healthlaw/pdfs/advancedirective/pdfs/issue7/lorio.pdf> [<https://perma.cc/2TQZ-XZCT>] (stipulating physician shortage negatively affects persons in rural areas or those insured by government programs); Fisher, *supra* note 3 (stressing lack of U.S.-born healthcare workers to meet demand, especially in areas with greatest needs).

74. See Cheng, *supra* note 38, at 168-69 (highlighting lifestyle concerns from administrative hassles and practice design). Medical school debt also strongly influences the decision-making process because student debt for primary care physicians can be “insurmountable.” See *id.* at 169-70; see also Gunselman, *supra* note 69, at

specializations in metropolitan areas, rural areas are depending on IMGs to fill the gaps in essential healthcare.⁷⁵

D. The Conrad Program: A Partial Solution to Addressing the Medical Shortage

1. Origins of the Conrad Program

In contrast to earlier years, the 1990s experienced a shift away from negative attitudes about IMGs, and towards a view that recognized the real contributions IMGs made in increasing physician access in rural areas.⁷⁶ Senator Kent Conrad's vision to solve the physician shortage in rural areas was the basis for initiating the Conrad Program in 1994.⁷⁷ Under the Conrad Program, states can recommend waiving the IMG's two-year foreign residence requirement if the IMG takes a job as a physician in an area that has been federally designated as suffering from a medical shortage.⁷⁸ Prior to the Conrad Program, the only methods available for IMGs to obtain waivers were if federal agencies recommended them, if fulfilling the requirement would subject the IMG's U.S. citizen or permanent resident spouse or children to exceptional hardship, or if the IMG would suffer persecution if he or she returned home.⁷⁹

96 (suggesting rural hospitals experience difficulty recruiting and retaining physicians); Lorio, *supra* note 73, at 15 (listing reasons why rural areas less appealing to physicians); Fisher, *supra* note 3 (noting specialists compensated up to 45% more than primary care physicians).

75. See *supra* note 9 and accompanying text (discussing IMGs' tendency to fill primary care positions); see also Fisher, *supra* note 3 (opining foreign-born physicians key to addressing primary care shortage); Katie Vloet, *Immigration Law and the Nation's Physician Shortage*, L. QUADRANGLE, Spring 2015, at 20, 21, <https://quadrangle.law.umich.edu/wp-content/uploads/2015/04/Spring2015.pdf> [<https://perma.cc/WXP7-2M3E>] (noting IMGs who work in underserved areas tend to stay in those communities).

76. See Aronson & Shenoy, *supra* note 47, at 22-23 (noting change in attitudes towards IMGs). IMGs started to be seen as "highly qualified foreign physicians[.]" and by returning home, the community they practiced in would lose a much-needed physician. See *id.* at 23.

77. See Immigration and Nationality Technical Corrections Act of 1994, Pub. L. No. 103-416, sec. 220, §§ 212(e), 214, 108 Stat. 4305, 4319-20 (codified as amended at 8 U.S.C. §§ 1182(e), 1184 (2018)) (implementing Conrad Program waiver). Senator Conrad argued there was a need for his home state of North Dakota, and many other states, to "turn every stone" to find an opportunity for these IMGs to continue practicing in rural areas without having to return home, as the current system was "extremely inequitable." See Aronson & Shenoy, *supra* note 47, at 23 (quoting 140 CONG. REC. S6747 (daily ed. June 9, 1994) (statement of Sen. Conrad)). Under the system at that time, it was difficult to work with federal agencies to find a sponsor for a waiver, because states could not seek waivers for IMGs. See *id.*

78. See Sostrin & Baker, *supra* note 11, at 45 (summarizing function of Conrad Program). Every IMG who receives such a waiver must practice in the shortage area for three years. See Gunselman, *supra* note 69, at 101; see also *infra* Section II.D.2 (outlining details of Conrad Program).

79. See 2 CHARLES GORDON ET AL., IMMIGRATION LAW AND PROCEDURE § 22.07 (Matthew Bender & Co. ed., rev. ed. 2018) (examining various waivers of two-year home residence requirement). There is also a way to obtain a waiver from a "no objection" letter from the physician's home country, but these letters are not available for IMGs pursuing GME. See Ware, *supra* note 61, at 147. Although waivers of the two-year home residence requirement are available, they are rare and difficult to obtain. See Cruz, *Closer Look*, *supra* note 46, at 306.

2. *The Conrad Program in Action*

Currently, the majority of IMGs obtaining waivers do so through the Conrad Program.⁸⁰ Under the original Conrad Program, each state's Department of Health was able to act as an interested government agency (IGA) and could sponsor up to twenty doctors for J-1 visa waivers.⁸¹ Since then, Congress has expanded the Conrad Program and increased the number of waivers offered per state, now offering up to thirty waivers per state.⁸² Additionally, as a result of the changes made in 2008, states may sponsor ten flex waivers per year out of the thirty available slots for IMGs not serving in federally recognized shortage areas, but in targeted areas of need.⁸³

Every IMG who receives a waiver must fulfill a three-year requirement to practice in either a Health Professional Shortage Area, Medically Underserved Area, Medically Underserved Populations, or a "flex" targeted area.⁸⁴ The U.S. Department of Health and Human Services (HHS) determines what constitutes such an underserved area.⁸⁵ Additionally, although each state establishes its own requirements and procedures for filing Conrad Program waivers, the IMG must meet general federal requirements to obtain a waiver.⁸⁶ The IMG must hold a

80. See Ware, *supra* note 61, at 147 (maintaining state and federally recommended waivers account for most J-1 physician waivers).

81. See Wendy Castor Hess & Karen M. Pollins, *Practical and Planning Issues in Populous Conrad 30 States: The King Solomon J-1 Waiver Approach* (reviewing Conrad Program's beginnings), in IMMIGRATION OPTIONS FOR PHYSICIANS, *supra* note 10, at 79, 81. The original legislation expired in 1996, but Congress has continually extended the deadline. See Gunselman, *supra* note 69, at 100.

