

THE “CONRAD STATE 30” IMPROVEMENT ACT: REMEDYING THE PHYSICIAN SHORTAGE

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I. INTRODUCTION

When Dr. Pritchard of Penn Yan, NY, a small town of 5,500, closed his general practice, his patients were left stranded.¹ The few remaining doctors in Penn Yan were overworked and could barely handle their own patient-load; the same held true for doctors in nearby towns.² In a short time, the region had seen the number of physicians drop by 10%.³ Dr. Pritchard’s patients, many of whom were elderly and battling illness, had to wait up to eighteen months before another doctor could treat them—an hour’s drive away.⁴

Such is the case in medical shortage areas across the nation. The ratio of physicians to the general population is growing increasingly smaller, and thousands of regions are currently designated by the Department of Health and Human Services as medically underserved or as having a shortage of health professionals.⁵ As a partial solution to the growing shortage, foreign medical graduates who have received medical training in the United States as holders of a J-1 visa often accept commitments, or visa waivers, to practice as primary care physicians in underserved areas rather than return to their nation of origin once their visas expire.⁶ Because many shortage areas are in impoverished rural regions or inner cities, it is often difficult to

¹ Michelle York, *Few Young Doctors Step in as Upstate Population Ages*, N.Y. TIMES, Jul. 23, 2007.

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ Greg Siskind & Bryan Stevenson, *Physician J-1 Waivers*, 17 HEALTH LAWYER 1, 6 (2005).

⁶ Amy Hagopian, *Health Departments’ Use of International Medical Graduates in Physician Shortage Areas*, 22 HEALTH AFFAIRS 5 (2003).

draw U.S. physicians to practice there, and foreign medical graduates have become a much-needed alternative.

The main program that grants visa waivers to foreign physicians, the “Conrad State 30” Program, is due to expire on September 30, 2012. While Congress has indicated its willingness to renew the program and make certain extensions to it, a bill that would make even greater improvements to the Program has remained in the Senate Committee on the Judiciary for much of 2009. U.S. Senator Kent Conrad of North Dakota introduced a bill to the Senate that would mandate not only the program’s renewal, but also its permanent establishment.⁷ The bill seeks to provide more incentives for foreign doctors to apply for a visa waiver, and attempts to make the process of application more flexible.⁸ This bill is necessary and has been long-awaited by the health care community and public health advocates. It is also crucial for Congress to further expand on the Conrad program over subsequent years to truly alleviate the growing health care shortage in the U.S.

A GROWING PHYSICIAN SHORTAGE

U.S. spending on health care has never been higher, but the country is currently facing an unprecedented shortage of physicians nationwide.⁹ The American Medical Association estimates that there are currently more than thirty-five million people in the United States living in areas without adequate access to doctors, and that it would take 16,000 new doctors to immediately fill that need.¹⁰ This physician shortage is expected to significantly worsen as the population continues to increase.¹¹ Estimates currently project that the U.S. population will increase to 345 million in 2020, from 285 million in 2002.¹² It is also projected, based on current rates of physicians entering and leaving the profession, that physicians will only number 964,700 in 2020; the percentage of physicians in the popula-

⁷ S. 2628, 111th Cong. (2009).

⁸ *Id.*

⁹ See generally AMERICAN ASSOCIATION OF MEDICAL COLLEGES, RECENT STUDIES AND REPORTS ON PHYSICIAN SHORTAGES IN THE U.S. (Center for Workforce Studies, April 2009) available at <http://www.aamc.org/workforce/stateandspecialty/recentworkforcestudies.pdf>. See also S. Keehan et al.: Health spending projections through 2016: modest changes obscure part D's impact. *Health Aff (Millwood)* 2007, 26(2): 242-253.

¹⁰ See Chris Talbott, *Why Foreign Doctors are in Shorter Supply*, PHILA. DAILY NEWS, Jul. 22, 2007.

¹¹ *Id.*

¹² AMERICAN MEDICAL ASSOCIATION, INTERNATIONAL MEDICAL GRADUATES IN THE U.S. WORKFORCE: A DISCUSSION PAPER, 17 (Venkat Rao, Chair, AMA IMG Governing Council ed., 2007) available at <http://www.ama-assn.org/ama1/pub/upload/mm/18/img-workforce-paper.pdf>. [hereinafter, A DISCUSSION PAPER].

tion will not increase as quickly as the population as a whole.¹³ By 2020, then, “the projected deficit will be 200,000 physicians, a shortage of 20 percent.”¹⁴ To alleviate this looming crisis, “over twenty-five new medical schools would be required over the next ten years.”¹⁵

For the most part, the shortage of physicians does and most likely will continue to severely impact rural areas and inner-cities.¹⁶ These areas are also more likely to have low-income, African American or Hispanic patients.¹⁷ Many communities in these areas most affected by physician shortages have no local access to physicians at all, and residents must travel many miles for even the most basic medical care. In others, there are too few physicians to adequately serve the community. Those that do practice in areas most heavily impacted by the physician shortage are often overworked and have extremely heavy caseloads.¹⁸ Moreover, in areas with the most severe shortages of physicians and other health professionals, there generally exist the nation’s “highest rates of infant mortality, heart disease, and other serious illnesses.”¹⁹

B. HOW THE PHYSICIAN SHORTAGE CAME TO BE

Throughout the latter half of the twentieth century, experts had frequently and loudly predicted that soon there would be a “massive oversupply of physicians” in the United States.²⁰ In 1991, the Council on Graduate Medical Examination (COGME) “predicted a surplus of 80,000 physicians by 2000 and a rise of 24 percent by 2010.”²¹ However, these fears were ultimately misplaced because by the end of the century there was a clear shortage of physicians.²² The marked decline has generally been attributed to several factors: decreased medical school applications combined with more doctors retiring or leaving the profession; more doctors specializing

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ See, e.g., Talbott, *supra* note 10.

¹⁷ Wang, Fahui & Wei Luo, *Assessing Spatial and Nonspatial Factors for Healthcare Access: Towards an Integrated Approach to Defining Health Professional Shortage Areas*, 11 HEALTH & PLACE 131, 132 (2005).

¹⁸ See, e.g., Chen, Pauline W., *Doctor and Patient: Where Have all the Doctors Gone?*, N.Y. TIMES, Dec. 11, 2008.

¹⁹ See, e.g., Talbott, *supra* note 10. (It is immaterial whether a higher incidence of disease is attributable to fewer physicians, or whether high incidence of poverty contributes to both higher incidence of disease and fewer physicians; in either circumstance, more physicians are needed to alleviate the problems faced by underserved medical communities.)

²⁰ See A DISCUSSION PAPER, *supra* note 12, at 4–6.

²¹ *Id.* at 6.

²² *Id.* at 4.

rather than practicing basic family medicine; large numbers of uninsured Americans; and an increasingly aging population.²³

From 1996 to 2000, medical school applications declined by 31%, from 46,967 applicants to only 32,183.²⁴ At the same time, large numbers of doctors have been and are currently retiring or leaving the profession.²⁵ Part of the reason for this is that the post-war population is aging, and many physicians are reaching retirement age at the same time.²⁶ Changes in the way that the profession operates are also blamed. Physicians increasingly feel that they “face a loss of control” over their practice “to government agencies and insurance companies.”²⁷ Since the 1960s, physicians have grown more frustrated with the profession overall because of growing external interference in their practice.²⁸ With the vast majority of patients now under managed care, insurance companies “require physicians to clear all major treatment decisions in advance,” and have implemented regulations that affect even the minutiae of how physicians run their practices.²⁹ Doctors frequently feel that this takes treatment decisions out of the physician’s control.³⁰ These changes also render the profession less autonomous and less prestigious than it once was, driving many physicians away and discouraging students from applying to medical schools.³¹

Exacerbating the physician shortage problem, only 2% of graduating medical students are showing interest or entering residency programs in primary care specialties, which include family medicine, internal medicine, pediatrics, obstetrics and gynecology.³² A study published by the Robert Graham Center has indicated that one of the “top reasons medical students do not choose a primary care specialty is its low average annual income.”³³

²³ See William McKay Bennett, Ron Rose & Dina Sakita, *Special Immigration Issues Related to the Employment of Foreign Physicians and Nurses*, 12 INT’L HUM. RTS. J. 8 (2003)

²⁴ *Id.* at 8.

²⁵ *Id.*

²⁶ *Id.*

²⁷ See, e.g., Lisa Belkin, *Sensing a Loss of Control, More Doctors Call it Quits*, N.Y. TIMES, Mar. 9, 1993.

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ See *id.*

³² U.S. Government Accountability Office, *Foreign Physicians: Data on Use of J-1 Visa Waivers Needed to Better Address Physician Shortages*, REPORT TO CONGRESSIONAL REQUESTERS, n. 13, Nov. 2006, available at <http://www.gao.gov/new.items/d0752.pdf>; Cardarelli, Robert, *The Primary Care Workforce: a critical element in mending the fractured U.S. health care system*, 3 OSTEOPATHIC MED. & PRIMARY CARE 11, 2009

³³ *Id.* at 11; see also R. Phillips et al. *Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices?* The Robert Graham Center: Policy Studies in Family Medicine and Primary Care 2009.

