



**Association of American Medical Colleges  
Statement for the Record  
before the  
Senate Committee on the Judiciary  
Subcommittee on Immigration, Citizenship, and Border Safety  
hearing, titled  
“Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce”  
September 14, 2022**

Thank you for the opportunity to submit a statement for the record on behalf of the AAMC (Association of American Medical Colleges) regarding the importance of physician immigration to the U.S. health care system, including the critical role physicians from other countries play in safeguarding our nation’s health and well-being by alleviating physician workforce shortages in underserved communities and diversifying our health care workforce to help improve the health of all. To that end, the AAMC recommends expanding the State Conrad 30 J-1 visa waiver program and enacting a permanent pathway to citizenship for Deferred Action for Childhood Arrivals (DACA) participants, among other immigration reforms to recruit and retain physicians, as delineated below.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 156 accredited U.S. medical schools; 14 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and nearly 80 academic societies. Through these institutions and organizations, the AAMC leads and serves America’s medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC’s U.S. membership and expanded its reach to international academic health centers. The AAMC also supports improving the immigration pathway for students, researchers, faculty, and other health professionals in addition to physicians.

The AAMC works closely with the Educational Commission for Foreign Medical Graduates (ECFMG), the sole U.S. Department of State-designated sponsor for foreign national physicians engaged in U.S. residency and fellowship training programs on J-1 visas. To practice in the U.S., physicians from other countries must complete rigorous educational curricula and U.S. examinations. The ECFMG verifies credentials and screens the individuals themselves in partnership with the Specially Designated Nationals (SDN) list maintained by the Office of Foreign Assets Control of the U.S. Department of Treasury. Only then are fully qualified

physicians from other countries eligible to apply and to compete for medical residency positions at U.S. teaching hospitals.

The U.S. health care workforce and the patients they serve rely on physicians from other countries, particularly in rural and other underserved areas. According to AAMC analysis of American Medical Association 2020 physician practice data, approximately 23% of active physicians practicing in the U.S. identified as foreign born, many of whom are now U.S. citizens or permanent residents. Their contributions are more profound than just a number indicates. Physician diversity has been widely recognized as key to excellence in medicine and quality care. Physicians from other countries have a unique cultural perspective — not just based on their nationality, race, or ethnicity, but also regarding the immigrant experience, which can affect patients' health and their health care experiences.

The importance of physicians from other countries is amplified as a result of growing nationwide health workforce shortages. The Health Resources and Services Administration (HRSA) estimates that in June 2022 the U.S. had a shortage of 16,477 primary care physicians and 7,632 mental health providers;<sup>1</sup> other specialties also are experiencing current shortages that are not measured by HRSA. The AAMC projects the overall physician shortage will grow to a total of between 37,800-124,000 physicians by 2034, including shortages of primary care physicians between 17,800-48,000 and a deficit of between 21,000-77,100 physicians across non-primary care specialties.<sup>2</sup> AAMC's workforce projections assume steady levels of physician immigration—significant reductions of physicians from other countries would drive up these projected shortages.

The academic medicine community has responded to consistent shortage projections and, since 2002, the number of first-year students in medical schools has grown by nearly 35% as schools expanded class sizes and 30 new schools opened;<sup>3</sup> currently, there are six additional medical schools that have applied to be considered for accreditation.<sup>4</sup> While U.S. medical schools continue to increase enrollment, medical school enrollment without commensurate increases in graduate medical education (GME) residency positions has no effect on the size of the workforce because GME training is required for licensure and medical practice in all states (and is critical to ensuring patient safety and quality of care). The entrance of physicians from other countries is also limited by the number of overall GME positions available. The AAMC supports the Resident Physician Shortage Reduction Act of 2021 (H.R. 2256, S. 834) to add 14,000 Medicare-supported GME positions over seven years. To partially address this need, the AAMC was pleased to see the end of the nearly 25-year freeze on Medicare funding for GME with the Consolidated Appropriations Act, 2021 (P.L. 116-260), which will add 1,000 new Medicare-supported GME positions.

Physicians from other countries are not displacing graduates of U.S. medical schools. According to the National Residency Matching Program (NRMP), in 2021, 92.8% (19,866) of seniors from

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<sup>1</sup> <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>

<sup>2</sup> <https://www.aamc.org/media/54681/download>

<sup>3</sup> <https://www.aamc.org/media/9936/download>

<sup>4</sup> <https://lcme.org/directory/candidate-applicant-programs/>

U.S. MD schools matched to residency programs.<sup>5</sup> After the NRMP Supplemental Offer and Acceptance Program (SOAP), only 552 U.S. MD seniors were left without a position in 2020. Studies have shown that more than 99% of all U.S. medical school graduates enter residency or enter full-time practice in the United States within six years after graduation.<sup>6</sup> Comparatively, in 2021, 54.8% (4,356) of non-U.S. graduates of international medical schools matched to residency programs.

