Testimony of

Sarah K. Peterson

Principal Attorney, SPS Immigration PLLC

"Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce"

Before the

Senate Committee on the Judiciary

Subcommittee on Immigration, Citizenship, and Border Safety

September 14, 2022

Introduction

Chair Padilla, Ranking Member Cornyn, and members of the Subcommittee, thank you for providing this opportunity to submit written testimony regarding the vital role International Medical Graduates ("IMGs")[1] and international nurses play in the provision of urgently needed healthcare to Americans. My testimony will focus on how we can effectuate smart immigration reform that will allow IMGs, international nurses, and other healthcare professionals to help address this country's ongoing shortage of access to medical care, ensuring that all Americans are able to access basic, primary medical care regardless of where they live in the United States.

My name is Sarah Peterson and I am the founding attorney of SPS Immigration in Minneapolis, Minnesota. I have exclusively practiced employment-based immigration and citizenship law for more than sixteen years focusing on physician immigration. I have represented healthcare systems, physician practice groups, clinics, universities, and foreign national physicians as they navigate through the complex U.S. immigration system. I teach an advanced immigration course at the University of Minnesota Law School as an Adjunct Professor and have been actively involved throughout my career both locally and nationally in effectuating smart immigration policy reform. I hold joint degrees in Law and Public Policy from the University of Minnesota Law School and the Hubert H. Humphrey School of Public Affairs, and I was a 2021-2022 Policy Fellow in the Humphrey School of Public Affairs Policy Fellows Program. Growing up in one of the poorest counties in Central Minnesota and having family who still lives in these rural communities, I have witnessed firsthand the impact of, and issues created by, the lack of access to healthcare in rural America. The opinions I am expressing today are my own and are based on my almost two

---

[1] Previously referred to as Foreign Medical Graduates or "FMGs," IMGs who are physicians who attend or have graduated from a medical school located outside the United States or Canada. https://www.nrmp.org/intro-to-the-match/the-match-terms-and-topics/?utm_source=search_results_page&utm_campaign=nrmp_search_page&utm_term=IMG%20definition, last visited September 5, 2022. This includes U.S. citizens who have graduated from a medical school outside the U.S. or Canada and excludes foreign-born physicians who have graduated from a medical school in the U.S. or Canada.

decades of physician and allied health immigration practice and experience advocating for smart immigration reform.[i]

The Growing Crisis of a Lack of Access to Basic Medical Care, Especially in Rural and Underserved Urban America

While this hearing is before the Subcommittee on Immigration, Citizenship, and Border Safety, I would submit to you that this hearing is not about immigration. The problem we are trying to solve is not one of immigration; it is instead an effort to solve the growing crisis of access to the most basic level of medical care in the United States, for all Americans. This hearing is about the way targeted, sensible immigration reform provisions can ensure access to desperately needed physicians and nurses in the United States, particularly in rural and underserved urban communities. With our rapidly aging U.S. population, a shortage of trained U.S. physicians and nurses, and a greater insured population following the Affordable Care Act ("ACA"), compounded by the ongoing COVID-19 pandemic burnout, demand for medical care is growing at an unprecedented pace.[2] At the same time, the U.S. is simply not training enough U.S. physicians or nurses to meet this serious need.

A recent Association of American Medical Colleges ("AAMC") study confirms the current and future dire state of the U.S. physician shortage.[3] The AAMC projects that physician demand in the U.S. will continue to grow faster than supply, leading to a projected total physician shortage of between 37,800 and 124,000 physicians by 2034.[4] The AAMC breaks down this figure further by projecting a shortage of primary care physicians of between 17,800 and 48,000 by 2034 and a shortage of medical specialists of between 21,000 and 77,100 physicians.[5] Further consider that the U.S. Department of Labor just released the latest unemployment figures and the unemployment rate plunged to 3.5%, matching a 53-year low.[6] These alarming statistics demonstrate the increased difficulties American will continue to experience when trying to access basic medical care.