Rather, students are increasingly showing more interest in specialties, which are generally more lucrative and prestigious than basic primary care.³⁴

Thirty minutes spent performing a diagnostic, surgical, or imaging procedure often pays three times as much as a 30-minute visit with a patient with diabetes, heart failure, headache, and depression. The median income of specialists in 2004 was almost twice that of primary care physicians, a gap that is widening. Data from the Medical Group Management Association indicate that from 1995 to 2004, the median income for primary care physicians increased by 21.4 percent, while that for specialists increased by 37.5 percent. A 2006 report from the Center for Studying Health System Change reveals that from 1995 to 2003, inflation-adjusted income decreased by 7.1 percent for all physicians and by 10.2 percent for primary care physicians. The 5 percent increase in Medicare payments for primary care announced in June 2006 is insufficient to narrow the gap.³⁵

In fact, the number of medical students who are becoming family medicine practitioners is declining to “near crisis proportions.”³⁶ “Between 1997 and 2005, the number of U.S. graduates entering family practice residencies dropped by 50 percent.”³⁷ As a result, it is increasingly difficult for underserved rural and low-income communities to obtain access to primary care physicians.³⁸

Low-income areas find it especially hard to find and attract doctors to their communities because many physicians prefer to practice in city centers and wealthier towns and suburban areas.³⁹ In these areas, incomes are highest and physicians are reimbursed with higher fees.⁴⁰ Also driving physicians to wealthier areas is the fact that many lower income have no health insurance coverage.⁴¹ One in five Americans is without health insurance, and a vastly disproportionate number of those are low-income patients who live in areas designated as medically underserved or as physician shortage

³⁴ See, e.g., Shannon Brownlee, *Overdose*, ATLANTIC MONTHLY, Dec. 2007, available at <http://www.theatlantic.com/doc/200712/health-care>

³⁵ Thomas Bodenheimer, *Primary Care—Will it survive?*, 335 NEW ENG. J. MED 861, 862 (2006).

³⁶ A DISCUSSION PAPER, *supra* note 12, at 10.

³⁷ Bodenheimer, *supra* note 35, at 862.

³⁸ *Id.*

³⁹ See, e.g., Brownlee, *supra* note 34; see also, York, *Few Young Doctors*, *supra* note 4 (discussing the difficulty of attracting young doctors to lower-income cities and rural towns).

⁴⁰ Glenn M Hackbarth, Robert D. Reischauer, & Mark E. Miller, *Geographic practice cost indexes*, Medicare Payment Advisory Commission, Aug. 12, 2003,

http://www.medpac.gov/publications/other_reports/Aug03_GPCI_2pgrKH.pdf.

⁴¹ See, e.g., Brownlee, *supra*, note 34.

areas.⁴² This drives down the profits that physicians can garner from their practice.⁴³ Many low-income patients, if covered at all, are covered by Medicaid, which is notorious for the low fees—generally far below market rates—that it pays physicians who treat Medicaid patients.⁴⁴

The same population demographics that are causing uncommonly large numbers of doctors to retire are creating an increased demand for health professionals, despite the decreased supply.⁴⁵ With large numbers of the post-war generation growing older, “the aging population requires more medical attention than ever before.”⁴⁶ Aging brings with it increased incidence of a whole host of medical conditions and diseases, and U.S. Census Bureau projections indicate that the percentage of people over the age of sixty-five will double over the next thirty years.⁴⁷ This will create an even higher demand for physicians just as the ratio of physicians to the general population continues to decline.⁴⁸

Congress has indicated its concern with this growing crisis.⁴⁹ Representative John Hostettler of Indiana spoke of an “overall shortage of physicians in the United States, a shortage that seems to be growing” at a 2006 Judiciary Committee hearing.⁵⁰ Representative F. James Sensenbrenner of Wisconsin has noted that the national press has also brought attention to “industry fears that shortages may become even more severe over the next decade due to the flat medical school enrollments, aging baby boomers and the high number of doctors headed for retirement.”⁵¹ An examination of this issue by Hostettler before the House Subcommittee on Immigration, Border Security, and Claims also made it clear that it was “apparent” that there “is in fact a growing physician shortage in the United States.”⁵²

⁴² *Id.*

⁴³ See Robert Pear, *Low Medicaid Fees Seen as Depriving the Poor of Care*, N.Y. TIMES, Apr. 2, 1991, at A1.

⁴⁴ *Id.*

⁴⁵ See York, *supra* note 1, at B1

⁴⁶ Bennett, *supra* note 23, at 1; see also York, *supra* note 4, at B1 (finding a lack of doctors in Binghamton, NY).

⁴⁷ Bennett, *supra* note 23, at n.3.

⁴⁸ See, e.g., York, *supra* note 1.

⁴⁹ See Full Committee Markup of H.R. 4997, H.R. 5219, H.R. 4239, and H.R. 6052 Before the H. Comm. on the Judiciary, 109th Cong. (2007)(statement of John Hostettler, Member, H. Comm. on the Judiciary)(hereinafter, Full Committee Markup Before H. Comm. on the Judiciary).

⁵⁰ *Id.*

⁵¹ *Id.* (statement of F. James Sensenbrenner, Chair, H. Comm. on the Judiciary).

⁵² *Id.* (statement of John Hostettler, Member, H. Comm. on the Judiciary).

C. FOREIGN MEDICAL GRADUATES AS A REMEDY TO THE SHORTAGE

Congress has dealt with alleviating physician shortages by enacting legislation to allow graduates of foreign medical schools to receive their training and practice in the U.S.⁵³ As a result, over the years foreign medical graduates have begun to provide a “safety net” for the U.S. health care industry, filling gaps that are not filled by domestic physicians.⁵⁴ In fact, the United States “has long depended on foreign medical graduates to fill its residency programs with well-qualified and highly intelligent physicians.”⁵⁵ Foreign medical graduates currently comprise about 40 percent of doctors in the inner cities of large metropolitan areas,⁵⁶ and as of 2007, approximately one in four physicians across the United States was a graduate of a foreign medical school.⁵⁷ One report placed their number at about 236,669 of 902,053 total practicing physicians nationwide.⁵⁸

Foreign medical graduates are seen as desirable substitutes for domestic healthcare workers for alleviating the health care gap because they are often more willing to work in areas or positions viewed by domestic physicians as undesirable.⁵⁹ This is partially because foreign medical graduates often seek to come to the United States because they view education in the United States as traditionally superior to medical education offered in other nations.⁶⁰ Moreover, physician salaries in the United States, even those in low-income areas, are often significantly higher than those in foreign medical graduates’ countries of origin.⁶¹

Foreign physicians are generally more likely to work for public organizations and institutions than are domestic doctors, who are increasingly seeking out private practice to obtain greater autonomy and better financial reward. Foreign medical graduates are also often more willing to work with populations that have been officially designated as health professional shortage areas.⁶² In addition, foreign physicians are often better-suited to

⁵³ See H.R. 4997 (reviving the I-1 visa waiver program for physicians).

⁵⁴ A DISCUSSION PAPER, *supra* note 12, at 10.

⁵⁵ Mahsa Khanbabai, *Foreign Medical Graduates-Remedies to Cure the Two-Year Flu*, 2 IMMIGR. PRAC. MANUAL § 27, § 27.1 (Massachusetts Continuing Legal Education, Inc., 2004).

⁵⁶ See A DISCUSSION PAPER, *supra* note 12, at 28.

⁵⁷ *Id.* at 4.

⁵⁸ *Id.* at 7.

⁵⁹ *Id.* at 11.

⁶⁰ See Khanbabai, *supra* note 55, at §27.1.

⁶¹ Vujicic, Marko, Pascal Zurn, Khassoum Diallo, Orvill Adams, & Mario R Dal Poz, *The role of wages in the migration of health care professionals from developing countries*, 2 HUM. RESOURCES FOR HEALTH 3, Tbl. 2 (2004)

⁶² Hart, Gary L., Susan M. Skillman, Meredith Fordyce, Matthew Thompson, Amy Hagopian, & Thomas R. Konrad, *Physicians in the United States: Changes Since 1981*, 26 HEALTH AFFAIRS 1159, 1165 (2007).

treat patients from immigrant communities, especially if they share the same language.⁶³ Many state public health departments, in looking for physicians who can best serve a community's needs, often give preferential treatments to physicians who can speak a language widely spoken in a medical shortage area in that state.⁶⁴ Physicians from the same nations of origin as their patients are also often more culturally sensitive and can better understand cross-cultural issues. Along the same lines, foreign physicians can often be helpful in training U.S. workers about the unique cultural needs of many immigrant communities.⁶⁵

Foreign medical graduates are also beneficial in staving off certain negative economic effects of a healthcare shortage.⁶⁶ A shortage of health care workers, for example, "may lead to economic ripple effects because companies will not relocate in areas with limited access to medical care for their employees and existing business entities may lose qualified employees because they seek a better quality of life and improved medical care elsewhere."⁶⁷ Economic ripple effects also result when populations as a whole have medical conditions that long go untreated—health care becomes increasingly expensive and individuals with untreated illnesses do not as meaningfully contribute to the labor force.⁶⁸ In addition, while U.S. medical education has traditionally been viewed as vastly superior to those found in many other nations, especially those countries that contribute large numbers of medical graduates to the U.S., other nations are catching up to the U.S. in quality education in the sciences.⁶⁹ The United States has an interest in having access to the best and most well-trained physicians serving its population, regardless of country of origin.⁷⁰

The Congressional Research Service has emphasized the need to continue recruiting foreign medical graduates, stating in one report that the presence of foreign doctors "in many rural communities of the United States has allowed states to ensure the availability of medical care to their

⁶³ See Khanbabai, *supra* note 55, at §27.4.2.