82. See Hess & Pollins, *supra* note 81, at 81 (tracing Conrad Program's extensions and amendments). Congress increased the number of waivers per state in 2002. See *id.*

83. See *id.* at 81-82 (describing additional flex waivers allocated to IMGs). Each state may choose whether to grant recommendations for flex slots, and many states that receive more than thirty waiver requests from facilities in federally-designated areas do not grant them at all. See *id.* at 86. In 2008, Congress extended the Conrad Program deadline and increased the flex slots from five to ten. See Sostrin & Baker, *supra* note 11, at 45. These flex slots are an important source of physicians for medically underserved areas and for populations that are not federally designated as shortage areas. See *id.*

84. See Immigration and Nationality Act of 1952 § 214(l), 8 U.S.C. § 1184(l) (2018) (setting forth requirements of interested state or federal agency waivers); Hess & Pollins, *supra* note 81, at 81 (stipulating requirements set by federal regulations); see also *Conrad 30 Waiver Program*, U.S. CITIZENSHIP & IMMIGR. SERVICES, <https://www.uscis.gov/working-united-states/students-and-exchange-visitors/conrad-30-waiver-program> [<https://perma.cc/ZJM3-7V3B>] (last updated May 5, 2014) (listing eligibility guidelines for Conrad waiver).

85. See AUSTIN T. FRAGOMEN, JR. ET AL., IMMIGRATION PROCEDURES HANDBOOK § 3:56, Westlaw (database updated Dec. 2019) (tracing history of federal government designating shortage areas). The Department of Housing and Urban Development and the Department of Agriculture originally sponsored the waiver programs until HHS took over in 2002. See *id.* The designations by HHS are published periodically in the Federal Register and can be searched on HHS's website. See *id.*; see also *Conrad 30 Waiver Program*, *supra* note 84 (noting HHS designates areas).

86. See Hess & Pollins, *supra* note 81, at 81 (explaining states write their own criteria in addition to federal requirements for waiver slots). The key factor states consider in approving waiver requests is "need" in a particular area, mostly based on physician-patient ratios. See *id.* at 83; see also Sostrin & Baker, *supra* note 11, at 47 (highlighting state-specific procedures for approving Conrad Program waivers). See generally Siskind Susser, PC, *Conrad State 30 Program Chart* (listing each state's requirements and filing procedures for Conrad Program), in IMMIGRATION OPTIONS FOR PHYSICIANS, *supra* note 10, at 263. In Massachusetts, for example, there is a required recruitment period, and the state will only use up to five flex waivers. See *id.* at 269. See generally

full-time, written offer and contract of employment in a designated area, must agree to begin working within ninety days of waiver approval, and must sign a statement agreeing to comply with the Conrad Program.⁸⁷ Finally, if the state grants the waiver, the IMG must obtain H-1B status in order to legally work pursuant to his or her contract.⁸⁸

3. Extensions and Amendments to the Conrad Program

According to the original legislation, the Conrad Program was set to expire in 1996, but Congress has continually extended and amended it ever since.⁸⁹ The Conrad Program has been well-received, as evidenced by its constant renewal, yet steps to make the Conrad Program permanent have been halted.⁹⁰ In 2008, Senator Conrad introduced a bill that would have eliminated the “sunset” provision of the Conrad Program to make it permanent, but the bill failed to advance to a vote.⁹¹

The Conrad Program was most recently set to expire in 2019, but after budget

Conrad State 30 Program FY 2018, SELTZER FIRM, <http://theseltzerfirm.com/wp-content/uploads/2018/02/Conrad-State-30-Program-FY2018.pdf> [<https://perma.cc/4S9A-GUUB>] (identifying number of slots each state filled in fiscal year 2017).

87. See Petitioner: [redacted], 2005 Immig. Rptr. LEXIS 30676, at *2-3 (Admin. App. Office Sept. 15, 2005) (reviewing eligibility requirements for waivers); Applicant: [redacted], 2000 Immig. Rptr. LEXIS 1350, at *4 (Admin. App. Office Aug. 14, 2000) (providing federal requirements to grant IGA waivers); Sostrin & Baker, *supra* note 11, at 46 (listing general requirements in every state’s guidelines); *Conrad 30 Waiver Program*, *supra* note 84 (indicating program requirements applied to all J-1 medical doctors). If the IMG’s home government funded the IMG’s program, the IMG will also have to obtain a “no objection” letter from his or her home country. See Hess & Pollins, *supra* note 81, at 82.

88. See *Kutty v. U.S. Dep’t of Labor*, 764 F.3d 540, 548 (6th Cir. 2014) (asserting any IMG on J-1 visa seeking waiver must obtain H-1B status for employment). To employ H-1B nonimmigrants, IMG employers must complete and file a Labor Condition Application with the Department of Labor (DOL) that attests to labor conditions and wage guarantees. See *id.* at 544. Once the IMG has fulfilled the three-year period of employment under an H-1B visa, he or she will become eligible to apply for an L nonimmigrant visa, an immigrant visa, or permanent residence. See *Conrad 30 Waiver Program*, *supra* note 84; see also Sostrin & Baker, *supra* note 11, at 46 (explaining J-1 waiver recipients not subject to annual H-1B visa cap limitation of 65,000).

89. See Aronson, *supra* note 10, at 66-69 (tracing Conrad Program extensions since 1994); *supra* notes 82-83 and accompanying text (discussing Congress increasing waiver slots and adding flex slots).

90. See Aronson, *supra* note 10, at 69 (declaring Conrad Program “highly innovative” and useful for recruitment); Gunselman, *supra* note 69, at 103 (observing Conrad Program’s continual success in renewals); Klaric, *supra* note 8, at 629 (commenting bill to make Conrad Program permanent did not progress).

