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International medical graduate perceptions of health policy: A pilot study

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ABSTRACT

Introduction: *International Medical Graduates (IMGs) have been a significant proportion of the American physician workforce since the 1960s. Nearly one-fourth of practicing physicians today are IMGs, and the total number of IMGs in graduate medical education is increasing. The purpose of this pilot project was to assess IMG perceptions in three major policy areas: (a) IMG impact on U.S. healthcare, (b) IMG impact on countries of origin, (c) bias/discrimination faced by IMGs.*

Methods: *A survey was conducted of IMGs in an Internal Medicine residency program based at a Queens, New York hospital.*

Results: *Surveyed population (n=27) was 41% PGY1, 30% PGY2, 22% PGY3, 7% PGY4. 55% were men, 78% were between 25-35 years old, and 70% had emigrated to the US within the last 10 years. Impact on U.S. Healthcare: 54% supported U.S. policies favoring immigration of IMGs willing to practice in underserved areas. 70% believed that IMGs would provide care in these areas for a longer period than U.S. graduates, due to satisfaction in serving that patient population (57%) and lack of better opportunities (22%). Justifiable reasons to reduce IMG immigration were to avoid a physician surplus (58%), to reduce harms to countries of origin (21%), and to avoid overcrowding residency programs (13%). Impact on Countries of Origin: 80% of the surveyed IMGs do not plan to return to their country of origin. 56% reported that physician emigration is a detriment to their countries of origin; 84% felt no personal obligation to help reduce the negative effects. Two-thirds received loans or subsidies for education from countries of origin. 31% supported policies for required subsidies repayment, 27% for required service after medical school graduation, 25% for more restrictive emigration policies, 19% for required return to the country of origin after residency training, and 12% for monetary compensation beyond subsidies repayment. Bias or Discrimination: Over one-third of respondents felt bias or discrimination in their work environment. 85% felt that medical professional organizations do not adequately address issues specific to IMGs and 77% reported a desire for greater involvement in such organizations.*

Conclusion: *There is growing debate in public policy over the status of IMG migration to the U.S. This pilot study was designed to explore IMG attitudes toward three major policy areas. A larger, multi-institutional study should be considered.*

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INTRODUCTION

International Medical Graduates (IMGs) are individuals who, after completing undergraduate medical education outside of the United States, have immigrated or returned to the U.S. to enter residency programs or gain licensure for medical practice. IMGs have been a significant proportion of the American physician workforce since the 1960s. At that time, a perceived physician shortage in the U.S. led to the establishment of a Special Skills Exception for physicians in immigration law, allowing easier entry into the U.S. for residency training and patient care. IMGs represented about 10% of the physician workforce in 1963, which nearly doubled by 1973 to 18%.[1,2] About one-fourth of all practicing physicians today are IMGs.[3] In addition, a significant proportion of residency slots go to IMGs. Since the early 1980s, the number of U.S. medical school graduates has remained constant at about 17,000 per year. The number of PGY-1 residency slots has, however, increased steadily and now exceeds the number of U.S. graduates by over 40%.[3] Nearly three-fourths of all IMGs in graduate medical education go on to practice medicine in the U.S.

Public policy has not remained stagnant during this period of rapid growth in IMG education and practice. As early as 1976, Congress made several changes to the Immigration and Naturalization Act in an attempt to decrease IMG entry into the U.S. One of these provisions limited the number of IMGs that could enter the country on J-Visa status. The 1976 amendments to immigration law tightened provisions originally set as part of the J-1 Exchange Visitor Program in 1948. But this same amendment also established a Substantial Disruption Waiver clause, allowing IMG-dependent hospitals to recruit IMG residents and negate the requirement to return to the country of origin.[4] Congress established this waiver to avoid abrupt changes to such programs, but also made explicit that IMG-dependent hospitals should decrease their dependency over time. Regardless of this condition, IMG dependence has only increased since 1976.

IMG involvement in the U.S. healthcare system has been controversial for over 40 years. While much has been written on healthcare provision by IMGs, an extensive literature search revealed few surveys documenting IMG perceptions and views of health policy. Given this background, the purpose of this pilot project was to survey IMGs currently in residency training for their perceptions in three major policy areas: (a) the role of IMGs in the U.S. healthcare system, (b) the impact of IMG migration on their countries of origin, and (c) discrimination/bias encountered in the work environment. Each area will be discussed within a policy context.