⁶⁴ See *id.*

⁶⁵ See A DISCUSSION PAPER, *supra* note 12, at 9 ("One example is a program developed in Dearborn, Michigan by ACCESS, a cooperative venture between an Arab community center and the University of Michigan Health System which serves the area's large Middle Eastern population. As reported in the January 21, 2005 issue of *Psychiatric News*, these programs were established in order to provide 'culturally competent, patient-centered services, and programs to Middle-Eastern women.' [International medical graduates] are well placed not only to staff such programs, but also to interact with U.S. colleagues in delivering care to an ever-increasingly diverse U.S. population.").

⁶⁶ *Id.* at 13.

⁶⁷ *Id.*

⁶⁸ See *id.* at 16.

⁶⁹ *Id.*

⁷⁰ *Id.*

residents.”⁷¹ In short, “both the doctor and the community benefit. The physician is able to remain in the United States to practice medicine, and an underserved community receives a doctor that is desperately needed.”⁷²

II. THE J-1 VISA PROGRAM IS THE PRIMARY METHOD BY WHICH FOREIGN DOCTORS ARE ADMITTED INTO THE UNITED STATES

The J-1 visa is a crucial method allowing foreign medical graduates entry into the United States to practice in underserved areas, “with more than 1000 waivers requested by states and federal agencies in each of fiscal years 2003 through 2005.”⁷³ The J-1 visa is a temporary nonimmigrant educational visa for participants in the Exchange Visitor Program.⁷⁴ Under the J-1 program, a foreign medical graduate can receive a visa from the U.S. Department of State after acceptance into a residency or fellowship program in the United States.⁷⁵ The J-1 visa is the most frequently desired visa for such training because it allows holders to be directly involved in patient care;⁷⁶ other visas available to foreign medical graduates, such as the HB-1 visa, allow for observation, consulting, teaching or research, but permit little or no direct patient care.⁷⁷

A. HISTORY OF THE J-1 PROGRAM

The J-1 program can be partially traced back over a hundred years of concerns about the U.S. health care system. In 1910, the Flexner Report delineated the inadequate nature of American health care, and the response to it culminated in the closing of many U.S. medical schools which were deemed to be inferior.⁷⁸ This reduced the number of physicians nationwide; physicians also declined in number throughout the pre-war period in the 1930s, “from 173 per 100,000 to 125 per 100,000.”⁷⁹ Following the Second World War, however, there was a surge in demand for improved health care nationwide.⁸⁰ The 1959 Bane Report by the U.S. Surgeon General’s office predicted that the U.S. would face a physician shortage of up

⁷¹ Alan Cowell & Scott Shane, 2 *Doctors Held in British Bomb Plots Had Looked to U.S.*, N.Y. TIMES, July 7, 2007, at A1.

⁷² Siskind, *supra* note 5, at 8.

⁷³ U.S. Gov. Accountability Office, *Foreign Physicians: Data on the Use of J-1 Visa Waivers Needed to Better Address Physician Shortages*, Report to Congressional Requesters (Nov. 2006).

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ See Bennett, *supra* note 23.

⁷⁷ See *id.* at 8.

⁷⁸ See A DISCUSSION PAPER, *supra* note 12, at 4.

⁷⁹ *Id.*

⁸⁰ *Id.*

to 40,000 by the 1970s.⁸¹ In response to the Bane Report, more medical schools were opened across the country to produce medical graduates to fill the expected deficit.⁸² The U.S. government also began looking to foreign medical graduates to fill the gap left by domestic medical graduates.⁸³ Congress began introducing legislation that set up a framework to alleviate the health care shortage.⁸⁴

In 1948, the Smith-Mundt Act was enacted by Congress to promote understanding between America and foreign nations, and included mandates for the establishment of centers to coordinate international exchanges.⁸⁵ This mandate led to the enactment of the Fulbright-Hayes Act in 1961.⁸⁶ That Act created the Exchange Visitor Program, which was intended to “increase mutual understanding between the people of other countries by means of educational and cultural exchange.”⁸⁷ The Exchange Visitor program would promote foreign understanding by bringing foreign nationals into the United States for a set period of time to gain new knowledge and ideas, who would then return to their home countries to share that new knowledge with their countrymen.⁸⁸ The Fulbright-Hayes Act of 1961 built upon the Immigration and Nationality Act of 1952—which reorganized the basic structure of U.S. immigration law—and mandated the “J” visa to “promote the interchange of persons, knowledge, and skills in the fields of education, arts, and sciences.”⁸⁹ To ensure that this exchange of ideas occurred, Congress included a two-year home country physical presence requirement for certain “J” visa holders, including physicians.⁹⁰ Because the policy behind the Exchange Visitor Program was to develop better understanding and closer ties between the residents of foreign nations and U.S. citizens, waivers of the two-year home country physical presence requirement were rarely granted, and only under a limited set of circumstances.⁹¹

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ Skyler G. Cruz, *Have Foreign Physicians Been Misdiagnosed? A Closer Look at the J-1 Visa*, 2 *LOY. INT'L L. REV.* 295, 295–96 (2005).

⁸⁶ *Id.*

⁸⁷ Mutual Educational and Cultural Exchange Act of 1961, Pub. L. No. 87-256, 75 Stat. 527 (codified as amended at 22 U.S.C. § 2451 et seq.).

⁸⁸ See Cruz, *supra* note 85, at 295–96.

⁸⁹ See *id.* at 296–97.

⁹⁰ Immigration and Nationality Act (INA) §212(e), 8 U.S.C. §1182(e).

⁹¹ See, e.g., Cruz, *supra* note 85, at 296.

Under this program, however, foreign physicians faced almost no restrictions;⁹² the process became even easier with the Immigration and Nationality Act of 1965, which ended the practice of national quotas and gave preferential treatment to applicants who had professional skills that were designated as in short supply.⁹³ Physicians were included in this group.⁹⁴

As a result, by the mid 1970s, just two decades after the creation of the 1952 INA, foreign doctors comprised approximately 21% of the total number of practicing physicians” in the United States.⁹⁵ In 1976, however, Congress enacted the Health Professions Educational Assistance Act (HPEA).⁹⁶ In doing so, Congress “declared an end to the physician shortage.”⁹⁷ Foreign medical graduates no longer were granted preferential treatment and began to face greater entry restrictions.⁹⁸ They were, for example, newly required to meet specific examination requirements.⁹⁹ The HPEA all but guaranteed that the J-1 visa became the only feasible path for foreign physicians who wanted to enter the U.S. for training.¹⁰⁰

B. APPLICATION PROCESS & SPONSORSHIP

Foreign physicians who attempt to enter the United States on a J-1 visa must first receive sponsorship by a Department of State-authorized sponsoring organization.¹⁰¹ The first step for receiving Department of State sponsorship is certification by the Educational Commission for Foreign Medical Graduates (ECFMG).¹⁰² The ECFMG is currently the only program authorized to certify foreign medical graduates to enter the U.S. for a residency program.¹⁰³ A non-profit organization,¹⁰⁴ the ECFMG serves as the sole organization through which all foreign medical graduates register for Step 1 and Step 2 of the United States Medical Licensing Examination (USMLE), passage of which is mandatory in order to apply for a U.S. residency or fellowship program.¹⁰⁵ As of 2002, certification also re-

⁹² *Id.*, n. 85, at 298.

⁹³ Immigration and Nationality Act (INA), PL 89-236, October 3, 1965, 79 Stat. 911.

⁹⁴ *Id.*

⁹⁵ See Cruz, *supra* note 85, at 298.

⁹⁶ Health Professions Educational Assistance Act (HPEA), Pub. L. 94-484, 1976 HR 5546 (1976).

⁹⁷ A DISCUSSION PAPER, *supra* note 12, at 5.

⁹⁸ *Id.*

⁹⁹ See *id.*

¹⁰⁰ See, e.g., Cruz, *supra* note 85, at 298.

¹⁰¹ Khanbabai, *supra* note 55 at §27.3.

¹⁰² *Id.*

¹⁰³ *Id.* at 301.

¹⁰⁴ See A DISCUSSION PAPER, *supra* note 12, at 5.

¹⁰⁵ *Id.* at 6.

quires that the applicant's medical school be listed in the *International Medical Education Directory*, that the applicant has attended at least four years of medical school, and that the applicant has received passing grades on the USMLE exams, the TOEFEL exam, and the Clinical Skills Assessment (CSA) test.¹⁰⁶ Physicians who come into the U.S. holding other visas, such as the H-1B, are not subject to these qualifications.¹⁰⁷

Once certified by the ECFMG, a foreign medical graduate may apply for acceptance into a U.S. medical residency or fellowship program.¹⁰⁸ Once accepted, the foreign medical graduate works with that program in order to obtain Department of State Sponsorship and final approval by the USCIS.¹⁰⁹

In addition, all ECFMG-sponsored physicians are subject to time limits on program duration (usually seven years, although extensions can sometimes be obtained) and are automatically subject to the two-year home country physical presence requirement after the completion of their program.¹¹⁰

Foreign medical graduates who come to the U.S. for clinical practice rather than research are *always* subject to the two-year home country physical presence requirement. This is because, under INA §212(e), the two-year home country residence requirement applies if a foreign national or resident has entered the United States to receive graduate medical education or training (*i.e.*, a residency or fellowship program that involves patient care services) under the sponsorship of the ECFMG.¹¹¹ The two-year home country residence requirement also applies if the program was financed in whole or in part, directly or indirectly, by the U.S. government, the government of the foreign physician's last country of residence, or a program that specializes in international exchanges.¹¹² Since virtually all foreign medical graduates are subject to the two-year home country physical presence requirement, they must leave the United States after their

¹⁰⁶ Bennett, *supra* note 23, at 8; Marcia N. Needleman, *Basic Immigration Law: F, J, and M Nonimmigrants*, BASIC IMMIGRATION LAW, PLI (2006).