Discussing this study, AAMC Chief Health Care Officer Dr. Janis Orlowsi confirmed that, according to data from the U.S. Health Resources and Service Administration ("HRSA"), "there is a shortage right now."[7] She continued with this clear message from physicians to Congress and the federal government:

> "*Wake up. Look at what the shortage is, and—if we are going to affect the worsening shortage that we anticipate in 10 to 15 years—we must act today."…"It is absolutely needed."*[8]

---

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7006215/, last visited September 5, 2022.
[3] "The Complexities of Physician Supply and Demand: Projections From 2019 to 2034," https://www.aamc.org/media/54681/download, last visited September 5, 2002.
[4] *Id*.
[5] *Id*.
[6] https://blog.dol.gov/2022/08/29/how-the-department-of-labor-is-celebrating-the-strength-of-americas-workforce-this-labor-day, last visited September 5, 2022.
[7] "Doctor shortages are here – time to act, Drs. Harmon [AMA President] and Orlowski [AAMC chief health care officer]weigh in," *AMA Moving Medicine* podcast, https://ama-moving-medicine.simplecast.com/episodes/doctor-shortages-are-here-time-to-act-drs-harmon-and-orlowski-weigh-in, https://www.ama-assn.org/practice-management/sustainability/doctor-shortages-are-here-and-they-ll-get-worse-if-we-don-t-act, last visited September 5, 2022.
[8] *Id*.

While these shortages have plagued rural and underserved urban areas for decades, they are now also becoming more common across the nation. Smart immigration reform, as it relates to physicians, nurses, and allied healthcare workers, is the surest mechanism to ensure that all Americans have access to nearby, timely healthcare.

Having practiced employment-based immigration law focusing on physician and allied health immigration for almost two decades, I have witnessed the shortage of physicians in the U.S. steadily grow, compounded by the aging U.S. population, COVID-19 pandemic, and burnout. During the COVID pandemic, IMGs were essential in the U.S.' fight to keep people in emergency rooms and intensive care units alive.[9] Because of our already-present shortage of physicians, the American Medical Association ("AMA") confirmed that the pandemic "forced states to recall retired physicians, expand scope of practice, and temporarily amend out-of-state licensing laws."[10] Yet we have seen few legislative or administrative fixes to address this ongoing and growing crisis. Experts from the AMA agree that if the U.S. does not address this physician shortage, more patients will continue to experience delays in access to primary care, which will particularly impact rural, marginalized, and low-income populations. Despite this, 25% of licensed doctors in the U.S. are IMGs, making it clear that IMGs play a critical role in the U.S.' provision of health care.[11] But this isn't enough, and we are running out of time. We should be doing more to support IMGs through smart immigration reforms.[12]

The ongoing physician shortage particularly impacts Americans living in rural and underserved urban communities. As of June 30, 2022, over 7,956 Primary Medical areas are designated as Health Professional Shortage Areas ("HPSAs"). This designation means that the people living in the area lack access to the number of providers required for the provision of the most basic preventative primary medical care services.[13] More than 83 million people in the U.S. currently live in a designated primary-care HPSA, and more than 14,800 practitioners are needed to remove the HPSA designation.[14] Often, American physicians are not attracted to these shortage areas and it is IMGs who address health inequities by serving in these rural and underserved urban areas.[15]

---

[9] https://immigrationforum.org/wp-content/uploads/2020/04/coronavirus-sta_45607438pdf.pdf, last visited September 5, 2022; and, https://www.tandfonline.com/doi/full/10.1080/20009666.2021.1915548, last visited September 5, 2022.

[10] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-2-14-AMA-Statement-for-the-Record-re-Immigration.pdf, last visited September 5, 2022.

[11] https://www.ama-assn.org/education/international-medical-education/how-imgs-have-changed-face-american-medicine, last visited September 5, 2022.