METHODS

IMGs currently in any year of training in an Internal Medicine residency program based at a hospital in Queens, New York were the survey population. Internal Medicine was chosen for the pilot project because about 50% of J-1 visa IMGs pursue residency training in this department, which accounts for about 36% of all IMGs in residency training.[2] Institutional Review Board approval was obtained prior to the study, and informed consent was obtained during survey administration. Surveys were distributed and collected at a required weekly meeting for Internal Medicine

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residents. Adequate time was given during the meeting for completion of the instrument.

RESULTS

Demographics. Twenty-seven IMGs were surveyed out of an eligible 35, as defined by the Residency Program Director, giving a 77% response rate. Of the respondents, 41% were PGY1, 30% PGY2, 22% PGY3, and 7% PGY4. Fifty-five percent were men, 78% were between 25-35 years old, and 70% had emigrated to the U.S. within the last 10 years.

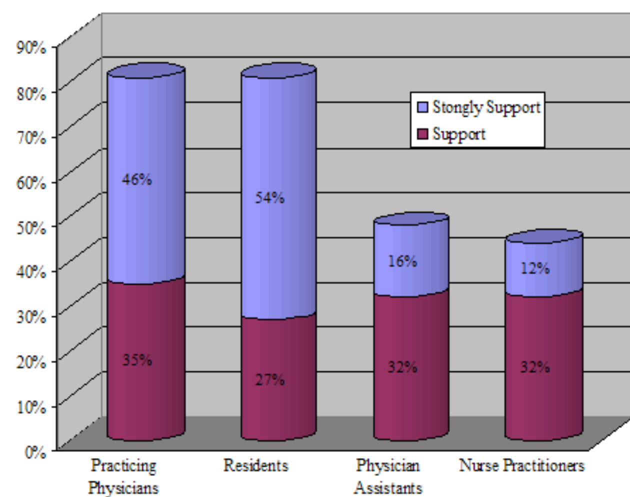
Impact on U.S. Healthcare. A previous analysis examining physician practice patterns on the national, regional, and state levels found that IMGs constitute a greater percentage of U.S. primary care physicians in rural areas with physician shortages than in rural areas without physician shortages.[5] The difference between IMGs and U.S. Medical Graduates (USMGs) was most evident at the state level of analysis, though there was also much variation between states. Another study examining cities found that, of 14 cities with large populations of 2.5 million or more, IMGs were disproportionately located in poverty areas in seven of the cities.[6] Of 36 cities with populations between 1 million and 2.5 million, 5 had IMG disproportions in poverty areas. Finally, in 27 cities with populations of 250,000 to 1 million, two cities had significant IMG disproportions in poverty areas. The authors of this study concluded that IMGs provided necessary services to underserved populations. A study conducted in 2000 analyzed physician distribution by counties to determine whether IMGs were found in disproportionate numbers in high need or underserved counties, as defined by four measures of medical need – infant mortality rate, socioeconomic status, proportion non-white population, and rural county designation.[7] The study found that "IMGs were more likely than USMGs to locate in states' counties characterized in need" and that IMG disproportions do not occur just by random chance.

This survey addressed many of the issues implicit in analyses of both IMG and USMG physician distribution. Respondents were asked whether there is a physician shortage in the U.S. and whether physicians are adequately distributed. Sixty-two percent of surveyed individuals felt there was a physician shortage; 92% felt that physicians are inadequately distributed. The survey also asked individuals to indicate their level of support (strongly support, support, neutral, do not support, strongly do not support) for a number of policy options to guarantee equity of healthcare in underserved areas of the country. The options were provision of care by physicians (USMG or IMG), residents (USMG or IMG), physician assistants, or nurse practitioners. Surveyed individuals indicated various levels of support as shown in **Figure 1**.

Surveyed IMGs were divided on the question of whether U.S. policies are justified in favoring the immigration of IMGs who are willing to practice in underserved areas, with 54% believing that such policies are justified. When asked which group, USMGs or IMGs, are more likely to stay in a medically underserved area for a long period of time, nearly 70% believed that IMGs would provide care for a longer period. Reasons for this difference were satisfaction gained in serving that patient population (57%) and lack of better opportunities (22%). Justifiable reasons for the U.S. to reduce IMG immigration were to avoid a physician surplus (58%), to discourage harms to nations that are effected by high rates of physician emigration (21%), and to avoid overcrowding residency programs (13%).