¹⁰⁷ *Id.*

¹⁰⁸ See A DISCUSSION PAPER, *supra* note 12, at 20.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ Immigration & Nationality Act, Pub. L. No. 82-414, 66 Stat. 163 (1952) (codified as amended at 8 U.S.C. §§ 1101-1524 (1994 & Supp. III 1997)). Section 212(e) enumerates grounds upon which alien individuals may be found inadmissible for entry into the United States. The two-year home country physical presence requirement is one such ground for inadmissibility. Foreign physicians holding a J-1 visa may not apply for permanent residency or citizenship without completing that two-year requirement.

¹¹² See, e.g., Bennett, *supra* note 23, at 9.

training program is complete.¹¹³ After this two-year period, foreign medical graduates who formerly held a J-1 visa may apply for re-entry on an H-1B or an L-1 non-immigrant visa, or as a U.S. permanent resident.¹¹⁴

III. A WAIVER OF THE TWO-YEAR HOME COUNTRY PHYSICAL PRESENCE REQUIREMENT MAY BE OBTAINED IN EXCHANGE FOR THREE YEARS OF PRACTICE IN A MEDICAL SHORTAGE AREA

The two-year home country physical presence requirement for J-1 visa holders may be waived under certain circumstances.¹¹⁵ This waiver allows foreign physicians to remain and practice in the United States under an H-1B visa without a two-year residence in the physician's home country.¹¹⁶

There are several ways a J-1 visa holder can obtain sponsorship from an interested government agency.¹¹⁷ A J-1 visa holder can, for example, demonstrate that his or her departure would result in an "exceptional hardship to a U.S. citizen or permanent resident spouse or child."¹¹⁸ A physician with a J-1 visa can also petition for a waiver if he or she cannot return to his or her country of last residence or nationality because he or she faces persecution "based on race, religion, or political opinion."¹¹⁹ For the most part, however, visa waivers are infrequently given for these reasons and it is often difficult for J-1 visa holders to meet the requirements for proof demanded by Department of State officials.¹²⁰ A J-1 physician can also obtain sponsorship from a federal agency or state public health agency (an "interested governmental agency") that requests that the foreign physician remain in the United States.¹²¹

In return for a waiver of the home country physical presence requirement, however, the Illegal Immigration Reform and Immigrant Respon-

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ See, e.g., Khanbabai, *supra* note 55, at §27.4.1.

¹¹⁶ *Id.*

¹¹⁷ See *id.* at §27.3.

¹¹⁸ Bennett, *supra* note 23, at 9.

¹¹⁹ *Id.*

¹²⁰ The Attorney General has argued and the courts have held that a two-year separation from spouse and child are not circumstances which constitute "exceptional hardship" so as to require a waiver of the two-year requirement. Therefore, often the only option for physicians in this situation is to obtain the sponsorship of an interested government agency. See *Gras v. Beechie*, 221 F. Supp. 422, 424 (S.D. Tex. 1963) (arguing that "the fact of separation, unfortunate though it is, is of a sufficiently lower order of hardship to take it out of the standard set up by Congress."); Inna V. Tachkalova, Comment, *The Hardship Waiver of the Two-Year Foreign Residency Requirement Under Section 212(e) of the INA: The Need for a Change*, 49 AM. U. L. REV. 549, 551 (1999); see also Bennett, *supra* note 23.

¹²¹ See Bennett, *supra* note 23, at 9.

bility Act (IIRIRA) of 1996 requires that any foreign physicians receiving the waiver must complete three years of service in medical practice in a geographic area designated by the Department of Health and Human Services as having a shortage of healthcare professionals.¹²² Areas designated as having a shortage of physicians are categorized in three main areas: (1) a health professional shortage area (HPSA); (2) a medically underserved area or medically underserved population (MUA/MUP); or (3) a mental health professional shortage area (MHPSA).¹²³ Physicians who receive a waiver must also maintain an H-1B visa status during that three-year period, and are free to pursue permanent residency.¹²⁴ The IIRIRA also requires that a doctor holding a J-1 visa waiver obtain a contract to work at least 40 hours per week.¹²⁵

Because foreign physicians who have received a J-1 visa waiver must fulfill the mandatory three-year service commitment in an HPSA, MUA, or MHPSA before being eligible for permanent resident status, programs involving foreign physicians thus represent “an overt effort [by Congress] to place foreign-trained doctors into areas with acute health care needs.”¹²⁶ Foreign doctors are an integral factor in the U.S. government’s strategy to increase the availability of health care in rural areas and inner-cities, the two regions most commonly identified as being underserved or suffering from a shortage of physicians and other health care professionals.¹²⁷ The waiver program is an important remedy to the two-year home residency rule, which was enacted long before the United States faced any concerns about a quickly increasing shortage of qualified physicians.¹²⁸

¹²² Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), Pub. L. 104-208, 110 Stat. 3009.

¹²³ See Siskind, *supra* note 5, at 6 (“HHS designates an area as HPSA based upon the ratio of primary care physicians to the local population. Generally, if the primary care physician to population ration is less than one in 3,000, and if certain other factors are present, the area will be designated as HPSA . . . MUAs are also underserved as determined by HHS, but this determination applies established criteria to an index of medical underservice. The index involves certain variables beyond the ratio of physicians to population, including infant mortality, poverty level, and age of the population.”).

¹²⁴ IIRIRA, *supra* note 122; see also, e.g., Ice Miller LLP, *Survey of Recent Developments in Health Law*, 39 IND. L. REV. 1051, 1098 (2006).

¹²⁵ IIRIRA, *supra* note 122.

¹²⁶ Cruz, *supra* note 85, at 301; see also Rob Paral, *Health Worker Shortages & the Potential of Immigration Policy*, 3 IMMIGR. POL’Y IN FOCUS, Issue 1, 6 (Feb 2004).

¹²⁷ See, e.g., A DISCUSSION PAPER, *supra* note 12, at 104.

¹²⁸ Siskind, *supra* note 5, at 3.

A. SEVERAL PROGRAMS OFFER WAIVERS FOR PRIMARY CARE PHYSICIANS

Both federal and state agencies sponsor J-1 visa waivers.¹²⁹ The “Conrad 30” program is regulated and run by state public health departments.¹³⁰ The Housing and Human Services program, the main federal program, runs the current federal waiver program (until 2002, the U.S. Department of Agriculture was the main federal sponsor of waiver applicants), but due to tight restrictions following September 11, 2001 and concerns about its arbitrary nature, that program is largely defunct.¹³¹ Several other agencies, such as the Appalachian Regional Commission and the Veteran’s Administration, also have small programs for issuing J-1 waivers to physicians.¹³²

1. State Program: The “Conrad State 30” Waiver Program

The “Conrad State 30” Program, officially known as the Physicians for Underserved Areas Act, is a popular method for foreign medical graduates to obtain a J-1 waiver.¹³³ Traditionally, only a federal agency could sponsor J-1 physicians for waivers of the two-year home residence requirement.¹³⁴ The Conrad 30 program as enacted in 1994,¹³⁵ however, permitted state public health departments, rather than federal agencies like HHS, to sponsor foreign medical graduates in their application for J-1 waivers.¹³⁶ The program authorizes thirty J-1 waivers per state per year, for distribution as each state sees fit.¹³⁷

The Conrad program is similar to federal J-1 waiver programs in that sponsorship is predicated on an agreement by the foreign medical graduate to provide care in areas that have been designated by the Secretary of Health and Human Services as medically underserved areas or health professional shortage areas.¹³⁸ The program is administered by individual state public health departments, and individual states must enact legislation to implement the program (some, for example, will only accept applicants for medically underserved areas rather than health professional shortage ar-

¹²⁹ U.S. Government Accountability Office, *Foreign Physicians: Data on Use of J-1 Visa Waivers Needed to Better Address Physician Shortages*, REPORT TO CONGRESSIONAL REQUESTERS, Nov. 2006, available at <http://www.gao.gov/new.items/d0752.pdf>.

¹³⁰ See Khanbabai, *supra* note 55, at §27.4.1.

¹³¹ See Hagopian, *supra*, note 6, at 5.

¹³² See, e.g., *id.* at 7–8.

¹³³ See *id.* at 5.

¹³⁴ Siskind, *supra* note 5, at 1.

¹³⁵ PL 103-416; 8 C.F.R. §212.7(c)(9).

¹³⁶ See Khanbabai, *supra* note 55, at §27.4.1.