91. See Margaret Bomba, Note, *Exploring Legal Frameworks to Mitigate the Negative Effects of International Health-Worker Migration*, 89 B.U. L. REV. 1103, 1121 (2009) (detailing 2008 bill). The Conrad Program’s sunset provision requires extensions after certain expiration dates, which would not be necessary if the Conrad Program became permanent. See *id.* Senator Conrad argued that the “looming deficit of doctors” meant it was “vital” to incentivize IMGs to practice in the United States. See *id.*; see also Klaric, *supra* note 8, at 628-29 (quoting 154 CONG. REC. S1272 (daily ed. Feb. 27, 2008) (statement of Sen. Conrad)) (offering overview of amendments introduced in 2008 legislation). The only change that resulted from the 2008 legislation was an increase in the flex slots from five to ten. See Aronson, *supra* note 10, at 70.

negotiations, Congress reauthorized it through the end of fiscal year 2020 without changes.⁹² If Congress does not further extend the Conrad Program, the entire waiver process would break down, risking about 1,500 physician placement applications in the United States and countless patients.⁹³ A recent bill—introduced in 2019, and stalled ever since—attempts to save the waiver program until 2021.⁹⁴ This legislation, the Conrad State 30 and Physician Access Reauthorization Act (Conrad Reauthorization Act), has bipartisan sponsorship and would amend the Conrad Program in various ways, including increasing the number of waiver slots per state to thirty-five per year when certain conditions are met.⁹⁵

E. Current Immigration Roadblocks for IMGs and All Foreign-Born Physicians

1. Stalling of Comprehensive Immigration Reform

Efforts towards reforming and permanently extending the Conrad Program have been hindered, mainly due to Congress's failure to implement comprehensive immigration reform.⁹⁶ Although discussions and proposals surrounding wide-ranging immigration reform have been raised across party lines, political divides have kept necessary reforms from moving forward.⁹⁷ Since 2005, Congress has been unable to pass immigration reform regardless of whether Democrats or Republicans controlled the executive or legislative branches.⁹⁸ Hope for

92. See *Congress Passes FY 2020 Spending Bills*, FRAGOMEN (Dec. 19, 2019), <https://www.fragomen.com/insights/alerts/congress-passes-fy-2020-spending-bills> [<https://perma.cc/FDA7-7642>] (indicating Conrad Program extended through end of fiscal year without changes).

93. See *Conrad 30 Reauthorization Bill Earns Bipartisan Support*, *supra* note 14 (contending failure to extend Conrad Program could disrupt patient care); see also Aronson & Shenoy, *supra* note 47, at 24 (stating Conrad Program places about 1,000 J-1 physicians per year in needed areas).

94. See Conrad State 30 and Physician Access Reauthorization Act, S. 948, 116th Cong. § 2(a) (2019) (proposing extending Conrad Program to 2021).

95. See *id.* §§ 3-6 (outlining proposed changes to Conrad Program). The bill would establish more employment protections for IMGs, allow IMGs on a J-1 visa to have dual intent, let states recapture any "lost" slots, and permit a six-month nonimmigrant status extension for any IMG who has been denied a waiver but agrees to seek another waiver in a different state. See *id.*; see also Ombok & Read, *supra* note 14 (noting bipartisan support for Conrad Reauthorization Act).

96. See Aronson, *supra* note 10, at 69 (suggesting reauthorization efforts for Conrad Program caught up in "paralysis" of immigration reform); Fisher, *supra* note 3 (stipulating immigration system poses significant barriers to IMGs working in healthcare).

97. See Dorothy Hanigan Basmaji & Alyssa Yeip-Lewerenz, *Building Walls in More Ways than One: The Face of Business Immigration Under the Trump Administration*, MICH. B.J., Feb. 2018, at 24, 24 (discussing attempts at immigration reform). The main immigration issue dividing Democrats and Republicans is a widespread disagreement about how to legally treat undocumented immigrants. See *id.*; Janice D. Villiers, *Closing the Borders: Reverse Brain Drain and the Need for Immigration Reform*, 55 WAYNE L. REV. 1877, 1896 (2009) (arguing comprehensive reform necessary).

98. See Greg Siskind, *The Impact of Immigration Reform on the Healthcare Sector*, HEALTH LAW., Apr. 2014, at 9, 9 (indicating immigration reform has died on numerous occasions). Comprehensive immigration reform could not pass even when Democrats controlled both the executive and legislative branches in 2009-2010. See *Why Immigration Reform Died in Congress*, *supra* note 17.

reform sparked in 2013, when the Senate passed major overhaul legislation created by the bipartisan “Gang of Eight,” but the Republican-led House of Representatives, led by Speaker John Boehner, brought the legislation to an abrupt halt.⁹⁹

The Senate-backed bill, the Border Security, Economic Opportunity, and Immigration Modernization Act (S. 744), touched almost every aspect of the U.S. immigration system, but in particular contained provisions that would have eased IMG immigration.¹⁰⁰ Specifically, the bill proposed making the Conrad Program permanent and making other improvements, such as allowing IMGs to attain any nonimmigrant status after waiver approval, allowing the total number of waiver slots to rise and fall based on nationwide slot usage, and creating more job protections for IMGs in the Conrad Program.¹⁰¹ The legislation would have also made it easier for IMGs to obtain green cards and would have raised the H-1B visa cap limit.¹⁰²

2. *The Impact of “Buy American and Hire American”*

Although the prospect of modern immigration reform peaked in 2013 with S. 744, the current administration has since made it more difficult for all qualified foreign-born physicians—trained both in and outside of the United States—to work in the U.S. healthcare system.¹⁰³ When Donald Trump took office, a new attitude towards immigrants began to develop with the President’s “America First” theory of economics and foreign policy.¹⁰⁴ On April 18, 2017, President

99. See Muzaffar Chishti & Faye Hipsman, *U.S. Immigration Reform Didn’t Happen in 2013; Will 2014 Be the Year?*, MIGRATION POL’Y INST. (Jan. 9, 2014), <https://www.migrationpolicy.org/article/us-immigration-reform-didnt-happen-2013-will-2014-be-year> [https://perma.cc/SRY2-3ZXQ] (discussing major immigration reform passed by Senate); Davis & Gomez, *supra* note 17 (noting Republican-controlled House continued to oppose Senate immigration bill).

100. See Border Security, Economic Opportunity, and Immigration Modernization Act, S. 744, 113th Cong. §§ 2401-05 (2013) (proposing amendments to physician immigration). The “Gang of Eight,” a group of bipartisan senators who introduced the bill, sought to bridge the political gap between Democrats and Republicans. See Nicholas J. Ferraro, Note, *The U.S. Senate Immigration Reform Bill and the Need for Amendments Before Passing*, 36 U. LA VERNE L. REV. 17, 18, 21 (2014) (discussing background of S. 744). The Senate bill tackled areas such as border security, immigrant visas, immigration enforcement, and nonimmigrant and work visa programs. See *id.* at 26; see also Chishti & Hipsman, *supra* note 99 (highlighting Senate bill would have reduced federal deficit by \$197 billion over ten years).