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7599012/, last visited September 5, 2022. But note, there were 1,433 fewer U.S. citizen and non-U.S. citizen IMGs who registered for the 2022 Match, compared with the 2021 Match. See, https://www.ama-assn.org/medical-students/preparing-residency/2022-match-again-sees-record-numbers-take-peek-behind-data.

[13] https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport, last visited September 5, 2022.

[14] https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D, last visited September 5, 2022.

[15] Lower salaries and lack of cultural opportunities in rural areas are top reasons physicians cite as reasons for not wanting to work in rural and underserved urban areas. The AMA Journal of Ethics, https://journalofethics.ama-assn.org/article/higher-pay/2009-05, last visited, September 5, 2022. Why rural America doesn't attract doctors, https://www.advisory.com/daily-briefing/2014/09/02/why-rural-america-doesnt-attract-doctors, last visited September 5, 2022.

Doctors, by themselves, aren't enough. Anyone who has ever been to a hospital knows the critical role that nurses and other health care workers play in providing medical care, and how hospitals, clinics, and doctor's offices would be unable to function without them. While the U.S. Department of Labor ("DOL") has designated nurses and physical therapists as shortage occupations ("Schedule A") so that employers do not need to test the U.S. labor market to pursue the green card process, there are few viable pathways for nurses to actually work in the U.S. while undergoing the permanent resident process. Not only are IMGs and international nurses crucial to the provision of primary and preventative medical care in the U.S., but it also makes strong economic sense as these IMGs and international nurses often remain in the community long-term. This, in turn, has a positive impact on local businesses and overall community vitality.

I represent a health care center in southern, rural Texas. This health care center has been simply able to recruit an OB/GYN physician for several years. Despite its best efforts to attract a physician to provide care, women are faced with either forgoing care altogether of having to drive over four hours to the nearest health care center to access care. Unfortunately, this story is not unique as 35 counties in Texas have no doctor at all. This very crisis is repeating itself over and over again across the United States, and it is getting worse.

Despite these clear unmet needs affecting tens of millions of Americans, our current immigration system for IMGs and nurses is outdated, complicated and difficult to maneuver, even for experts in this field. A series of concrete legislative and administrative reforms would be a major step forward that will help the U.S. better address the physician and nurse shortage crisis and ensure that all Americans have access to medical care.

The Historical Role of High Skilled Physicians & International Nurses in Addressing the Ongoing Shortage of Medical Care

Dr. Osaf Ahmed, an IMG from Pakistan who came to the United States in 1995, practices in Show Low, a small city in eastern Arizona. Dr. Ahmed treats 10 to 20 patients each day, many of them elderly people unable to travel 3 ½ hours to Phoenix to seek medical care. Like many IMGs, Dr. Ahmed came to this rural area through the "Conrad 30" program, and-- like many IMGs placed in rural and underserved areas all around the United States – he stayed. He stayed because he wanted to provide care for people who need it; people who without him may have no other option for obtaining the medical care they need. Dr. Ahmed notes that while he is proud of where he is from, he is even prouder of where he is today. This is the IMG success story – one of so many.[16]

The United States has a long and rich tradition of employing IMGs to serve our healthcare shortage needs.[17] However, in the 1970's, Congress was concerned that there might be too many IMGs compared to U.S. physicians, so it passed the Health Professionals Educational Assistance Act ("HPEAA") of 1976, in part to address

---

[16] https://cronkitenews.azpbs.org/2018/11/20/international-doctors-vital-to-arizona-rural-communities/, last visited September 5, 2022.

[17] For a comprehensive review of the U.S. immigration system for IMGs, see Kristen Harris' Testimony in "Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System," before the House Committee on the Judiciary Subcommittee on Immigration and Citizenship, February 15, 2022, https://docs.house.gov/meetings/JU/JU01/20220215/114411/HHRG-117-JU01-Wstate-HarrisK-20220215.pdf, last visited September 5, 2022.

this concern.[18] Through this legislation, Congress implemented a variety of measures aimed to not only increase the number of U.S.-trained physicians, but also to more strictly govern the role of IMGs in the United States. Additionally, Congress sought to direct IMGs, to the extent possible, to practice in rural and underserved urban areas.