¹³⁷ *Id.*

¹³⁸ *Id.*

eas, or vice versa).¹³⁹ Each public health department also sets its own eligibility requirements for a J-1 waiver.¹⁴⁰ The federal government's main requirement of states is that any employer seeking a waiver must certify its inability to attract a U.S. physician for the position;¹⁴¹ states retain the authority to define what "primary care" means, to set limits on which subspecialties they will approve, and to set application procedures.¹⁴² Because, however, the purpose of the program is to attract new foreign medical graduates to vacancies in health professional shortage areas and medically underserved areas in rural and urban settings, states often place only minimal additional restrictions on where physicians may be placed. Following the disbandment of the U.S. Department of Agriculture's waiver program in 2002, all fifty states, along with Guam, the U.S. Virgin Islands, and the District of Columbia now participate in the Conrad 30 program.¹⁴³ It is currently the primary program through which foreign physicians receive J-1 waivers.

Once a state's department of public health selects physicians to sponsor for visa waivers, the state requests a waiver from the U.S. Department of State.¹⁴⁴ If the Department of State deems granting the waiver to be in the public interest, the Department then requests the waiver from the U.S. Citizenship and Immigration Services (UCIS), which is the ultimate decision-maker regarding J-1 visa waivers.¹⁴⁵ UCIS usually recommends an applicant for sponsorship upon request by the Department of State.¹⁴⁶

The Conrad program legislation typically includes a sunset provision so that Congress may periodically review the program and alter it as need requires.¹⁴⁷ Congressional renewal of the Conrad Program is often accompanied by amendments seeking to expand the program and make it more effective.¹⁴⁸ In fall 2002, the program was expanded from Conrad 20 to Conrad 30 in order to provide states with more waivers.¹⁴⁹ This was neces-

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.* at §27.5.

¹⁴² See Siskind, *supra* note 5, at 7.

¹⁴³ : Siskind, *supra* note 5, at 8.

¹⁴⁴ Khanbabai, *supra* note 55, at §27.4.1.

¹⁴⁵ See *id.*

¹⁴⁶ See *id.*

¹⁴⁷ See, e.g., Siskind, *supra* note 5, at 1, 8; Modification of Visa Requirements with respect to International Medical Graduates, Pub. L. 108-441, Dec. 3, 2004, 118 Stat. 2630.

¹⁴⁸ *Id.*

¹⁴⁹ See, e.g., Siskind, *supra* note 5, at 1, 8.

sary in light of the fact that the U.S. Department of Agriculture had shuttered its own waiver program in early 2002.¹⁵⁰

The Conrad program was also renewed for subsequent two-year periods in 2004 and 2006.¹⁵¹ In 2004, Congress expanded the program to permit sponsorship of specialists as well as primary care physicians, in circumstances where there is a shortage of specialists in a given area.¹⁵² In 2006, several measures were added, further expanding the program. Congress exempted foreign physicians who applied for J-1 waivers from a cap on H-1B visas,¹⁵³ and allowed states to use five “flex slots”¹⁵⁴ out of thirty available visas for use by physicians who are outside of shortage areas if the physician will be serving individuals from shortage populations.¹⁵⁵ States including North Dakota, Nebraska, and Pennsylvania have already begun utilizing this option.¹⁵⁶

The program was set to expire on March 6, 2009;¹⁵⁷ on March 20, 2009, however, President Obama signed into law a bill that extended the date by which J-1 holders may qualify for the Conrad program until September 30, 2009.¹⁵⁸ On October 28, 2009, the program was extended again until September 30, 2012.¹⁵⁹ No provisions have been made for the Conrad visa waiver program beyond that date.

¹⁵⁰ Ester, Karma A., *Immigration: Foreign Physicians and the J-1 Visa Waiver Program*, CRS Report For Congress, Congressional Research Service, (The Library of Congress), June 17, 2004.

¹⁵¹ Pub. L. 108-441; *See also, e.g.*, Ice Miller, *supra* note 124, at 1098–99.

¹⁵² *Id.*

¹⁵³ Modification of Visa Requirements with respect to International Medical Graduates, *supra* note 84.; H-1B visas are requisite for J-1 physicians with waivers. The number of H-1B visas is limited, and the cap is quickly met at the beginning of each fiscal year. If physicians were not exempted from the cap, the program could not exist. *See* Siskind, *supra* note 5, at 3 (“on October 1, 2004, the first day of the 2005 fiscal year, US Citizenship and Immigration Services announced that all non-exempt H-1B visas had been issued for the entire year and no new cases could be approved for start dates prior to October 1, 2005. That could have effectively shut down all federal waiver programs had Congress not stepped in and permanently solved this problem.”); *See also* Scott D. Pollock & Fatima G. Mohyuddin, *Alternative Options to Consider in Light of the H-1B Visa Cap*, 54 FED. LAW. 46, (2007) (“The 65,000 H-1B visa cap for the current fiscal year (Oct. 1, 2007 to Sept. 30, 2008) was reached on the very first day petitions could be filed—April 2, 2007.”).

¹⁵⁴ “Flex slots” are waivers, within the five per-state limit, issued to foreign medical graduates who do not practice in medically underserved areas, but who do practice in facilities that serve patients who reside in such areas., *infra* n. 163.

¹⁵⁵ Modification of Visa Requirements with respect to International Medical Graduates, *supra* note 84. *See also* Siskind, *supra* note 5, at 1, 8 (Congress expanded the number of available Conrad waivers from 20 to 30).

¹⁵⁶ *See* Siskind, *supra* note 5, at 8.

¹⁵⁷ Pub. L. No. 110-362.

¹⁵⁸ Pub. L. No. 111-9, 123 Stat. 989.

¹⁵⁹ Pub. L. 111-83, 123 Stat. 2142.

Congress, however, has indicated its willingness to see the program continue. The House of Representatives, for example, approved a measure that would extend the program for five years instead of two years, as they had done in the past.¹⁶⁰ Because the Senate, however, was not prepared to extend related E-verify legislation¹⁶¹ past March 6, 2009, both houses approved an amendment to extend the Conrad program for only five months.¹⁶² That piece of legislation, signed by President Bush on October 8, 2008, also increased the number of “flex slots,” the per state limit on the number of waivers issued to foreign medical graduates who do not practice in medically underserved areas, but who do practice in facilities that serve patients who reside in such areas.¹⁶³

A bill currently in Committee would go even further in expanding the Conrad State 30 Program. On March 18, 2009, Senator Kent Conrad of North Dakota, the original sponsor of the Conrad Program, introduced a bill (the “Conrad State 30 Improvement Act”) to the U.S. Senate in anticipation of the Conrad Program’s then-expected expiration in 2009.¹⁶⁴ This bill seeks primarily to remove the sunset provision attached to the Conrad 30 legislation, making the program permanent.¹⁶⁵ The bill also seeks to make the program more flexible and allow states to increase the number of allotted waivers beyond thirty, if necessary.¹⁶⁶ Under this proposed plan, if an adjusted¹⁶⁷ 90% of available waivers nationwide are used in any given fiscal year, 35 waivers per state rather than 30 become available in that year. The following fiscal year, the waiver cap is again reset to 30.¹⁶⁸ Moreover, the bill seeks to extend the exemption of physicians from H-1B caps but renders them immune to the standard six-year limit on H-1B vi-

¹⁶⁰ Pub. L. No. 110-362.

¹⁶¹ Dep’t of Homeland Sec.: E-Verify,

http://www.dhs.gov/xprevprot/programs/gc_1185221678150.shtm. E-Verify is “an online system operated jointly by the Department of Homeland Security and the Social Security Administration (SSA). Participating employers can check the work status of new hires online by comparing information from an employee’s I-9 form against SSA and Department of Homeland Security databases.” *Id.*

¹⁶² See Congressional Record (House, Sept. 27, 2008, pH10267).

¹⁶³ Pub. L. No. 110-362, *supra* note 88.

¹⁶⁴ S. 2628, 111th Cong. (2009).

¹⁶⁵ *Id.* The bill is co-sponsored by Senator Sam Brownback of Kansas.

¹⁶⁶ Conrad State 30 Improvement Act, GovTrack.us.

<http://www.govtrack.us/congress/bill.xpd?bill=s111-628> (explaining the current status of S. 2672); see S. 2628, 111th Cong. (2009).

¹⁶⁷ The calculation of 90% of waivers allotted to states nationwide does not factor in waivers from states who have only sponsored 5 waiver applications or fewer in any one of three previous fiscal years. For example, if twenty-seven states each sponsored thirty waiver applicants, and twenty-three states each sponsored only three waiver applicants, only the first twenty-seven states would be counted in calculating whether 90% of waivers had been used. In that case, all fifty states would be allotted an extra 5 waivers, for a total of thirty-three per state. *Id.*

¹⁶⁸ *Id.*

sas.¹⁶⁹ It newly exempts physicians from green card caps, as well.¹⁷⁰ Finally, under the Improvement Act, the number of “flex slots” would be increased from five to ten.¹⁷¹ The bill was referred to the Senate Committee on the Judiciary and has since not yet been scheduled for debate.¹⁷²

2. Federal Program: Housing & Human Services

Until 2002, the U.S. Department of Agriculture (USDA) had been the largest sponsor by far of J-1 visa waivers for foreign physicians.¹⁷³ The political environment and security concerns following the attacks of September 2001, however, led to a review of the USDA’s involvement in sponsoring J-1 visa waivers. During that review, the “USDA forwarded seven pending applications to the Department of State for screening. Three of the applicants turned up on government watch lists.”¹⁷⁴ As a result, in February 2002, the USDA made a determination that the agency would stop participating in the J-1 visa waiver program, “citing security concerns and the inability to conduct adequate background and site checks.”¹⁷⁵ The nineteen conspirators involved in the September 11 attacks were all foreign nationals, several of whom had entered the United States on student and visitor non-immigrant visas.¹⁷⁶ As a result of the attacks, there was and still is a heightened interest in evaluating the security risk of all foreign nationals entering the United States.

