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NEW VISA LIMITS FOR FOREIGN MEDICAL GRADUATES: CRISIS IN SUBSPECIALTY CARE IN USA

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In June 1999, new regulations affecting Education Council for Foreign Medical Graduates (ECFMG) sponsorship of visas for foreign medical graduates (FMGs) wishing to come to the United States (US) were published in the Federal Register. The new rules specified that in future ECFMG could only sponsor trainees who were accepted by an Accreditation Council for Graduate Medical Education (ACGME)-accredited program. Furthermore, the duration of ECFMG sponsorship is limited to the length of training accredited by ACGME. These new regulations are a particular imposition for subspecialty programs which are not ACGME-accredited like congenital cardiac surgery or thoracic transplantation, and for those FMGs wishing to train in these cutting-edge areas. This article will examine why these regulations both for the US as well as for other countries make little sense and should be revoked.

QUALITY OF CARE

The first priority of any government health policy must be to optimize the quality of care provided to that government's constituents. A subspecialty such as congenital cardiac surgery is personnel-intensive requiring a large number of highly trained intensive care nursing staff as well as physicians. Residents spend limited time on a congenital rotation as part of their basic training in cardiothoracic surgical training, and during that time acquire a basic understanding of the terminology and concepts of the specialty. Fellows have usually completed some or all of their general cardiothoracic training and are acquiring more advanced concepts and operating skills. The ability of fellows to provide a skilled level of assistance in the operating room as well as managing the many surgical aspects of intensive care management are essential for optimal outcome for patients with complex congenital cardiac problems. An example of the level of expertise required is the current management of a cardiac arrest in a postoperative patient. While in the past simple cardiopulmonary resuscitation techniques were applied and could have been provided effectively by a general surgery resident rotating through the service, today rapid resuscitation extracorporeal membrane oxygenation (ECMO) should be available in any congenital cardiac program. This necessitates in-house expertise to be able

to cannulate a tiny neonate for cardiopulmonary bypass with cardiac massage continuing. Failure to achieve cannulation expeditiously will almost certainly result in brain injury or death. In order to be able to provide this level of care around the clock, a very much larger number of residents and fellows are required than are needed for permanent staff positions. There are three options: use lower level, less skilled rotating residents who more than likely have no interest in pursuing the subspecialty and have not yet acquired the necessary skills; train many more US physicians in the specialty than can possibly be employed in that specialty; or employ foreign fellows who come to the US to gain experience and learn advanced concepts that they can take back to their own country. I believe strongly that the last option is the best.

QUALITY OF FOREIGN MEDICAL GRADUATES

The hurdles that were already facing FMGs wishing to come to the US before the June 1999 restrictions were formidable. They must pass preliminary English examinations and then the same licensing examinations as US graduates. In 1998, a new examination was added as a further barrier. The clinical skills assessment requires FMGs to come to Philadelphia and to undertake a practical examination of their English skills as well as their skills in evaluation and management of patients. They must then return to their home country, wait weeks for the results of the examination and only then apply for a J1 visa (a training visa usually granted to physicians entering the US as residents or fellows) with ECFMG sponsorship. There are time limits for each stage of the process. Physicians who are prepared to undergo this rigorous set of requirements and pay the many expenses involved are usually highly motivated individuals. Furthermore, there are usually many applications by FMGs for subspecialty fellowship positions so that programs are able to accept only the very best trained FMGs often coming from highly prestigious international centers.

COST

It is difficult to calculate the total cost of educating a fellow in any country to the level required for various subspecialties, but it is clearly a large number. In the US in cardiothoracic surgery, for example, in addition to

government subsidization of the basic doctor of medicine (MD) degree, there are 5 years of general surgical training which are supported through Medicare at a level of at least USD70,000 per year and then up to 3 years of cardiothoracic residency. In the case of FMGs, this cost is borne by the fellow's country of origin. And yet foreign countries are happy to have their physicians come to the US as subspecialty fellows. Why? Because it is exactly the cutting-edge subspecialties which are not ACGME stand-alone residency programs in which the US leads the world because of its foresight and investment in medical research. Do physicians need to come from Australia to the US to do a general pediatric residency? Absolutely not. But will they and therefore their country benefit from the experience offered in subspecialty areas that are vastly larger than anything offered in Australia because of population differences alone? Absolutely. Perhaps one way to view the issue is that the US has invested huge resources in research both in absolute terms as well as relative to the population of the country. While there is a moral obligation to share this knowledge with the rest of the world, there is also the fiscal reality that those countries that have not been burdened by research costs can contribute at least in part by providing the basic training of fellows that will then be of direct benefit to US patients.

BUT THEN THEY STAY . . .

There is often more than a hint of xenophobia in discussions surrounding the granting of training visas for foreign physicians. The argument is usually along the lines that once we let them in, there will be no getting them to leave. The reality is that this is entirely under the control of the Immigration and Naturalization Service (INS). The J1 training visa with which ECFMG sponsors

foreign physicians carries a mandatory foreign residence requirement, that is, the FMG must return to his or her country for 2 years before he or she can be granted a change of visa status such as a green card. In the past, though rarely today, waivers of the foreign residence requirement could be obtained with sufficient support by a sponsoring institution, for example, a hospital that wished to offer the FMG a staff position. While some will argue that this keeps a US-trained physician out of a job, the fact is that either the job is likely to be in an underserved location where there are no US applicants or the FMG is demonstrably better than any US applicant. It is highly improbable that with current labor laws an institution would be able to achieve a financial or any other advantage in offering a job to an FMG rather than a US applicant, so the decision is likely to be based on merit alone. Why should there be affirmative action for US physicians?

WIN/WIN

For decades, the US has been the medical education mecca of the world, supplanting the United Kingdom which held this role in the mid-20th century and Germany which held this role at the end of the 19th and early 20th centuries. There are medical leaders in countries around the globe who honed their knowledge and expertise in US institutions. Patients throughout the world benefit from their skills. At the same time, there are millions of US patients who have benefited from the skills that those same physicians brought to this country and practiced while they were working here. It would be a tragedy for the quality of care of both US patients as well as patients in countries throughout the world if the present restrictions on FMGs practicing in subspecialty areas are allowed to stand.

ABOUT THE AUTHOR

The above article appeared recently as an opinion piece on CTSNet. The article written by Richard A Jonas, Cardiovascular Surgeon-in-Chief, Children's Hospital, Boston and William E Ladd Professor of Surgery at Harvard Medical School, outlines new challenges facing foreign physicians wishing to come to the US to undertake training in subspecialty areas such as congenital cardiac surgery. Dr. Jonas is personally familiar with the challenges facing foreign physicians wishing to come to the US since he undertook his basic cardiothoracic training at Green Lane Hospital in Auckland, New Zealand, as well as at Royal Children's Hospital in Melbourne, Australia. Dr. Jonas' program at Children's Hospital, Boston, provides the congenital teaching component for cardiothoracic surgical trainees who rotate from the other major Harvard teaching hospitals, that is, Brigham and Women's Hospital, Beth Israel Deaconess, Massachusetts General Hospital, and other cardiothoracic residencies in Massachusetts, namely the University of Massachusetts and Boston University programs. In addition, senior trainees and junior staff from many foreign countries have undertaken clinical fellowships working in Dr. Jonas' program in Boston.

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