Residency program directors seek the best candidates, regardless of citizenship status or national origin, through a highly competitive selection process, and after rigorous evaluation some students may be unable to find a residency position in the United States. Numerous factors can contribute to a student not matching, including not being competitive in first-choice specialty; medical licensure exam scores; poor interviewing or interpersonal skills; not applying to, interviewing for, or ranking enough programs; concerns raised in the Medical Student Performance Evaluation (also known as the “Dean’s Letter”); professionalism concerns; school reputation; or poor SOAP strategy.<sup>7,8</sup>

The AAMC provides regularly updated resources, tools, effective practices, and other materials to support students, medical school advisors, and program directors in the residency selection process. U.S. medical schools assist unmatched students with residency application guidance, finding residency vacancies, mental health support services, student debt management, and in pursuing master’s degree programs or additional research and clinical experiences to enhance their competitiveness. The AAMC is deeply committed to improving the transition from medical school to residency — from the beginning of a student’s specialty research and selection process through the completion of residency and on to clinical practice. Supporting the well-being, training, professional development, and equitable treatment of all medical students and residents is critical to the health of the nation.

### **Predictable, expedient, and efficient immigration processes for physicians and teaching hospitals improve U.S. health care and benefit patients.**

Thousands of physicians from other countries who are currently in the U.S. treating patients and roughly 4,300<sup>9</sup> new immigrant physicians who match each year to medical residency programs at U.S. teaching hospitals encounter significant barriers to remain in or enter the country. This is because the U.S. immigration and visa systems are not optimally designed for the health professions and the extended continuum of medical education, training, and state licensure. For example, the 3-month window between when physicians match to residency programs in late March and program start dates on or around July 1, requires certainty in U.S. Citizenship and

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<sup>5</sup> [https://www.nrmp.org/wp-content/uploads/2021/08/MRM-Results\\_and-Data\\_2021.pdf](https://www.nrmp.org/wp-content/uploads/2021/08/MRM-Results_and-Data_2021.pdf)

<sup>6</sup> Sondheimer HM, Xierali IM, Young GH, Nivet MA. Placement of US Medical School Graduates Into Graduate Medical Education, 2005 Through 2015. *JAMA*. 2015;314(22):2409–2410. doi:10.1001/jama.2015.15702

<sup>7</sup> Sondheimer HM. Graduating US Medical Students Who Do Not Obtain a PGY-1 Training Position. *JAMA*. 2010;304(11):1168–1169. doi:10.1001/jama.2010.1316

<sup>8</sup> Bumsted, Tracy MD, MPH; Schneider, Benjamin N. MD; Deiorio, Nicole M. MD Considerations for Medical Students and Advisors After an Unsuccessful Match, *Academic Medicine*: July 2017 - Volume 92 - Issue 7 - p 918-922 doi: 10.1097/ACM.0000000000001672

<sup>9</sup> [https://www.nrmp.org/wp-content/uploads/2021/08/MRM-Results\\_and-Data\\_2021.pdf](https://www.nrmp.org/wp-content/uploads/2021/08/MRM-Results_and-Data_2021.pdf)

Immigration Services (USCIS) processing that will enable new medical residents to enter the country in a timely fashion, start training, and treat patients. As a result, premium processing for additional fees has become the norm, yet even premium processing has been suspended in 2015, 2017, and 2019 during this critical window between matching and program start dates, creating disruptions and uncertainty.

Most physicians from other countries enter the U.S. for residency training on temporary nonimmigrant J-1 “exchange visitor” or H-1B “specialty occupation” visas. Both visa pathways have pros and cons. While the AAMC believes the J-1 visa is the most appropriate pathway for residency training and supports a balanced approach that prevents international “brain drain,” the 2-year home-country return requirement can pose a very substantial barrier for retaining physicians that U.S. teaching hospitals have invested in training. The H-1B visa does not have a 2-year home-country return requirement, but is designed for temporary employment, more expensive than J-1 visas, subject to numerical caps, and sometimes not long enough to cover the full duration of residency training.

Recently, teaching hospitals and H-1B applicants have been subject to additional requests for evidence (RFE) that often necessitate hiring immigration attorneys and drive up costs. Frequently, these RFEs are regarding H-1B prevailing wage data, which is incongruent with medical residency where all residents in the same training year at the same teaching hospital have the same stipend level rather than a traditional salary. In fact, using regional or market data beyond the institution-level can unintentionally require different stipends for these physicians than their peers. Ultimately, prevailing wage determination for medical residents is an unnecessary and counterproductive administrative burden for teaching hospitals.

The COVID-19 pandemic has further illustrated the importance of physicians from other countries, as well as how immigration reforms can help improve access to care. Emergency immigration policy changes improved patients’ access to physicians by exempting providers from certain COVID-19 travel restrictions, extending visa stays, and allowing temporary flexibility for practice location or switching employers. In light of this success, ongoing workforce shortages, and multiple public health crises, Congress should consider expanding some of these reforms and/or making them permanent. For example, we were pleased the USCIS published guidance expediting the issuance of Employment Authorization Documentation for essential health care workers in response to COVID-19, and we believe this should be standard practice. Increasing predictability for physicians from other countries and their employers, reducing backlogs or prioritizing physician applications, and streamlining physician processing throughout the immigration pathway ultimately benefits most the U.S. patients these providers will treat.