The J-1 visa application process typically requires a security background check on each applicant;¹⁷⁷ following September 11, guidelines for conducting security checks became more stringent.¹⁷⁸ While the response to September 11 did not produce significant substantive changes to U.S. immigration law, it did cause the existing laws to be much more rigorously enforced.¹⁷⁹ The USDA subsequently announced that the decision to stop issuing J-1 waivers was based on a lack of adequate staff and resources

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ See Hagopian, *Health Departments’ Use*, *supra* note 133.

¹⁷⁴ Ester, *supra*, note 150.

¹⁷⁵ *Id.*

¹⁷⁶ See, e.g., Marquis, Christopher, *A Nation Challenged: Immigration; INS Proposes New Limits on the Length of Visas*, N.Y. TIMES, Apr. 9, 2009.

¹⁷⁷ Khanbabai, *supra* note 55, at §27.6.

¹⁷⁸ Harvey, Kathleen Alfred Hupp & Mira Mdivani, *Immigration Law Update for Employment, Corporate, and Business Lawyers*, 74 OCT J. KAN. BAR ASSOC. 6, 8 (2005).

¹⁷⁹ See *id.*; see also Elizabeth A. Goss, *F-1 Student Visas and J-1 Exchange Visitors*, I Immigration. Practice Manual § 4, § 4.1.3, (Massachusetts Continuing Legal Education, Inc.)(2004) (describing the increase in enforcement of immigration laws nationwide after September 11).

needed to make sure the DHS's security considerations were sufficiently resolved.¹⁸⁰

Currently, the main federal agency that grants J-1 visa waivers is the Department of Health and Human Services (HHS). On June 12, 2003, HHS announced it would begin sponsoring waivers of the two-year physical presence requirement to fill the gap left by the USDA's decision to stop issuing J-1 visa waivers.¹⁸¹ Prior to the 2002 decision, the USDA granted J-1 visa waivers to over 1,000 doctors a year,¹⁸² and the decision to drop the program severely curtailed the number of foreign physicians who received recommendations for a J-1 waiver.¹⁸³ Although HHS has traditionally only granted J-1 waivers for research work of national significance, the new waiver program permitted the agency to sponsor physicians with primary care practices as well.¹⁸⁴ HHS also requires that the agency or organization which sponsors the physician must be private or non-federal, or an HHS agency.¹⁸⁵

In addition, the Appalachian Regional Commission (ARC) grants a small number of J-1 waivers to foreign physicians, with the understanding that those physicians will practice in underserved rural areas throughout Appalachia.¹⁸⁶ The Veterans Administration (VA) is able to sponsor waivers "where the loss of a foreign physician will be disruptive to the VA program."¹⁸⁷

However, the new HHS visa sponsorship program also added new rules for entry under the J-1, in which eligibility for a J-1 waiver was severely restricted.¹⁸⁸ HHS will not issue a waiver, for example, if waivers are still available under the Conrad 30 program, the Appalachian Regional Council, or the VA program.¹⁸⁹ HHS also limits the types of health care facilities that may sponsor applicants, and requires that those facilities be in areas that have only the most severe shortages of health professionals.¹⁹⁰ As a result of these tightened regulations, since the new program's incep-

¹⁸⁰ See U.S. Gov't Accountability Office, *Foreign Physicians: Data on Use of J-1 Visa Waivers Needed to Better Address Physician Shortages*, REPORT TO CONGRESSIONAL REQUESTERS, Nov. 2006, available at <http://www.gao.gov/new.items/d0752.pdf>; see also Hagopian, *Health Departments' Use*, *supra* note 133.

¹⁸¹ See Khanbabai, *supra* note 55, at §27.5.

¹⁸² Talbott, *supra* note 10.

¹⁸³ *Id.*

¹⁸⁴ See Khanbabai, *supra* note 55, at §27.5.

¹⁸⁵ *Id.*

¹⁸⁶ See, e.g., Siskind, *supra* note 5, at 7.

¹⁸⁷ Bennett, *supra* note 23, at 9.

¹⁸⁸ See Khanbabai, *supra* note 55, at §27.5.

¹⁸⁹ See Siskind, *supra* note 5, at 6.

¹⁹⁰ See *id.* at 7.

tion in 2003, HHS has approved J-1 waivers at a much lower rate than did the USDA.¹⁹¹

HHS maintains that this reduced number is due to a smaller applicant pool, arguing that more foreign physicians are applying for waivers through state J-1 programs (*i.e.*, the Conrad 30 Program), which tend to have fewer restrictions on entry and eligibility.¹⁹² Waiver applicants and state public health workers, however, argue that the decrease in waivers granted by federal agencies is not due to lack of interest or greater interest in state J-1 programs, but because the HHS process is too long and tedious and the process is often confusing and arbitrary, discouraging many potential applicants from applying (There has also been a shortage of other J-1 workers as a result of the new HHS rules and procedures).¹⁹³ Whatever the reason, it is widely believed that foreign medical graduates now have little choice but to obtain sponsorship from a “Conrad 30” state department of public health.¹⁹⁴

Claims that the HHS process is too complicated and too arbitrary are exacerbated by the fact that certain nationalities trigger special security reviews, which can significantly lengthen the process.¹⁹⁵ These reviews go beyond the standard security check; all applicants are already required to undergo a check for a match against names on the terrorist watch list, and a comparison of the applicant’s fingerprints and digital photograph against databases of known or suspected terrorists.¹⁹⁶ Male applicants from “twenty-six predominantly Muslim nations throughout the Middle East, Central Asia, and Southeast Asia were designated for special treatment.”¹⁹⁷ There are also concerns that physicians from Muslim or Middle Eastern nations of origin are being given discriminatory treatment and being denied more frequently than other groups.¹⁹⁸

¹⁹¹ *Id.*

¹⁹² Khanbabai, *supra* note 55, at §27.4.1.

¹⁹³ See David T. Denhardt, , Letter to Editor, Should Immigration Be by Chance or by Worth?, N.Y. TIMES, June 12, 1989, §A at 18; see also Karen B. Koenig, *J-1 “Trainee” Synopsis*, IMMIGRATION LAW: BASICS AND MORE 101, 106 (ABA Continuing Legal Education, ed. 2007); see also Nicole Cotroneo, *Visa Denials Mean Unfinished Business*, N.Y. TIMES, May 20, 2007 (explaining that there has also been a shortage of other J-1 workers as a result of the new H.H.S. rules and procedures); see also Cotroneo, *supra* note 115.

¹⁹⁴ Khanbabai, *supra* note 55, at §27.5.

¹⁹⁵ Charles Foster, *Legally Entering and Staying in the U.S.A.*, 66 TEX. BAR J. 38 (2003).

¹⁹⁶ Cowell & Shane, *supra* note 71.

¹⁹⁷ Foster, *supra* note 195; see See Hagopian, *supra* note 133; see also A DISCUSSION PAPER, *supra* note 12, at 6 (This includes Pakistan, Iran, Egypt, Iraq, Turkey, Syria, and other nations that contribute sizeable numbers of foreign medical graduates to the United States each year.)

¹⁹⁸ See Talbott, *supra* note 10.

The allegedly discriminatory treatment stems from fears about terrorist activity that caused the disbandment of the USDA J-1 waiver program. Even prior to the USDA's decision to stop participating in the J-1 program, the J-1 visa had been under some scrutiny because of the fear that terrorists might use the visa to enter the United States. As far back as 1993, in the aftermath of the initial World Trade Center bombing, there were fears that terrorists could obtain entry into the U.S. via temporary nonimmigrant visas such as the J-1.¹⁹⁹ In fact, a government investigation concluded that some of the suspects involved in the 1993 World Trade Center bombing had entered the U.S. on student visas.²⁰⁰ This discovery was responsible for the implementation of more stringent controls and regulations for foreign students through the 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA).²⁰¹ The IIRIRA was enacted by the Clinton Administration in the aftermath of the Oklahoma City bombing;²⁰² although the suspect in that incident was a U.S. citizen, the Oklahoma City bombing combined with the World Trade Center attack three years earlier left many legislators and government agencies highly concerned about the prospect of yet another bombing.²⁰³ These concerns translated, in part, into restrictions on legal, nonimmigrant visas rather than controls on illegal immigration, as the law's name implies.²⁰⁴ Many of those IIRIRA controls also affected holders of the J-1 visa.²⁰⁵

In April 2002, four Pakistani crewmen illegally received visa waivers from an INS immigration officer and later disappeared.²⁰⁶ This security breach led the Commissioner of the INS to implement a "zero-tolerance" policy in regard to INS employees who did not follow INS regulations and guidelines; as a result, many INS officers became reluctant to approve non-immigrant applications, which drastically slowed application processing times.²⁰⁷ Events later in 2002 seemed to solidify some of the INS's fears, for example when a Swedish suspect alleged to have attempted the hijacking of a Swedish, London-bound flight was discovered to have enrolled in a U.S. flight school in September 2006 after likely obtaining entry with J-1

¹⁹⁹ Goss, *supra* note 179 at § 4.1.3.