Through the HPEAA, Congress also mandated that all IMGs who trained in J-1 status were categorically subject to the Immigration and Nationality Act ("INA") Section 212(e)[19], which requires physicians to return to their home country for two years after undergoing Graduate Medical Education ("GME") in the U.S.[20] At that time, Congress sought to not only protect U.S. physicians but also ensure that IMGs were well-trained and working predominantly with medically underserved patients. This is how INA Section 212(e) has become *the* legislation that has shaped the entire course of physician immigration for the past fifty years.

Over time, and due to a variety of factors, the medical programs at which IMGs trained began to increasingly require IMGs to train in J-1 status rather than sponsoring IMGs to enable them to train in H-1B status. This also coincided with a downward shift in the number of U.S. physicians being trained and a heavier reliance on IMGs. The result is the current system where the U.S. is simply not training enough U.S. physicians and IMGs are heavily relied upon to fill this increasing gap. Because most of these IMGs now require a J-1 waiver of the two-year home residence requirement to avoid having to leave the U.S. after completing their training, it is important to understand how the J-1 waiver process works.

One of the most recent and important advances in J-1 waiver law happened in 1994, through bi-partisan legislation championed by Senator Kent Conrad (D-ND). To address the staggering physician shortages in North Dakota, and to harness the ability to retain U.S.-trained physicians, Senator Conrad championed what became known as the "Conrad State 20" J-1 waiver legislation[21] because he saw an opportunity to complement the U.S. medical system using U.S.-trained foreign-national physicians. Specifically, Senator Conrad opined:

> *My proposal [for a State Conrad program] is by no means the entire solution to our health care needs in rural America. We must do more to reform our graduate medical education system so that our Nation produces more primary care practitioners. And we must provide additional incentives for physicians, nurse practitioners, physician's assistants, and others to practice in rural America. But the proposal I am introducing today will make a very real contribution to augmenting the physician supply in rural areas that need qualified physicians.*[22]

---

[18] https://files.eric.ed.gov/fulltext/ED148192.pdf, last visited September 5, 2022.
[19] 8 USC Section 1182(e).
[20] Compare Clinical Physicians to the rest of the J-1 occupations that do not have a mandatory two-year home residence requirement categorically, but rather are subject on a case-by-case basis in the event of being listed on the corresponding skills list or government funding.
[21] Currently known as the Conrad State 30 J-1 waiver program.
[22] 140 Cong. Rec. at S6747.

Nearly 30 years later, the only modernization we have seen to this program was to increase the limit to 30 IMGs per state in 2002.[23] As a result, State Conrad 30 programs are oversubscribed, and Senator Conrad's creative J-1 waiver solution no longer provides enough J-1 waiver numbers to meet the demand. Over this same timeline, the U.S. Census Bureau estimates the country's population increased by 23 million people from 2010 to 2020.[24] The U.S. population is projected to climb further -- to 363 million by 2034, with 22.9 million—or two-thirds of the growth—estimated to be people 65 or older who will require more care as they age. Further, a recent survey conducted by the Mayo Clinic shows that "One in five physicians say it is likely they will leave their current practice within two years. Meanwhile, about one in three doctors and other health professionals say they intend to reduce work hours in the next 12 months."[25] They found that "burnout, workload, fear of infection, anxiety or depression due to COVID-19 and the number of years in practice were associated with intent to reduce work hours or leave."[26] These statistics evidence the direct and unrelenting physician and nursing shortage faced by the U.S., a growing U.S. population, especially over the age of 65, and the need for Congress to immediately effectuate smart immigration reform to address this growing crisis.