**AAMC urges Congress to permanently authorize and expand the State Conrad 30 J-1 visa waiver program.**

The State Conrad 30 J-1 visa waiver program has been a highly successful program for underserved communities to recruit both primary care and specialty physicians after they complete their medical residency training. This program allows up to 30 physicians per state to

remain in the U.S. in underserved communities (including rural and urban community health centers) after completing medical residency on a J-1 visa, which otherwise requires physicians to return to their home country for at least 2 years.

At minimal administrative cost to the federal government, the Conrad 30 program has brought more than 15,000 physicians to underserved areas over the last 15 years. That is comparable to (if not more than) the National Health Service Corps (NHSC) scholarship and loan repayment programs for U.S. citizens. Yet while Congress has rightly recognized the vital role the NHSC plays in caring for our nation's most vulnerable patients by steadily increasing funding, most recently with \$800 million in supplemental funding in the American Rescue Plan, Conrad 30 waiver limits have not been increased in two decades. The Conrad 30 program also allows states and governors more flexibility in specialty choice and practice location to recruit physicians with the most appropriate skills where they are most needed.

The AAMC endorses the bipartisan Conrad State 30 and Physician Access Reauthorization Act (H.R. 3541, S. 1810), which among other improvements would allow Conrad 30 to expand beyond 30 slots per state if certain nationwide thresholds are met. We applaud this bipartisan reauthorization proposal for recognizing these physicians as a critical element of our nation's health care infrastructure, and we support the expansion of Conrad 30 to help overcome hurdles that have stymied growth of the physician workforce.

Importantly, H.R. 3541 would also allow three Conrad 30 slots per state to be used by academic medical centers, permit "dual intent" for J-1 visa physicians seeking graduate medical education, and establish new employment protections and a streamlined pathway to a green card for Conrad 30 participants.

### **AAMC urges Congress to enact legislation for a permanent pathway to citizenship for DACA participants.**

AAMC supports a permanent pathway to citizenship for individuals with DACA status, including approximately 34,000 health care providers.<sup>10</sup> Medical school applicants and matriculants with DACA status continue to increase year after year, with more than 200 currently enrolled in medical school or completing their residency training. DACA and the corresponding work authorizations for the 34,000 health care providers enhance our nation's health care capacity at a time we can ill-afford to lose valuable personnel. As 33 health professional education organizations presciently warned the Supreme Court in an October 2019 amicus brief:

The risk of a pandemic ... continues to grow, since infectious diseases can spread around the globe in a matter of days due to increased urbanization and international travel. These conditions pose a threat to America's health security—its preparedness for and ability to withstand incidents with public-health consequences. To ensure health security, the country needs a robust health workforce. Rescinding DACA, however,

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<sup>10</sup> [https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/?\\_ga=2.263308748.1987884036.1644598394-852236830.1644598394](https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/?_ga=2.263308748.1987884036.1644598394-852236830.1644598394)

would deprive the public of domestically educated, well-trained, and otherwise qualified health care professionals who have been provided education in reliance on their ability to continue to work in the United States as health care professionals.<sup>11</sup>

The COVID-19 pandemic has also pulled back the curtain on longstanding social, economic, and health inequities in the United States that providers participating in DACA can help address. Health professionals with DACA status encompass a diverse, multiethnic population, who are often bilingual and more likely to practice in underserved communities hit hardest by a pandemic.

The AAMC urges Congress to pass a permanent pathway to citizenship for individuals with DACA status, such as the bipartisan Dream Act of 2021 (S. 264) or the House-passed American Dream and Promise Act of 2021 (H.R. 6). These bills would ensure that these undocumented Americans are able to continue their employment, education, training, and research in the health professions.

**AAMC supports reducing green card backlogs and prioritizing health care workers.**

AAMC supports addressing the backlog of applications for green cards by lifting per country caps that are impeding physicians entering the U.S. from certain countries. At the same time, we are concerned that limiting the aggregate number of green cards each year only shifts the problem from one country to another. This is particularly problematic for nurses who, depending on state licensure requirements, may not be eligible for H-1B specialty occupation visas and instead apply directly for immigrant visas and green cards, potentially facing decade-long wait times while overseas.

To break these backlogs, the bipartisan Healthcare Workforce Resilience Act (H.R. 2255, S. 1024) would authorize the recapture of unused immigrant visas and redirect them to 25,000 immigrant visas for professional nurses and unused 15,000 immigrant visas for physicians. Importantly, these visas would be issued in order of priority date, not subject to the per country caps, and premium processing would be applied to qualifying petitions and applications.



Thank you again for the opportunity to submit this statement for the record on the importance of physicians from other countries and the critical roles they play in the U.S. health workforce. Ultimately, our nation’s health security depends on access to providers and maintaining a sufficient physician workforce, through reasonable, predictable immigration policies that help recruit and retain foreign physicians from diverse backgrounds to rural and other underserved communities. The AAMC looks forward to working with the Senate Judiciary Committee and Congress on a balanced approach to immigration and citizenship policy that attracts individuals who want to contribute to improving the health of our nation and people everywhere.

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<sup>11</sup> <https://www.aamc.org/media/37271/download?attachment>