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² See Donald S. Dobkin, *The Diminishing Prospects for Legal Immigration: Clinton Through Bush*, 19 ST. THOMAS L. REV. 329, 331 (2006) (discussing events that led to more restrictive immigration regulations).

²⁰³ See *id.*

²⁰⁴ See *id.* at 331–32.

²⁰⁵ *Id.* at 334–35.

²⁰⁶ *Id.* at 342.

²⁰⁷ *Id.* at 342.

status.²⁰⁸ While the suspect was later shown to not be directly affiliated with any terrorist organization, background checks that routinely would have been conducted during his application for a J-1 visa in 1996 failed to pick up the suspect's previous criminal history in Sweden, suggesting that security procedures in evaluating J-1 applicants were faulty or at least lax.²⁰⁹

While the public health community has issued its concerns for the state of healthcare in rural and low-income communities after the USDA disbanded their J-1 waiver program, recent security developments have made it unlikely that the Department of Homeland Security (DHS), the HHS, or other federal agencies will reconsider their emphasis on maintaining strict security restrictions in evaluating J-1 visa and waiver applicants.²¹⁰ On June 29, 2007, London police intercepted and frustrated a car bombing attempt.²¹¹ The following day, June 30, a Jeep was set on fire at a Glasgow airport in connection with another failed car bombing.²¹² Eight individuals were arrested in connection with the plots; all eight were foreign health care workers residing in Britain, and at least seven of the eight were physicians.²¹³ The failed car bombing attempts have since caused debate in Britain regarding whether British regulations for hiring foreign physicians (which are in most respects similar to U.S. regulations and restrictions) should be tightened.²¹⁴ Members of the security community and the federal government in the United States have also voiced their concerns regarding foreign physicians in US medical programs after information was uncovered that two of the physicians arrested in connection with the London and Glasgow car bomb attacks had contacted the ECFMG about practicing medicine in the United States.²¹⁵

For some, such instances have justified fears concerning security loopholes in the J-1 waiver program; it is therefore unlikely that the federal government will reinstate in any real way an expansive waiver program akin to the one run by the USDA.²¹⁶ It is also unlikely that agencies such as the Department of State or USCIS will permit HHS to lessen the scrutiny of J-1 waiver applicants from Middle Eastern and Muslim nations of ori-

²⁰⁸ Alan Cowell, *Detainee Had Studied to be a Pilot in U.S.*, N.Y. TIMES, Sept. 1, 2002, at A6.

²⁰⁹ *Id.*

²¹⁰ See, e.g., Cowell & Shane, *supra*, note 71.

²¹¹ *Id.*

²¹² Cowell & Shane, *supra* note 71.

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ See *id.*

²¹⁶ See, e.g., Sampson, Kurt, *Physician Arrests in UK Bombings Raise Stateside Concerns About Screening for Terrorism*, 7 NEUROLOGY TODAY 1, 13 (2007).

gin.²¹⁷ The new policies for security review have also been shown to cause a significant backlog in visa applications from foreign students, medical and others, not only from designated nations but across the board.²¹⁸ These excessive delays in processing applications, combined with the extremely limited number of visas actually granted since 2003, have led critics to describe the HHS waiver program as “largely nonfunctioning.”²¹⁹

IV. CONGRESS SHOULD APPROVE THE “CONRAD STATE 30” IMPROVEMENT ACT AND FURTHER MEASURES MUST BE TAKEN

While the three-year extension of the Conrad program by Congress is commendable, the “Conrad State 30” Improvement Act,²²⁰ as introduced in early 2009 by Senator Conrad, presents a necessary partial solution to the difficulties foreign medical graduates face in obtaining waivers. The most important of the changes proposed in the Act is the removal of the two-to-three-year sunset provision that has been attached to the legislation since it was enacted in 1994.²²¹ Effective changes and expansions to the program can only truly be made when legislators can stop debating about its renewal and begin seriously considering ways to make foreign medical graduates a more effective remedy to the physician shortage. Program infrastructure can also be better built up once the program is permanent and its long-term existence is secured.

The measure to provide permanency for the Conrad program, however, is likely to face some opposition in Congress. U.S. Representative Hostettler, for example, has commented that he preferred to “reauthorize the program for 2 years, rather than permanently,”²²² arguing that because “the physician shortage in the United States is a multifaceted problem, and I believe we should revisit the issue from time to time so we don’t lose sight of the real problems that need to be addressed.”²²³ He continued further, explaining where some of these problems lie: “A 2-year reauthorization will also give us opportunity to address problems faced by larger states like Texas, where the need for waivers each year exceeds thirty, without

²¹⁷ *Id.*

²¹⁸ Siskind, *supra* note 5, at 5.

²¹⁹ *Id.*

²²⁰ S. 2628, 111th Cong. (2009).

²²¹ *Id.*

²²² *Full Committee Markup Before H. Comm. on the Judiciary, supra* note 50, at A2 (statement of John Hostettler, Member, H. Comm. on the Judiciary).

²²³ *Id.*

disadvantaging small states.”²²⁴ Other members of Congress have expressed the same concerns.

While these concerns are valid, reconsideration of the Conrad program after so short a period does not truly lend itself to finding real solutions to the physician shortage problem. The debate in such cases easily becomes not how to expand the program or make it more efficacious, but whether or not it should continue to exist. That is the wrong debate for legislators to have when more and more people are being left without adequate access to health care. In addition, over the past six years, change has been minimal with each subsequent renewal of the Conrad program. While Congress has taken several important steps to make the program more flexible for foreign physicians, since 2002 only 10 more waivers have been allocated to each state, for a total of approximately 500 extra waivers per year. More are needed to even begin to make up for the waiver slots lost when the USDA stopped its sponsorship program.²²⁵ Rather than incorporating a sunset provision, the Conrad Improvement Act should keep the provision making the program permanent but amend it to mandate periodic reviews of the shortage situation by a federal agency (rather than Congress) which could then make appropriate updates to the program. This would likely lead to more efficient review by those with greater familiarity with the program and likely fewer political motivations than exist in Congress.

The Improvement Act’s program to remove limits for J-1 waiver holders on H-1B visa and green card caps is also a commendable measure that will provide great incentives for foreign doctors to seek out waiver sponsorships rather than return to their country of origin for two years, and will help doctors who are already participating in the Conrad program to remain practicing in underserved areas. Foreign physicians who hold J-1 waivers spend three years practicing in underserved areas.²²⁶ After living in an area so long, many physicians set down roots—raise families, make ties to the community—and in many cases may be reluctant to leave. If exempted from the six-year limit on H-1B visas and able to obtain green cards, those physicians are more likely to remain practicing in those areas. As a whole, foreign physicians are also more likely than domestic physicians to work in designated health professionally shortage areas and medically underserved areas.²²⁷ Approving the exemption provisions of the

²²⁴ *Id.*

²²⁵ *Id.* At the time the USDA program was disbanded, the agency was sponsoring approximately 1,000 waivers per year.

²²⁶ Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), Pub. L. 104-208, 110 Stat. 3009.

²²⁷ See Hart, *supra* note 62, at 1165.

Conrad State 30 Improvement Act is likely to be helpful in maintaining those trends, to the benefit of patients in medical shortage areas.

Providing incentives to attract more foreign physicians to the Conrad waiver program also serves U.S. interests because the federal government currently heavily subsidizes medical training and residency programs.²²⁸ In order to ensure that greater numbers of physicians are trained, the federal government has stepped in to provide the funding for that training.²²⁹ Because foreign medical graduates participate in residency programs through a J-1 visa, their education is almost entirely paid for by federal funding through Medicare.²³⁰ So that funding does not go to waste, the federal government should want to provide incentives for foreign medical graduate to practice in the U.S., rather than return to their country of origin for two years or even permanently.

The congressional increase of the number of permissible “flex slots,” per the October 2008 five-month extension of the Program, was a step forward in making the Conrad Program more effective in providing doctors to underserved individuals. This flexibility is useful towards alleviating the health care shortage because often, it is often the case that patients have to travel for many miles to see a physician for even the most basic care.²³¹ In such circumstances, limiting waiver physicians to practice only within the geographical confines of a HPSA- or MUA-designated area would ultimately not allow them to serve populations with no health care facilities.

Similarly, there may be medically underserved populations—groups with an especially high incidence of infant mortality, poverty, and certain diseases—who do not reside in MUA-designated geographic areas. The “flex” plan allows these patients access to doctors in their own communities.²³²

If circumstances warrant it over the next years, Congress should also consider providing larger numbers of “flex” slots. However, any provision increasing the proportion of “flex” slots should be properly balanced with maintaining enough slots for physicians who serve within the geographic boundaries of underserved areas. Creating a mechanism by which state public health departments can report to federal legislators about the chang-

²²⁸ See e.g., Gottlieb, Scott, *Medicare funding for medical education: a waste of money?*, USA TODAY, Nov. 1997.

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ See, e.g., Pear, Robert, *Shortage of Doctors an Obstacle to Obama Goals*, N.Y. TIMES, Apr. 26, 2009.