101. See S. 744 §§ 2401-04 (detailing proposed amendments to Conrad Program); Siskind, *supra* note 98, at 10-11 (listing improvements to Conrad Program).

102. See S. 744 §§ 2306-07, 2405 (setting forth changes to physician immigration). The bill would have granted IMGs priority to receive a green card, exempted them from an immigrant visa quota, and removed the requirement to prove their intent to return home with a J-1 visa. See Siskind, *supra* note 98, at 11.

103. See Chishti & Hipsman, *supra* note 99 (recognizing momentum for immigration reform in 2013); Salkin, *supra* note 18 (highlighting many have expressed worry about effects of President’s immigration policies on IMGs); Schwartz & Lohr, *supra* note 16 (contending Trump Administration preventing immigration of foreign workers into United States).

104. See Cyrus D. Mehta & Sophia Genovese, *The Effects of ‘America First Foreign Policy’ and ‘Buy American Hire American’ on the Foreign Affairs Manual*, 22 BENDER’S IMMIGR. BULL. 1247, 1247 (2017) (focusing on Trump’s “America First” foreign policy). Trump’s policy can be described as a “radical departure” from

Trump's policy came to life when he signed the BAHA Order.¹⁰⁵ The BAHA Order called for new rules and guidance to fight fraud and abuse in the U.S. immigration system, particularly in the H-1B visa program.¹⁰⁶ Federal agencies responded to the call for action by implementing policies that put U.S. workers first, and, while the H-1B category has historically allowed for professional foreign candidates in entry-level positions, agencies began to favor awarding H-1B petition approvals to the most skilled and highest-paid foreign workers.¹⁰⁷

The implementation of the BAHA Order brought widespread insecurity for all foreign-born physicians—who make up roughly 25% of the U.S. physician workforce, and who would need an H-1B visa to work in the United States.¹⁰⁸ The BAHA Order has impacted the way federal agencies adjudicate immigration cases, including no longer giving deference to previously approved H-1B cases requesting extensions, and issuing more Requests for Evidence (RFEs), thereby raising the standard of proof at the agency level in the absence of regulation.¹⁰⁹ This resulted in heavy delays in visa processing, and has left hospitals throughout the country without the foreign-born doctors on whom they desperately rely.¹¹⁰

previous foreign policies which welcomed immigrants. *See id.*; *see also* Basmaji & Yeip-Lewerenz, *supra* note 97, at 24 (discussing Trump's policies to limit legal immigration).

105. *See* Exec. Order No. 13788 § 2, 82 Fed. Reg. 18,837 (Apr. 18, 2017) (setting forth President Trump's new BAHA Order). The BAHA Order seeks to "create higher wages and employment rates" for U.S. workers, and to "rigorously enforce and administer the laws governing entry into the United States." *See id.* § 2(b); Basmaji & Yeip-Lewerenz, *supra* note 97, at 24-25.

106. *See* Exec. Order No. 13788 § 5, 82 Fed. Reg. at 18,838-39 (granting federal leaders authority to reform H-1B program); Mehta & Genovese, *supra* note 104, at 1247-49 (offering overview of BAHA Order guidance).

107. *See* Basmaji & Yeip-Lewerenz, *supra* note 97, at 25 (addressing steps federal agencies took to combat fraud and abuse). The DOL, Department of Justice, and DOS all issued guidance that focused on protecting U.S. workers and stepping up enforcement efforts. *See id.* U.S. Citizenship & Immigration Services (USCIS) also announced measures it would take to "deter and detect" H-1B fraud. *See Putting American Workers First: USCIS Announces Further Measures to Detect H-1B Visa Fraud and Abuse*, U.S. CITIZENSHIP & IMMIGR. SERVICES, <https://www.uscis.gov/news/news-releases/putting-american-workers-first-uscis-announces-further-measures-detect-h-1b-visa-fraud-and-abuse> [<https://perma.cc/7EH7-3S92>] (last updated Apr. 3, 2017) [hereinafter *Putting American Workers First*] (setting forth new efforts to protect U.S. workers); *USCIS Director L. Francis Cissna on New Agency Mission Statement*, U.S. CITIZENSHIP & IMMIGR. SERVICES (Feb. 22, 2018), <https://www.uscis.gov/news/news-releases/uscis-director-l-francis-cissna-new-agency-mission-statement> [<https://perma.cc/E9KP-FBC5>] (last updated Feb. 22, 2018) (implementing USCIS's new mission statement reflecting principles including USCIS serves and protects Americans, not immigrants).

108. *See* Jordan, *supra* note 71 (stating foreign-born physicians comprise 25% of physicians in United States). In 2016, the DOL approved U.S. employers to fill about 10,500 H-1B physician positions in the United States. *See* Peter A. Kahn & Tova M. Gardin, *Distribution of Physicians with H-1B Visas by State and Sponsoring Employer*, 317 JAMA 2235, 2236 (2017) (reporting on U.S. hospitals' usage of H-1B program); Salkin, *supra* note 18 (highlighting IMGs concerned about effects of Trump's immigration policies).

109. *See* Veronica Guinto, "Buy American, Hire American" – Hurting U.S. Companies?, AM. IMMIGR. LAW. ASS'N (July 17, 2018), <https://www.aila.org/publications/newsletters/insight/2016-2019/buy-american-hire-american-hurting-us-companies> [<https://perma.cc/HL3Z-ENDL>] (detailing BAHA Order's influence on H-1B cases). By no longer giving deference to previously approved cases, a person requesting an H-1B extension with the same employer would have to prove anew that they are still qualified for that position. *See id.*; *see also* Ducharme, *supra* note 9 (describing one IMG's experience with stricter RFE request).