Impact on Countries of Origin. There are at least two ways in which IMGs have major impact on the countries they leave behind to pursue residency training or clinical practices in the U.S. The first is that physician emigration tends to occur most from developing countries, which also tend to have an insufficient number of physicians to meet their national needs. Recruitment by relatively more developed nations such as the U.S. further exacerbates shortages and burdens social services, including those that go into producing medical graduates. The World Health Organization, for example, estimates that there are only 800 physicians in all of Zambia, though nearly 1500 are required to meet the social need. Of the 600 Zambian graduates produced in 23 years of teaching at the Lusaka medical school, only 50 work in the Zambian health service.[8] The situation is similar in many other developing nations. Striking a balance between the individual freedoms and rights of this group and their responsibilities to the societies which provided for their training remains a challenge, and it is unclear from the literature what role more developed nations should have in this dilemma.

Figure 1: Level of Support for Policy Options to Increase Equity in Healthcare



The second major impact on countries of origin occurs when IMGs, after completion of graduate medical training abroad, return to serve their countries. At least one study has found that physician training opportunities in the U.S. for IMGs from Latin America have a beneficial effect on teaching, research, and medical administration once emigrating IMGs return to their countries of origin. Compared to physicians who attained similar academic rank in their medical schools but did not seek training abroad, this group spent more time teaching, conducting research, fulfilling administrative duties, publishing in competitive national or international journals, and generally held higher academic positions.[9]

The survey asked several question concerning IMG impact on their countries of origin. When asked for their major reasons for immigrating to the U.S., surveyed IMGs reported a number of factors, including a desire to pursue clinical opportunities available in the U.S., join family members in the country (this includes individuals living in the U.S. prior to medical school), leave hostile social or political factors in their countries of origin, and provide new social opportunities for their families (see **Figure 2**, multiple choices permitted).

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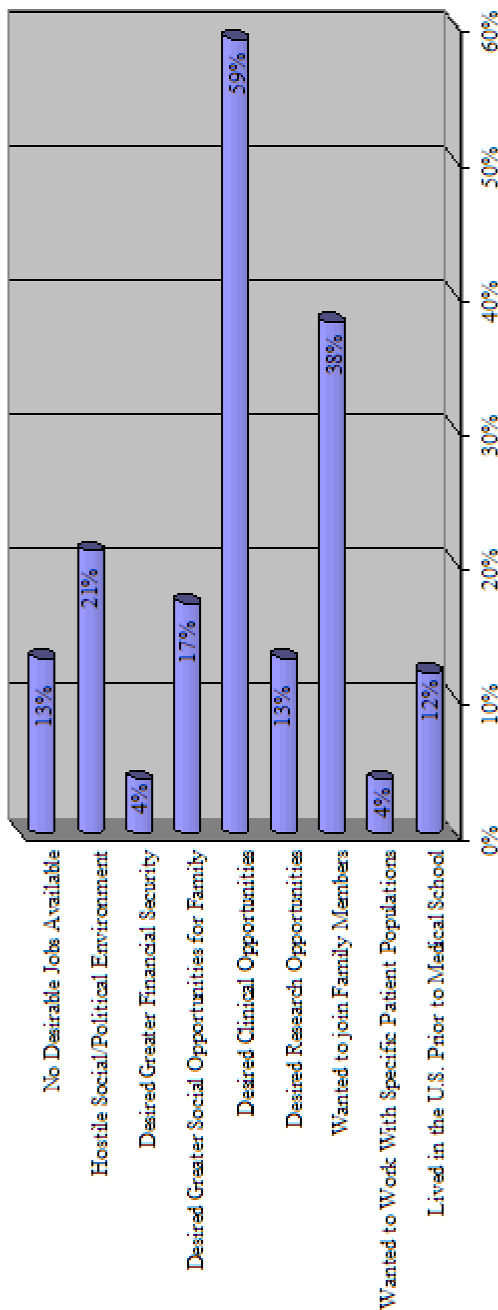
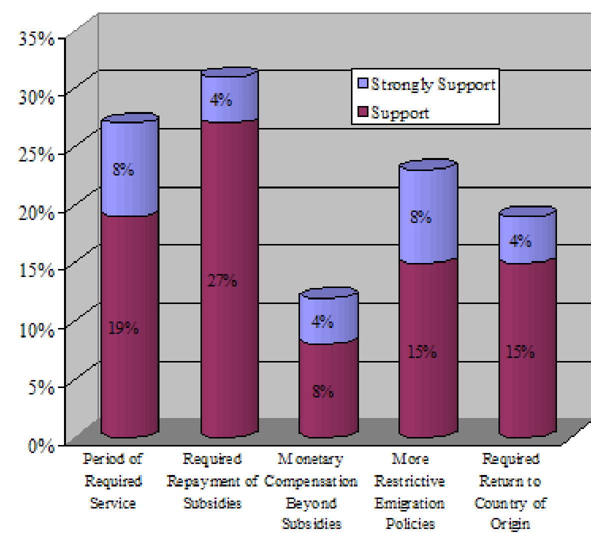


