

Immigration, Graduate Medical Education, and Ethical Dilemmas

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On January 27, 2017, President Donald J. Trump signed an executive order banning nationals of 7 countries from entering the United States for at least 90 days.¹ From the perspective of graduate medical education (GME), the timing of that executive order was challenging. When the ban was issued, residency program directors were wrapping up the interview season and getting ready to submit their rank lists. In subsequent weeks, federal judges issued temporary restraining orders, and a federal appeals court rejected the government's request to reinstate the executive order. On March 6, 2017, after programs already submitted their rank lists, a second executive order was issued that maintained the "ban" for 6 out of the 7 countries, and added a provision for case-by-case waivers in special circumstances.²

The ultimate implications of the executive orders were unknown when residency programs had to make key decisions regarding whether or not to place international medical graduates (IMGs) from the affected nations on their rank order lists, and many program directors felt confused and uncertain. Training programs and hospital leaders want to ensure they get the best residents from the applicant pool, yet at that time the reality of the proposed immigration changes left them with a real dilemma.

Residents and fellows are necessary to the enterprise of medical education. If programs ranked physicians who could not obtain a visa and legal status in the United States, then this could undermine the educational process not only for residents unable to join their programs, but also for the other residents, students, and faculty forced to function in smaller teams with more limited capacity, due to missing members of the workforce. The reduced number of residents could compromise patient care. So, what were programs to do? Avoid IMGs altogether? Not rank IMGs from the 7 countries listed in the ban? Avoid ranking any IMGs who are from a "Muslim-majority country," given speculation

at the time about potential future expansion of the travel ban to additional countries? In any of these scenarios, would program leaders be discriminating against applicants based on religion or nationality?

IMGs are an important source of physicians that training programs and health care systems in the United States have relied on for years. Almost a quarter of practicing physicians in the US are IMGs.³ Additionally, the physician workforce increasingly consists of IMGs,⁴ but not just any IMGs. The United States attracts the very best in science and in medicine, and recent evidence suggests that IMG physicians may provide higher-quality care than those trained in the United States.⁵ This evidence is not shocking, and it highlights the reality of the "extreme vetting" process for IMGs who match into US residency programs. As a consequence, IMGs who train and then practice in the United States are usually the best of the best.

The other reality is that recruiting and hiring IMGs is not a discretionary choice; it is a necessity to fill available residency positions in the United States, particularly in primary care specialties. In the 2017 Match, the number of non-US citizen IMGs who matched was 3814, the highest level in history.⁶ A total of 69% of matched foreign-trained physicians were in the primary care disciplines of family medicine, internal medicine, and pediatrics. Within the specialty of internal medicine, 54% of matched positions were filled by IMGs.⁶ There are simply not enough US-trained physicians to fill all the available residency and fellowship positions, despite the fact that the number of US medical school graduates is increasing each year.⁶ At a time when the nation is facing a real shortage of primary care physicians, changes to the immigration system may prove detrimental to maintaining access to quality care for our patients.

Major US stakeholder organizations in medical education issued statements and open letters expressing serious concerns about the executive order's violation of core professional values, and the potential harm that such a travel ban could have on patients

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and the US health care system. This included the Accreditation Council for Graduate Medical Education (ACGME), the Association of American Medical Colleges, and the Alliance for Academic Internal Medicine, as well as professional societies, such as the American Academy of Family Medicine, the American Academy of Pediatrics, and the American College of Physicians.^{7–12} In an open letter, the ACGME described the “profound moral distress this executive order has provoked within the health care community.”⁷ The leaders of these organizations also urged educational programs not to allow politics to affect their decisions about the ranking of applicants. They encouraged programs and educators to “use [the situation created by the executive order] to make ourselves more committed to our values, less tolerant of discrimination and disparities, more supportive of inclusion, and more courageous in our pursuit of equity and excellence, kindness, compassion, and quality medical care for the American public.”⁷

With much of the media attention focusing on the situation of refugees, and the limits imposed on immigration from certain nations, some may have overlooked the impact of the executive order on IMG residents. Yet a key policy change that affected and continues to affect all IMGs who are non-US citizen residents, whether from Muslim-majority countries or not, is that “effective immediately,” Section 8 in the first executive order suspended the visa interview waiver program.¹ Most IMG residents used this program to renew their visas, since it was typically much faster. In the absence of this program, residents now have to complete an interview at a consulate, and these interview appointments typically require a long wait time. This, in combination with existing delays in the Student and Exchange Visitor Information System, makes international travel a risky proposition for any resident who requires a visa, despite their citizenship or country of origin.

Many perceive the proposed changes to the immigration system, whether in effect or temporarily halted by court order, to be unwelcoming toward IMGs. The combination of the perception of not being welcomed and the reality of additional regulations and rules restricting residents’ ability to travel, impose real psychological and physical difficulties far beyond inconvenience. Many GME programs are dependent on IMGs, and GME leadership can only speculate as to how the proposed travel restrictions may impact them in the short term and the long term. A remaining unanswered question is whether this unwelcoming environment, and the increased hardship from the new immigration rules, may drive the best IMGs into other more “friendly” countries, and

negatively affect the quality of the care patients receive in the United States.

Keeping in mind the difficult decisions many IMGs have to make, one of our patients said to an IMG resident, “I am glad you are already here and you are my doctor, please don’t go to visit your family, I am afraid I will lose you if you do!”

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