110. Ducharme, *supra* note 9 (explaining how visa situation threatens status of foreign-born physicians nationwide); Jordan, *supra* note 71 (concluding visa application delays could hurt Conrad Program and patients it

For instance, in rural Montana, where one hospital serves around 230,000 people and 60% of doctors are foreign and practicing on work visas, the hospital does not know when it can expect the arrival of a Romanian doctor it has spent nine months recruiting.¹¹¹

3. *The Major Halt to Immigration: The Travel Ban*

Concerns over visa processing of foreign-born physicians only increased when President Trump signed another executive order in 2017, the Travel Ban, which temporarily banned all entry of citizens from seven predominantly Muslim countries for ninety days.¹¹² After several legal challenges to the original and second versions of the Travel Ban, a third version, titled a “Presidential Proclamation,” was upheld by the Supreme Court.¹¹³ The current Travel Ban restricts citizens from Iran, Libya, North Korea, Syria, Venezuela, Yemen, and Somalia from entering the United States on certain visas.¹¹⁴ Specifically for foreign-born physicians wishing to enter the country on an H-1B or J-1 visa, the Travel Ban completely bans all nonimmigrants from North Korea and Syria, subjects all nonimmigrants from Venezuela and Somalia to additional inspections, and treats IMGs on J-1 visas from Iran with “enhanced screening and vetting.”¹¹⁵ Those affected by the ban may qualify under an exception, or the government can grant them a waiver, but these waivers are rare and difficult to obtain.¹¹⁶

helps). In one Long Island hospital, a new doctor’s cubicle remains vacant due to unexplained delays in visa processing. *See* Schwartz & Lohr, *supra* note 16 (observing more frequent government denials and delays in issuing work visas).

111. *See* Jordan, *supra* note 71 (acknowledging struggles of small-town U.S. hospitals waiting for foreign doctors).

112. *See* Trump v. Hawaii, 138 S. Ct. 2392, 2403 (2018) (discussing first version of executive order signed by President Trump). Congress and prior administrations recognized the seven countries as places that posed “heightened terrorism risks.” *See id.* These countries were Iran, Iraq, Libya, Somalia, Sudan, Syria, and Yemen. *See id.*; *see also* 5 GORDON ET AL., *supra* note 79, § 63.11 (providing Travel Ban overview); Donald G. McNeil, Jr., *Trump’s Travel Ban, Aimed at Terrorists, Has Blocked Doctors*, N.Y. TIMES (Feb. 6, 2017), <https://nyti.ms/2kFkSza> [<https://perma.cc/3FB5-8XCE>] (describing Travel Ban’s immediate effects on doctors attempting to enter United States).

113. *See* Trump, 138 S. Ct. at 2403-05, 2423 (reviewing multiple legal challenges against versions of Travel Ban). Federal courts entered injunctions against both the first and second version of the ban, until the Supreme Court granted certiorari and stayed the injunctions in 2017. *See id.* at 2403-04. In a decision released on June 26, 2018, the Court held that the third version of the Travel Ban had a “national security justification[.]” and overturned the injunction, and that the President did not exceed his authority in implementing the executive order. *See id.* at 2415, 2423. *See generally* Proclamation No. 9645, 82 Fed. Reg. 45,161 (Sept. 24, 2017) (setting forth third version of Travel Ban).

114. *See* Proclamation No. 9645, 82 Fed. Reg. at 45,165-67 (listing countries subject to revised Travel Ban).

115. *See id.* (detailing Travel Ban policies and application). Although J-1 visa holders from Iran are met with stricter vetting procedures, all other holders of nonimmigrant visas from Iran (except F and M visas) are banned, including H-1B visas. *See id.* at 45,165.

116. *See id.* at 45,167-69 (outlining scope and limitations including exceptions and waiver process). The ban does not apply to U.S. green card holders, already admitted persons, dual nationals using the passport of a nondesignated country, or diplomats. *See id.* at 45,167-69. A consular officer or Customs and Border Protection grant waivers on a case-by-case basis for those who demonstrate that denying entry would cause undue hardship, entry would not pose a threat to national security, or entry would be in the national interest. *See id.* at 45,168-

Two countries listed on the ban—Iran and Syria—are the sixth and tenth largest foreign contributors of physicians and surgeons to the United States respectively, and about 8,000 doctors practicing in the United States went to medical schools in countries included in the ban.¹¹⁷ The Travel Ban therefore has a wide-ranging impact on the U.S. healthcare system, which heavily relies on physicians from these specified countries.¹¹⁸ The widespread effects of the ban have already become apparent, as 18% fewer IMGs from banned countries have applied for ECFMG certification in 2017 compared to 2016, and some now worry that IMGs will turn to programs in Europe and Canada with less stringent immigration obstacles.¹¹⁹

III. ANALYSIS

A. Assessing Attempts at Conrad Program Reforms

The U.S. physician shortage will undoubtedly continue at a critical pace unless drastic policy changes are made that acknowledge IMGs' untapped potential.¹²⁰ Although the Conrad Program has been a major initiative in alleviating

69; see also Abigail Hauslohner, *Coveted Exemptions from Trump's Travel Ban Remain Elusive for Citizens of Muslim-Majority Countries*, WASH. POST (May 22, 2018), https://www.washingtonpost.com/national/coveted-waivers-for-trumps-travel-ban-remain-elusive-for-citizens-of-muslim-majority-countries/2018/05/22/d48cc8d8-48b6-11e8-827e-190efaf1f1ee_story.html [https://perma.cc/79RV-REAF] (alleging hundreds or thousands of people who meet waiver qualifications receive denials). The government has not provided much information about how to obtain a waiver, and even if the government grants a waiver, it does not guarantee the person will receive a visa to enter the United States. See Hauslohner, *supra*.

117. See Belluz & Frostenson, *supra* note 18 (discussing top origin countries of foreign-born physicians); Ducharme, *supra* note 9 (noting recent estimates of doctors in United States from banned countries).

118. See Belluz & Frostenson, *supra* note 18 (arguing Travel Ban affects healthcare in various ways). According to one study, more than 15,000 doctors in the United States are from the seven Muslim-majority countries implicated by the Travel Ban. See McNeil, *supra* note 112. Many are uncertain if applicants in physician training programs in the United States will be able to obtain visas to begin their programs. See Kevin B. O'Reilly, *Revised Travel Ban May Leave Residency Applicants in Limbo*, AMA (Mar. 14, 2017), <https://www.ama-assn.org/education/international-medical-education/revised-travel-ban-may-leave-residency-applicants-limbo> [https://perma.cc/YM5T-D2R6] (recognizing hundreds of doctors from banned countries have applied for residency programs).