I have watched firsthand how J-1 waiver usage has evolved over my career. In my early years of practice, State Conrad J-1 waiver numbers were commonly available year-round. However, over time, the State Conrad Waiver programs have become more and more competitive, forcing state Departments of Health to implement administrative review programs including conducting lotteries or developing selection criteria to help determine and prioritize the most dire and urgent healthcare needs. Consider that in Fiscal Year 2021, the most recent year with available data, 23 states completely filled all 30 slots, meaning U.S.-trained international physicians who needed waivers were turned away and employers who desperately needed to add physicians to their team were left without access to candidates who could have filled those vacancies.[27] Additionally, eight states received more than 25 J-1 waivers, putting us closer than ever most states not having enough Conrad waivers to meet healthcare demand.[28] This isn't a local or regional problem – it is a national crisis. Rather than giving state Departments of Health the ability to ensure that all underserved communities have access to essential healthcare, states are forced to determine how to allocate the limited numbers, often not driven by need but rather through an administratively neutral means – sometimes as random as first-come, first-served or a lottery – to administer the high demand for too few numbers. The impact on IMGs willing to work in these rural and underserved areas is also dire as often physicians believe they have found a rewarding opportunity only to learn in the spring – right before their GME training program ends – that their waiver was not selected due to the shortage of numbers. This leaves them

---

[23] 21st Century Department of Justice Appropriations Authorization Act § 11018(a), Pub. L. No. 107-273 (2002).
[24] https://www.ama-assn.org/practice-management/sustainability/doctor-shortages-are-here-and-they-ll-get-worse-if-we-don-t-act, last visited September 5, 2022.
[25] *Mayo Clinic Proceedings: Innovation, Quality & Outcomes,* "COVID-Related Stress and Work Intentions in a Sample of U.S. Health Care Workers," https://www.mcpiqojournal.org/article/S2542-4548(21)00126-0/fulltext, last visited September 5, 2022.
[26] *Id*.
[27] https://3rnet.org/Portals/0/adam/Basic%20Content/QxXpO-cnfkeKBY1XymXi7Q/Content/FFY%202021%20-%20October%202020%20to%20September%202021.pdf.
[28] *Id*.

scrambling for alternative options, of which there are few, and many end up leaving the U.S. altogether. Further, given these dire statistics regarding the lack of viable J-1 waiver numbers, many desperate healthcare facilities simply forego altogether the J-1 waiver program as it is expensive, takes significant time, and is ultimately unreliable in terms of ensuring the healthcare facility will actually be able to employ the sponsored IMG. This results in my clients in Minnesota to Indiana, Florida, California, and many more states, being simply unable to recruit sufficient physicians to staff their needs because there is not a workable mechanism to waive the two-year home residence requirement necessary to timely and reliably attain work authorization. The inevitable outcome of this crisis is that American patients suffer longer patient wait times and untreated medical issues. It is patients turning up in Emergency Rooms with illnesses that could have been avoided by basic preventative care, and increasing costs for hospitals, towns, states, and the American taxpayer.

In line with Senator Conrad's original reason to create the Conrad program, which was a bi-partisan effort then and remains so today,[29] we must build on and expand his legislation - which is now almost 30 years old - to retain physicians who have completed U.S medical training to increase healthcare access for Americans living in rural and underserved urban areas. Because 212(e) is the primary statutory driver for IMGs immigration journey, it is important to improve existing laws by legislatively and administratively providing access to more J-1 waiver options. This will, in the short term, allow U.S.-trained IMGs to continue to provide basic, primary medical care to the most underserved, rural, and indigent Americans. Additionally, for these physicians to remain in the U.S. long-term, it is important to revise the "green card" process to ensure that these IMGs have a viable pathway to stay in the U.S. and in the communities in which they have built their lives. This is smart immigration policy.