²³² Pub. L. No. 110-362.

ing needs they face can allow the “flex” provision to be updated as necessary.

Likewise, the “90%” provision of the Improvement Act would also do much to bring foreign physicians directly to patients in shortage areas. Under this provision, the amount of waivers allotted to each state is increased by five annually, from thirty to thirty-five, if 90% or more of the waivers available nationally are used; the calculation of 90% of waivers nationwide does not include, however, waivers from states that have sponsored only five or fewer applications in that year or two previous fiscal years.²³³ The program is also reset at thirty each year.²³⁴ The purpose for this adjusted calculation is that some states or territories do not actively participate in the Conrad program.²³⁵ Therefore, the legislation only considers those states which make active use of the program and have real need for more physicians. Nevertheless, in the event that an adjusted 90% of waivers are granted nationwide, all fifty states are allotted the extra five waivers.²³⁶

This is a significant and necessary provision that the Congress should work to approve. In many states, the Conrad programs are extremely competitive and all thirty available waivers are distributed.²³⁷ As such, Congress should at the very least consider raising the annual allotted waivers to forty-five or even fifty per state in order to provide an adequate number of physicians nationwide.²³⁸

The legislation could be altered so as to directly increase the number of waivers, as it did when the Conrad 20 program became the Conrad 30 program in 2002,²³⁹ but there are a number of other methods by which the number of waivers could be increased. The “90%” plan of the current Improvement Act could be expanded upon, with graduated increases to the total waiver allotment. An 85 percent nationwide waiver usage rate could, for example, trigger a raise of total waivers from thirty to thirty-five per state; 90% would then further increase the total number of waivers per state to forty, and 95% could bring the total to forty-five.

However calculated, a graduated system such as the one described above would ensure a balance between granting enough waivers to every

²³³ Conrad State 30 Improvement Act, S. 2628 (Mar 18, 2009).

²³⁴ *Id.*

²³⁵ “States varied, however, in the number of waivers they requested in fiscal years 2003 through 2005. For example, in fiscal year 2005, about one-quarter of the fifty-four states requested the maximum of thirty waivers, about one-quarter requested ten or fewer, and two (Puerto Rico and the Virgin Islands) requested no waivers.” Government Accountability Office, *supra* note 32.

²³⁶ Conrad State 30 Improvement Act, S. 2672 (Feb. 27, 2008).

²³⁷ See Khanbabai, *supra* note 55, at §27.5.

²³⁸ See Government Accountability Office, *supra* note 32, at 13.

²³⁹ See, e.g., Siskind, *supra* note 5, at 1, 8.

state that needs more, but without allowing larger, more popular states to draw waivers away from states that may not receive as many applicants. States would receive additional waiver slots only when the vast majority of states had granted all or most of their allotted waivers. All states would also receive equal numbers of extra waivers, which would work to ensure fairness among states across the board.

Moreover, rather than the current provision resetting the total number of waivers to thirty each year, legislation could increase the waiver allotment for a set number of years, after which it could be reviewed by legislators. This would also allow for a more in-depth review of the current situation and its demands. After every two years,²⁴⁰ or whichever period Congress deems appropriate, statistical evidence and testimony from state public health agencies could be examined in order to give a better picture of where the state of healthcare in the U.S. is at that point. Waivers could then be allocated on the basis of any new findings that are made.²⁴¹

Of course, each state also likely requires varying numbers of physicians, and does not have the same percentage of their population living in underserved areas. The total populations of states also vary widely.²⁴² This would suggest that states should be allocated different numbers of waivers based on their need for more physicians to provide adequate coverage for medical shortage areas in each state. U.S. Representative Conyers has described this issue, explaining that “[r]ight now, some states who receive J-1 doctors through the Conrad 30 Program don’t use their allotment of thirty waivers each year, while other states find that thirty waivers are insufficient to meet the medical needs of their communities.”²⁴³

Nevertheless, members of Congress have been reluctant to distribute waivers unevenly among the states. Representative Conyers has argued that Congress must develop a solution which “ensures that states which fill their annual allotment of J-1 doctors can get more of them to meet their

²⁴⁰ Two to three years would provide a long enough period to notice any changes in the way the shortage is affecting populations, but would be a short enough time frame in which to respond effectively to any such changes.

²⁴¹ This method would also demand more attention be paid to the issue. While this may be helpful for ensuring adequate numbers of physicians to underserved areas, decision-making in this area would also potentially have a greater likelihood of being hampered by political debate and minor differences of opinion among legislators, and therefore may not be the most effective means possible of ensuring regular review of the Conrad program.

²⁴² Compare, for example, the population of California (36,756,666) with Wyoming (532,668) as of July 1, 2008. U.S. Census Bureau, Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: Apr. 1, 2000 to July 1, 2008. (NST-EST2007-01). <http://www.census.gov/popest/states/tables/NST-EST2008-01.xls>.

²⁴³ *Full Committee Markup Before H. Comm. on the Judiciary*, (statement of Conyers, H. Comm. on the Judiciary).

needs, without impinging on any other state.”²⁴⁴ Representative Hostettler, too, has stated the need for a solution that will provide an “opportunity to address problems faced by larger states...where the need for waivers each year exceeds 30, without disadvantaging small states.”²⁴⁵

This reluctance derives partially from political considerations. Legislators are loath to vote or signal approval in any way for measures which may appear to disadvantage their constituents. Thus, it is unlikely that most plans for an uneven distribution of Conrad waivers would succeed, as it would likely be exceedingly difficult to garner the requisite support.

Moreover, there are also public policy concerns which add to the complexities of this issue. If large numbers of waivers become available in larger states, even if those states have more medical shortage areas than other states, large states may still be disproportionately advantaged. Often, large states with more metropolitan and cosmopolitan areas are viewed by medical professionals as being more desirable—a view that has contributed to the very physician shortage that the Conrad program is meant to address. More waivers allotted to larger states, therefore, may lead to a glut of applications to those states, to the detriment of smaller states that are also in need of physicians. A similar situation may arise where some states are perceived as having more liberal restrictions on achieving waiver sponsorship; some states, for example, demand a four- or five-year commitment from foreign physicians, rather than three years.

Legislators might seek to influence HHS to expand their program, to “balance out” any perceived or real inequality as Conrad waiver physicians are distributed nationwide. Thus, if certain states are achieving disproportionate numbers of waiver applications, the national reach of the federal agency could work to place physicians in states that are receiving fewer applications but have no less need for more doctors. Also, the HHS program has no cap on the number of waivers it may sponsor.²⁴⁶ As such, it is possible to effectively redistribute physicians across the states. This, however, would require a major reworking of how HHS currently runs their program,²⁴⁷ as well as additional funding for the program to create the resources and manpower that can handle an increased number of waiver requests.

While the Conrad program is certainly useful and should be expanded to effectively alleviate the physician shortage, most agree that using foreign

²⁴⁴ *Id.*

²⁴⁵ *Id.* (statement of John Hostettler, Member, H. Comm. on the Judiciary).

²⁴⁶ Nevertheless, HHS gives out waivers only sparingly. See discussion *supra* Part III.A.

²⁴⁷ See discussion *supra* Part III.A.b.

physicians to substitute for a lack of U.S. trained doctors is a “temporary fix to a much larger problem,” and that “Congress must also focus on other ways to address the shortage.”²⁴⁸ Some of the solutions that have been frequently discussed include:

... expanding medical school slots for American citizens and permanent residents, increasing the scope of work that can be performed by non-physicians, improving preventative health care, instituting new programs to get American physicians to work in areas with the worst shortages and in specialties facing the most demand, and, possibly even rationing health care.²⁴⁹

Additionally, Senator Charles E. Schumer of New York recently introduced legislation, “which is still in committee, aimed at directing \$200 million in federal funds toward recruiting efforts, from providing grants to doctors who choose to practice in underserved areas to developing programs for young people considering careers in health care.”²⁵⁰ Others argue that ensuring higher salaries for primary care physicians in shortage schedule, by altering the current fee schedule for Medicare, would help draw physicians into rural areas.²⁵¹

CONCLUSION

There can be no mistake that the complexities of how to resolve the physician shortage are contentious and multifaceted. These complexities will also likely take many years to fully and adequately resolve. Nonetheless, “increasing the number of J-1 physicians who are able to stay in the United States after their training would be the easiest and probably one of the least controversial strategies for dealing with this increasing crisis.”²⁵² As such, Congress should approve S.628, the “Conrad State 30” Improvement Act, as a means to quickly increase the number of physicians who are serving patients in underserved areas. As legislators continue to evaluate this bill, they must also consider sizeable expansions to it to truly alleviate the growing health care crisis. Congress should make every effort to provide more flexible and effective measures to bring adequate health care to the U.S.

²⁴⁸ *Full Committee Markup Before H. Comm. on the Judiciary* (statement of John Hostettler, Member, H. Comm. on the Judiciary).

²⁴⁹ Siskind, *supra* note 5, at n.7.

²⁵⁰ York, *supra* note 4.

²⁵¹ See, e.g., Pear, *supra* note 231; Arvantes, James, *Speakers Say Medicare Payment Rates Major Reason for Physician Shortages*, American Academy of Family Physicians, Apr. 23, 2007.

²⁵² Siskind, *supra* note 5, at n.7.