Urgent Issues Facing Immigrant Physicians in the United States in the COVID-19 Era

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As of 25 June 2020, the United States has endured more than 2.3 million cases of coronavirus disease 2019 (COVID-19) and 121 117 deaths (1). Available resources are stretched thin, and health care workers are overwhelmed. The COVID-19 pandemic has exposed vulnerabilities of the U.S. health care system beyond anyone's imagination. As we witness this disease ravage country after country, killing hundreds of thousands of people worldwide, doctors, nurses, and other health care professionals involved in taking care of COVID-19 patients directly place their own lives and the lives of their family members at risk. The most recent data from the Centers for Disease Control and Prevention show 84 557 cases and 469 deaths among health care professionals (1).

Among health care workers in the United States, 1 segment of physicians—international medical graduates (IMGs)—are highly valued members of inpatient specialties, such as hospital medicine and critical care. The term *international medical graduates* includes physicians who are U.S. citizens or legal permanent residents and attended medical school outside the United States as well as non-U.S. citizens who were born outside the United States and received their medical training (residency and fellowship) in the United States. The IMGs constitute 24.5% of all actively practicing specialists in the United States (2), and most of these physicians work in rural and underserved areas throughout the country (3). Of note, they also constitute a substantial percentage of the physician workforce in states with a large number of COVID-19 cases and deaths (Table) (4, 5). Simply put, a patient admitted to the hospital has a greater than 1-in-3 chance of being treated by an IMG physician (6).

Many IMGs serve U.S. communities on temporary visas, such as H-1B (temporary employment) and J-1 (exchange visitor) visas; we refer to these physicians as *immigrant physicians* in this essay. Immigrant physicians and their families are especially vulnerable during the COVID-19 pandemic because of several interrelated issues that hinge upon their visa status. For example, if an immigrant physician dies, his or her family are subject to immediate deportation, because the family would lose its immigration status with the death of the primary visa holder. An equally devastating situation would occur if the immigrant physician developed a permanent or prolonged disability, because most disability insurance companies require applicants to have permanent U.S. resident status to qualify for long-term disability benefits. With many health care employers suffering economically during this pandemic, another potentially challenging situation for immigrant physi-

Table. Distribution of IMGs in States With the Highest Mortality From COVID-19*

State	COVID-19 Cases, n	COVID-19 Deaths, n	IMGs, n (% of Total State Health Care Work Force)
New York	392 037	30 839	30 684 (36.2)
New Jersey	168 834	12 857	16 373 (41)
Massachusetts	106 650	7799	13 108 (33.6)
Illinois	137 402	6842	13 802 (32.2)
Pennsylvania	85 678	6467	10 742 (23.5)
Michigan	67 716	6091	10 451 (27.4)

COVID-19 = coronavirus disease 2019; IMG = international medical graduate.

*Distribution of IMGs in the states is based on data from American Community Survey 2018 and CATO Institute calculations (4, 5).

cians is loss of employment, which again would compromise their immigration status. At the other end of this spectrum, many physicians could potentially provide assistance in the COVID-19 “hot spots” but cannot do so because their work status is tied to their visa-sponsoring employer. Finally, many immigrant physicians have children who were born outside the United States but have been raised here. When these children attain the age of 21 years, they lose their dependent status and are forced to return to the country of their birth, despite spending almost their entire lives in the United States.

Most immigrant physicians are admitted to the United States for residency training on an H-1B temporary employment or J-1 exchange visitor visa (7). Candidates with J-1 visas are required to return to their home country for 2 years after completing their residency, or they must finish a 3-year “waiver” position in a designated underserved area before they can file for legal permanent status or a green card. Residents holding H-1B visas may apply for a green card after they complete their residency.

Although all immigrant physicians must maintain legal status in the United States throughout their training and beyond, the path to becoming a permanent resident is prolonged for many physicians. They apply for green cards under the “employment-based” (EB) category, which has an annual cap of 140 000 green cards, with a fixed quota of 7% allotted to each country; there are no differential allotments to various professions. Furthermore, green cards are distributed in multiple categories, such as EB-1, EB-2, or EB-3, depending on the applicant's qualifications. Although the EB-1 visa is reserved for internationally acclaimed professionals, a substantial percentage of physicians apply for the EB-2 visa, which has stringent eligibility criteria. Once the application is approved, the applicant must wait for their country's approval date to become cur-

rent. Although many other countries have current approval dates, the last EB-2 application approved for Indian physicians was 2009, and 2016 for Chinese physicians (8). Under the current laws, decades will pass before anyone from India or China can receive permanent residency.

With the COVID-19 pandemic hitting us hard, we need immigrant physicians more than ever. Removing the per-country cap for green card allocation for physicians, increasing the green card numbers, and awarding green cards to immigrant physicians after a few years of service in medically underserved areas are some possible ways to address this challenge. Several bills based on these concepts have been introduced in Congress. A bipartisan initiative, the Healthcare Workforce Resilience Act, proposes awarding 15 000 unused immigrant visas (green cards) from previous years to immigrant physicians (9), regardless of nationality. The Conrad State 30 and Physician Access Reauthorization Act is another bill aimed to encourage physicians to practice in underserved communities by granting them legal permanent status after 5 years of service in such areas (10). These steps are encouraging, but the urgency of the situation in these uncertain times cannot be overstated and needs the wholehearted support of the entire medical community and the nation.

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Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M20-4103.

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Ann Intern Med. doi:10.7326/M20-4103

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