The Immigration Journey for IMGs & International Nurses is Lengthy, Unpredictable, and Difficult to Navigate

The immigration journey of an IMG is complex and lengthy and depends largely on whether the IMG undergoes GME in J-1 status or H-1B status. It also depends on their country of birth, both for J-1 waiver options and "green card" pathways.[30] If the IMG is in J-1 status for Graduate Medical Education ("GME"), the physician generally requires a J-1 waiver to remain in the U.S. to treat patients and once granted, in most instances, the physician will work in H-1B status to treat patients in an underserved rural or underserved urban community for a minimum three-year period.[31] The physician must then be sponsored by their employer for the "green card" process to remain and practice medicine in the U.S. long-term. If the physician instead completes medical training in the U.S. in H-1B status, the physician risks using all six-years of permitted initial H-1B status before successfully

[29] *See*, "Creation of the Conrad Waiver Program," Immigration Options for Physicians, 3rd Edition, P. 55 – 62.
[30] Indian citizens not only are the second highest number of IMGs training each year, closely behind Canada, but they also face the longest backlog in their ability to achieve permanent resident status, or their "green card," due to country limits in immigrant visa availability. *See*, ECFMG J-1 Visa Sponsorship: Top 10 Nations of Origin for Exchange Visitor Physicians 2020 Calendar Year, EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES, https://www.ecfmg.org/resources/2020-EVSP-Data-Nations.pdf, last visited September 5, 2022.
[31] There are J-1 waiver options for IMGs who can document that having to return to their home country would impose exceptional hardship on their U.S. citizen spouse or child, or, that the physician himself or herself would face persecution on account of race, religion, or political opinion should he or she be required to return to their home country. These options do not require three years of service in an underserved area. *See* INA § 212(e), 8 U.S.C. § 1182(e); 8 C.F.R. § 212.7(c)(5).

completing the "green card" process, leaving few viable options to remain in the U.S.

The immigration journey of international nurses in the U.S. commonly means the nurse has received a Bachelor of Science in Nursing (BSN) from a U.S. university[32] and then has one year of post-degree work authorization ("OPT") during which the nurse must either achieve "green card" status or depart the U.S. However, only 8% of international students pursue healthcare degrees. Alternatively, employers can sponsor nurses living abroad through the "green card process" ultimately requiring an interview at a U.S. Consulate to be able to travel to the U.S. on a green card. This is a lengthy and complex process, exacerbated by the COVID-19 pandemic, which means it could be years before the nurse is eligible to enter the U.S. to work.

How Congressional Action Can Immediately Ensure Healthcare Equity for All Americans

There are a variety of simple, targeted, and common-sense legislative reforms that will make this immigration journey more predictable for IMGs and permit employers to recruit and employ critically needed physicians and nurses more robustly. This will help to immediately address the growing shortage of access to healthcare currently faced by rural and underserved urban Americans. Thus, it is imperative that Congress immediately act to pass the following two pending bills that have strong and consistent bi-partisan support, in both the Senate and House, and further U.S. interests in ensuring the provision of primary healthcare to all Americans:

- Conrad State 30 and Physician Access Reauthorization Act, S.1810 (H.R.3541)
- Healthcare Workforce Resilience Act, S.1024 (H.R.2255)

CONRAD STATE 30 AND PHYSICIAN ACCESS REAUTHORIZATION ACT

I would like to personally thank Senator Klobuchar for championing the Conrad State 30 and Physician Access Reauthorization Act ("Conrad Reauthorization Bill") by being the original sponsor of this bill, and I would like to thank Ranking Member Cornyn, and Senators Tillis, Coons, and Blumenthal for co-sponsoring this legislation. I would like to thank Ranking Member Cornyn and Senators Tillis, Feinstein, Coons, and Booker for co-sponsoring the Healthcare Workforce Resilience Act. Passage of these bi-partisan bills will bring important relief to underserved populations and J-1 physicians and international nurses alike.