119. See Ducharme, *supra* note 9 (addressing drop in applicants for ECFMG certification). One Iranian doctor chose to pursue a residency program in Canada instead of the United States because of the potential immigration obstacles. See *id.* If U.S. political trends continue, IMGs may decide to enter programs in Europe, the United Kingdom, or Canada, where their job and immigrant status would be more protected. See *id.*; see also Rowaida Abdelaziz, *More Than 37,000 Visa Applications Denied in 2018 Due to Trump's Travel Ban*, HUFFPOST (Feb. 27, 2019, 1:03 PM), https://www.huffpost.com/entry/travel-ban-visa-applications_n_5c76c4f3e4b08c4f555691a3 [https://perma.cc/3EME-ZR4X] (detailing over 37,000 visas denied and only 2,673 applicants granted waivers).

120. See DALLE ET AL., *supra* note 2, at 35 (projecting physician demand to grow faster than supply); Rampell, *supra* note 5 (arguing physician shortage would decrease if United States allowed IMGs to practice with less barriers).

the shortage, reforms must be made to the Conrad Program to address the evolving healthcare landscape in the United States.¹²¹ The proposed Conrad Reauthorization Act includes many beneficial reforms to the Conrad Program, but even if passed, this bill would still be insufficient to solve physician shortages.¹²²

In particular, a mere increase of only five waiver slots per state is not sufficient to achieve the underlying goal of significantly improving physician shortages in rural or underserved communities.¹²³ Having a set number of slots per state is inadequate because inevitably, more populous states will lose out as their spots are filled much more quickly, and less populous states are left with slots unfilled.¹²⁴ For example, New York has continually received over thirty Conrad Program applications on the first day applications can be filed, and fills all open positions, while Alaska filled zero slots in fiscal year 2017, and had not filled a spot before then since 2015, when it only filled two of its thirty available slots.¹²⁵ Additionally, because of the rapid shift in demographics and underserved areas requiring greater need, a different system is needed that would offer more waivers and give preference to fill positions dedicated to these populations.¹²⁶ Congress should therefore adopt a system where the number of waiver slots and flex slots are allocated according to each state's demand and need, and not restricted to a generic set limit per state.¹²⁷

B. The Time Is Now: Immediate Comprehensive Immigration Reform

The proposed comprehensive immigration reform bill, S. 744, presented great efforts to try to reform the Conrad Program, including changing the way waiver slots are allocated based on nationwide waiver usage.¹²⁸ Under the bill, all states

121. See Aronson, *supra* note 10, at 77-78 (acknowledging Conrad Program's success but offering considerations for future extensions). Data has shown that IMGs have performed "gap-filling" services and take positions U.S. physicians tend to shy away from. See *id.* at 77.

122. See *supra* notes 94-95 and accompanying text (introducing Conrad Program reform bill and detailing proposed changes); see also Bomba, *supra* note 91, at 1105 (arguing Conrad Program only short-term solution and detracts from need for long-term policy change).

123. See Conrad State 30 and Physician Access Reauthorization Act, S. 948, 116th Cong. § 5 (2019) (proposing new changes including increasing waiver slots); Aronson, *supra* note 10, at 78 (indicating need for increasing waiver limit or national pooling arrangement).

124. See Sostrin & Baker, *supra* note 11, at 48 (stating whether waiver slots fill quickly depends on which state applicant applies to). Less populous states tend to not fill all of their waiver slots right away, and therefore offer a higher chance of success than more populous states. See *id.*

125. See *id.*; see also *Conrad State 30 Program FY 2018*, *supra* note 86 (identifying slots filled or unfilled per state).

126. See DALL ET AL., *supra* note 2, at 36 (declaring changing demographics "primary driver" of physician demand); Klaric, *supra* note 8, at 616 (acknowledging fears of increasing physician shortages from aging population and more doctors retiring); Lorio, *supra* note 73, at 15-16 (stressing need for physicians to serve Medicaid patients and pursue primary care positions).

127. See Aronson, *supra* note 10, at 78 (considering eliminating waiver allotment to afford for "national pooling arrangement").

128. See *supra* notes 100-02 and accompanying text (detailing proposals of Senate-backed comprehensive immigration reform bill).

would have been allotted thirty-five waivers each year, but only if 90% of the waivers available to the states receiving at least five waivers were granted and used by an IMG in the previous fiscal year.¹²⁹ Further, S. 744 would have allowed each state to receive an additional five slots per year for each subsequent year that the aforementioned condition of utilizing waivers is satisfied.¹³⁰ This proposed method is exactly the type of system that would make more waiver slots available to the more populous states that tend to use all of their waiver slots every year.¹³¹

Another promising aspect of the S. 744 reform bill was the proposal to make the Conrad Program permanent.¹³² Eliminating the Conrad Program's expiration provision is beneficial because it would quell fears that Congress might not extend the Conrad Program.¹³³ On the other hand, some critics have argued that plans to make the Conrad Program permanent would be "disconcerting[,]" calling the Conrad Program only a "gap-filling mechanism" that detracts from the possibility of a long-term solution targeting the root of the physician shortage.¹³⁴

Therefore, legislators should consider other options in addition to the reforms presented in S. 744 that could provide IMGs an easier pathway towards practicing medicine in the United States.¹³⁵ One such reform could be eliminating the two-year foreign residence requirement specific to IMGs who participated in GME programs.¹³⁶ Although eliminating the requirement would negate the necessity of waivers offered through the Conrad Program, it would align with Senator Conrad's original intent to end the inequality of forcing IMGs to return home

129. See Border Security, Economic Opportunity, and Immigration Modernization Act, S. 744, 113th Cong. § 2404(a)(6) (2013) (describing proposal for changing method for allocating waivers).

130. See *id.* (outlining method allowing for increasing waiver slots). This increase in waiver slots per year would continue indefinitely unless the total number of waivers granted in a year is 5% lower than in the last year in which there was an increase in the number of waivers available. See *id.* § 2404(a)(6)(B).

131. See *id.* § 2404(a)(6) (outlining proposed allotment system for waivers). The bill itself notes that forty-five or more waivers could potentially be allotted per state for a fiscal year. See *id.* § 2404(a)(6)(A)(ii); see also Siskind, *supra* note 98, at 10-11 (suggesting S. 744's waiver allotment method allows for increase in number of slots available per state).