Nearly 80% of the surveyed individuals reported that they do not plan to return to their country of origin for the majority of their professional careers. Of the 19% who reported that they would return to their countries of origin, about 4% indicated that they were obligated to do so by visa status, while the remainder reported that they would return after a few years of clinical practice or teaching in the U.S. When asked about financial aid for medical education in their countries of origin, nearly two-thirds of the surveyed IMGs reported that they received some sort of assistance, ranging from full subsidies (34%) to loans which they must repay (16%); 38% reported that they received no financial aid. Fifty-six percent of respondents reported that physician emigration is a detriment to their countries of origin. However, 84% reported that they felt no personal obligation to help reduce the negative effects.

The survey also asked individuals to indicate their level of support (strongly support, support, neutral, do not support, strongly do not support) for a number of policy options to reduce the negative impact of physician emigration on their countries of origin: a period of required service after graduation from medical school (and prior to emigration), required repayment of subsidies for medical education, monetary compensation beyond simple repayment of subsidies, more restrictive emigration policies, and required return to the country of origin after residency training. The surveyed individuals indicated various levels of support as shown in **Figure 3**.



Discrimination/Bias. Few previous studies have systematically examined potential discrimination faced by IMGs when applying to residency programs or in clinical settings. In this survey, respondents were asked whether they felt any kind of bias or discrimination in their work environment. Over one-third of the surveyed IMGs said that they did. Sources of encountered discrimination are summarized in **Figure 4** (multiple choices were permitted). Respondents were also asked to identify the primary reasons for bias or discrimination faced by IMGs. Doubts or assumptions about clinical skills (57%) and misunderstandings or a lack of communication (30%) accounted for a majority of the responses.

To address the issue of more system-wide bias, several questions were asked about respondent involvement in professional medical organizations. Eighty-five percent of surveyed individuals reported that they generally felt that medical professional organizations do not adequately address issues specific to IMGs and 77% reported that they desire greater involvement in such organizations. The primary barriers to their involvement were lack of knowledge about how to get involved (43%), status as an IMG (38%), lack of time (14%), and lack of outreach from professional organizations (5%). Issues of greatest importance to surveyed

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IMGs were: immigration policies (29%), prejudice or discrimination in the workplace (24%), receiving adequate clinical training (16%), English language training (12%), overcoming cultural barriers (8%), and opportunities for employment after residency (8%).

DISCUSSION AND CONCLUSIONS

Though limited in size, this pilot project suggests a few areas for further study. First, IMGs immigrate for a variety of reasons and generally have an overwhelming desire to do so. While IMGs have mixed views about their impact on their countries of origin and what expectations from these countries are justifiable, further policy alternatives to decrease harms to countries of substantial IMG migration are required. IMG input on this issue should be sought. Second, surveyed IMGs recognized a need for improving the number or distribution of physicians in the U.S. They generally felt that IMGs are capable of filling this need, though they were divided on whether IMGs should be specifically recruited for this purpose. An important issue, not addressed in this survey, is how to guarantee the quality of physicians responding to our social need. Finally, a significant portion of surveyed IMGs felt bias in their work environment and in professional medical organizations. As IMGs form such a large part of the physician workforce, such views should be further explored and addressed as appropriate.

There is a current and growing debate in public policy about whether IMG immigration to the U.S. should be re-evaluated. At stake are an array of basic issues including individual freedom, social subsidies for residency training, and government responsibilities to people both in the U.S. and abroad. Perhaps the most significant conclusion of this study is that further research of IMG views and perceptions is warranted. A multi-institutional study with a larger sample size would allow for appropriate stratification and analysis of this heterogeneous population.

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