132. See S. 744 § 2401 (striking Conrad Program's expiration provision); Siskind, *supra* note 98, at 10-11 (discussing improvements to Conrad Program proposed by S. 744).

133. See *supra* notes 92-93 and accompanying text (emphasizing failure to extend Conrad Program could result in its demise).

134. See *supra* note 3 and accompanying text (listing roots of physician shortage); see also Bomba, *supra* note 91, at 1131 (contending making Conrad Program permanent hinders long-term solution to fill healthcare vacancies). Due to the lack of federal funding to collect data on J-1 physicians in the Conrad Program, it is not known whether these J-1 physicians provide a long-term solution to the United States' healthcare professional shortage, so making the Conrad Program permanent may not be the best solution to the shortage. See Gunselman, *supra* note 69, at 105.

135. See Dowse, *supra* note 41, at 63 (advocating for system allowing IMGs to more easily practice in United States); Rampell, *supra* note 5 (stating medical workforce could grow with greater efforts to use IMGs' skills).

136. See *supra* notes 60-62 and accompanying text (detailing two-year foreign residence requirement for certain J-1 visa holders); see also Cruz, *Closer Look*, *supra* note 46, at 306-07 (questioning foreign residence requirement's efficiency).

after GME training.¹³⁷ Additionally, one of the core reasons the foreign residence requirement was originally created was because Congress reasoned there was not a physician shortage—which is no longer the case.¹³⁸ Without the foreign residence requirement as an impediment, trained IMGs could work immediately in hospitals and clinics that desperately rely on them for help.¹³⁹

Although removing the foreign residence requirement and eliminating the Conrad Program waiver process could disincentivize IMGs from working in underserved areas, legislators could create programs encouraging IMGs to work in these areas through other means—such as offering easier pathways to permanent residence or financial incentives.¹⁴⁰ Another major critique of allowing IMGs easier access to practicing in the United States is that such less restrictive access will exacerbate the “brain drain” from underserved countries.¹⁴¹ Although it is not clear that physician migration must be restricted in order to improve international healthcare, the United States could alleviate the problem by creating programs that incentivize IMGs to participate in and contribute to global healthcare projects, or engage in telemedicine.¹⁴² Ultimately, when it comes to the essential role IMGs play in the U.S. healthcare system, compelling trained doctors with

137. See Sostrin & Baker, *supra* note 11, at 45 (noting Conrad Program waives foreign residence requirement); *supra* note 77 and accompanying text (summarizing Senator Conrad’s original intentions). Significantly, IMGs who work as educators or researchers are not subject to the two-year foreign residence requirement. See Ware, *supra* note 61, at 143.

138. See *supra* note 67 and accompanying text (reviewing motives for applying foreign residence requirement to IMGs). The fear that IMGs would take jobs from U.S.-educated doctors is unwarranted, mainly because of the physician shortage the United States is currently facing, and the tendency for IMGs to practice in fields facing more severe shortages. See Cruz, *Closer Look*, *supra* note 46, at 306-07; *supra* note 72 and accompanying text (affirming contributions IMGs make to primary care shortage areas).

139. See Dowse, *supra* note 41, at 63 (contending barriers to foreign-born physicians result in “brain waste” of valuable intellect and skills); Jordan, *supra* note 71 (stressing small U.S. towns depend on foreign-born doctors); Letter from All. for Acad. Internal Med. et al. to L. Francis Cissna, *supra* note 4 (emphasizing hospitals rely on IMGs). It has been argued that because foreign-born physicians are so vital to U.S. healthcare, immigration laws should allow for easier pathways and expedite the process for them to practice in the United States. See Bomba, *supra* note 91, at 1113.

140. See Bomba, *supra* note 91, at 1131 (arguing eliminating Conrad Program “poor remedy” to healthcare worker shortage). Comparisons can be made to other countries’ immigration systems, such as Canada, which allows easier access to permanent residence for IMGs after working a certain amount of time. See Cruz, *Closer Look*, *supra* note 46, at 304, 307. Other incentives could include loan forgiveness, providing flexible hours, reducing workload by hiring more staff, or offering allowances for housing and transportation to physicians who work in rural and underserved areas. See Gunselman, *supra* note 69, at 106-09.

141. See *supra* note 69 and accompanying text (outlining brain drain problem); see also Bomba, *supra* note 91, at 1107 (noting concerns surrounding migration of health workers because it worsens human resource discrepancies).

142. See Nwadiuko et al., *supra* note 70, at 765 (contending unproven United States should restrict IMG immigration to solve brain drain problem). Data suggests that many IMGs in the United States already contribute to medical efforts to aide their home countries, including through charities, capacity-building projects, and global health training opportunities. See *id.* at 765-66. Other solutions to the brain drain problem include increasing the supply of healthcare workers in the developing world and creating international agreements that address physician migration. See Bomba, *supra* note 91, at 1111, 1113 (doubting whether actions from United States could solve brain drain problem); Gunselman, *supra* note 69, at 114 (suggesting physicians consult with patients in remote areas using telemedicine).

significant U.S. ties to return to their home countries does not alleviate the physician shortage, but only worsens it.¹⁴³

C. Patient Lives at Stake: The BAHA Order and the Travel Ban

The Trump Administration's restrictive policies are now the latest threat to IMGs.¹⁴⁴ Both the BAHA Order and the Travel Ban function not as the protection the Trump Administration presents the policies to be, but as scare tactics to shut out necessary foreign medical professionals.¹⁴⁵ President Trump must either rescind or implement changes to certain aspects of the executive orders that affect IMGs in order to expedite visa delays for the benefit of timely patient care.¹⁴⁶

The BAHA Order has severely impacted the visa adjudication process for all IMGs who are filling necessary positions throughout U.S. hospitals.¹⁴⁷ Federal agencies issuing the increased visa RFEs claim they are ensuring employers are complying with eligibility requirements to "protect the wages, working conditions, and jobs of U.S. workers[.]" but have been seeking information they have never sought before from applicants who have worked in their positions for years.¹⁴⁸ This protectionist agenda is counterintuitive because while federal agencies claim they are protecting the jobs of U.S. workers, U.S. hospitals are waiting on IMGs trapped in visa delays to fill positions U.S.-citizen doctors are not taking.¹⁴⁹ This policy is unfair and disastrous to the healthcare system, and

143. See Amini, *supra* note 69, at 481 (cautioning excluding IMGs could have "grave consequences" for U.S. healthcare system); Cruz, *Closer Look*, *supra* note 46, at 300 (describing ties made by IMGs through several years of training in United States); Klaric, *supra* note 8, at 617-19 (emphasizing use of IMGs to remedy physician shortage); see also *supra* note 4 and accompanying text (discussing U.S. healthcare system's reliance on IMGs).

144. See Schwartz & Lohr, *supra* note 16 (describing Trump's policies' "chilling effect" on interests of IMGs entering GME programs); see also *supra* note 103 and accompanying text (introducing policy changes Trump Administration implemented).

145. Compare Mehta & Genovese, *supra* note 104, at 1247 (discussing Trump's "America First" foreign policy), and *Putting American Workers First*, *supra* note 107 (emphasizing efforts to protect jobs of U.S. workers), with Ducharme, *supra* note 9 (noting IMGs deterred from practicing medicine in United States), and Salkin, *supra* note 18 (citing widespread insecurity among IMGs).

146. See O'Reilly, *supra* note 118 (raising concerns regarding broad impact of Travel Ban on healthcare). While it is important to maintain a reliable system for vetting people from foreign countries, it is also essential that such a system does not affect patient access to basic healthcare, or prevent foreign-born physicians from training or attending medical conferences in the United States in order to encourage the exchange of medical knowledge around the world. See *id.*; see also Letter from James L. Madara to L. Francis Cissna, *supra* note 1 (urging expedited review of visa applications for foreign-born physicians).

147. See *supra* notes 108-10 and accompanying text (describing effects of BAHA Order). A recent decline in IMGs who are applying to graduate residency programs in the United States has sparked concerns that Trump's harsh immigration policies are negatively affecting the U.S. healthcare system, which relies on these IMGs. See Cruz, *Fewer Foreign Doctors*, *supra* note 4.

148. See Ducharme, *supra* note 9 (describing Israeli-born doctor's difficulty with recent RFE). In one doctor's case, after presenting the same resident stipend information he had used in applications for the last four years, USCIS suddenly requested more specific data they had never requested before, and which does not exist for resident physicians. See *id.*; see also Letter from James L. Madara to L. Francis Cissna, *supra* note 1 (urging USCIS to continue to accept resident stipend data previously recognized).

149. See *Putting American Workers First*, *supra* note 107 (demonstrating effect of BAHA Order and USCIS's plans for stringent H-1B compliance checks); see also Belluz & Frostenson, *supra* note 18 (observing

changes must be made to accelerate the visa process for these IMGs.¹⁵⁰

The Travel Ban is similarly detrimental to the healthcare system, which recruits many IMGs from the banned countries.¹⁵¹ Although the Supreme Court has upheld the ban, President Trump could make changes to the waiver process to give qualified IMGs an easier way to bypass the ban.¹⁵² Under the Travel Ban, waivers are granted to those whose entry is in the United States' national interest and who pose no threat to national security.¹⁵³ IMGs entering U.S. training programs likely pose little to no threat to national security, and are essential to U.S. national interest because of the benefit they bring to the nationwide physician shortage and U.S. healthcare in general.¹⁵⁴ Therefore, such Travel Ban waivers should be allocated to account for the nation's present needs.¹⁵⁵

IV. CONCLUSION

IMGs play a vital role in the U.S. healthcare system, as shown by their willingness to work in rural and underserved areas that experience the most critical physician shortages. Without IMGs' help, hospitals throughout the country will lack the necessary resources to provide efficient care to those who desperately need it. Unfortunately, however, the current immigration system places many formidable barriers that have prevented and deterred these IMGs from contributing to U.S. healthcare needs. Through the multiple steps of ECFMG certification, the J-1 visa process, the foreign residence requirement, the narrow Conrad Program exception, and the restrictions and delays from executive orders, an IMG's pathway to alleviating the U.S. physician shortage is costly, time-consuming, and unpredictable.

Although some of these steps assure quality medical training and patient care,

foreign-born physicians tend to practice where physician shortages most prevalent); *supra* notes 110-11 and accompanying text (citing examples of hospitals waiting on doctors halted by visa delays).

150. See Letter from James L. Madara to L. Francis Cissna, *supra* note 1 (requesting federal agencies quickly process visa applications to "avoid unnecessary delays"); *supra* note 110 and accompanying text (detailing effects of delays in visa processing).

151. See McNeil, *supra* note 112 (declaring Travel Ban "ensnared" doctors important to Americans' well-being). One Iranian oncologist, who was set to start working in California and who had lived in the United States since 2007, had to leave the country to get his new visa stamp, and found himself stuck in Iran unable to return to care for his patients. See *id.*; see also *supra* notes 117-18 and accompanying text (summarizing Travel Ban's impact on training programs in United States).

152. See *supra* notes 113-16 and accompanying text (discussing Supreme Court ruling and waiver entry process). There is skepticism surrounding whether the Trump Administration is properly applying waiver standards to those who qualify, because they have become seemingly impossible to get. See Hauslohner, *supra* note 116.

153. See Proclamation No. 9645, 82 Fed. Reg. 45,161, 45,167-69 (Sept. 24, 2017) (setting forth exceptions to Travel Ban and waiver process).

154. See Belluz & Frostenson, *supra* note 18 (emphasizing doctors from banned countries alleviate physician shortage); see also Hauslohner, *supra* note 116 (noting minimal guidance from DOS on waiver process).

155. See McNeil, *supra* note 112 (asserting foreign-born physicians "crucial" to U.S. healthcare). When a medical training program relying on IMGs for patient care loses out on even one doctor, it could be devastating—especially for small, underserved hospitals. See Ducharme, *supra* note 9.

the United States should not continue policies that unnecessarily make the process harder for previously trained and qualified doctors whose presence benefits the country. Congress must enact reforms, such as expanding the Conrad Program or completely eliminating the foreign residence requirement, and President Trump must amend his executive orders to allow easier pathways for IMGs to enter the United States. By welcoming IMGs and opening more doors to qualified medical professionals, the United States can achieve a healthcare system that provides equal access to essential medical care for all patients throughout the nation.

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