The Conrad Reauthorization Bill provides much needed and long overdue reforms to help increase access to healthcare in underserved areas by amending the current statute to permit the 30 J-1 waivers provided to each state to rise and fall based on a state-by-state need rather than limiting each state to 30 waiver slots. This legislation also smartly permits qualifying physicians who timely but unsuccessfully applied to a State Conrad 30

[32] Only 3% of the approximate 1.1 million international students were enrolled in U.S. institutions in school 2019-20 pursued health professions, such as nursing. https://www.migrationpolicy.org/article/international-students-united-states-2020#fields_study. Last visited, September 5, 2022.

waiver program – due to the shortage of numbers - to extend their status to remain in the United States and re-apply for such service in the next fiscal year, which is another opportunity to ensure access to healthcare.[33] The Conrad Reauthorization Bill also restores a Conrad 30 number to an issuing state in instances when a physician relocates to another state in cases of extenuating circumstances.[34] Finally, the Conrad Reauthorization Bill permits J-1 waivers sponsored by Academic Medical Centers to exceed the 30 slots by up to three additional slots per state, in the event a given state has "maxed out" its default 30 slots.[35]

I have seen first-hand the absurd results that come from the rigid rules of our current, outdated system. Had it been in place just last year, this legislation would have been incredibly helpful to one my clients who sought to employ a U.S.-trained anesthesiologist at a hospital in Illinois. That hospital at which they sought to employ the anesthesiologist was literally *across the street* from the border of a designated underserved urban area. In that case, because the clinic itself was not physically located in the underserved area – although the anesthesiologist was serving the same patient demographics – the physician was not granted a J-1 waiver due to the badly oversubscribed Illinois J-1 waiver program that receives well over 30 applications each year. Given the shortage of anesthesiologists in the U.S., this lack of access to a J-1 waiver means that patient wait times for critical surgical procedures are delayed when employers cannot readily employ U.S. trained anesthesiologists due to the artificial and outdated limit on Conrad J-1 waiver numbers and rigidly applied rules.

Further, the Mayo Clinic each year must prioritize which doctors to sponsor for the limited Conrad J-1 waiver slots, knowing that not all will be selected. Last year, the Mayo Clinic had 23 physicians that needed Conrad Waivers and only received 10. One doctor, a highly influential oncologist treating breast cancer patients, has been waiting 7 years to obtain a waiver. Another physician resigned after 5 unsuccessful attempts to be selected for the limited Conrad J-1 Waiver slots and returned to his home country. This physician was one of the very few physicians worldwide who had unique training and skillset to treat complex gastroenterology disorders. The Mayo Clinic, as one of the leading gastroenterology departments in the world, now faces a gap in clinical staff training which results in patients, including those from medically underserved areas, facing longer wait times to see a specialist with this skillset. This is just one example of the many outstanding physicians that have resigned from the Mayo Clinic due to the limited availability of Conrad J-1 waivers. Alternatively, if a doctor has no other temporary work options, the Mayo Clinic is forced to rescind the offer of employment, and these positions are almost always in the underserved areas where the need is greatest. The U.S. should encourage and support, through smart immigration reform, the ability of states to grant J-1 waivers based on need.

There currently exists the Physician National Interest Waiver ("PNIW") which can allow a physician who works full-time for five years in a designated rural or underserved area to move forward in the green card process.[36] However, this does not solve the problem of the employment-based green card backlog, where

---

[33] Conrad Bill § 4(d).
[34] Conrad Bill § 4(f).
[35] Conrad Bill § 5(b).
[36] INA §203(b)(2)(B)(ii); 8 U.S.C. §1153(b)(2)(B)(ii).

individuals born in China or India often have to wait 15 to 20 years for a green card "number" in the quota to become available – even if they are granted a PNIW. The Conrad Reauthorization Bill fixes this problem, and permits physicians who practice in a designated rural or underserved urban area to be exempt from the annual numerical green card limit.[37] This would have immediate and immense impact on physicians born in India or China who have completed GME in the U.S. and commit to working in rural and underserved urban areas, and who otherwise might need to wait upwards of 15 to 20 years to get a green card. Further, this bill importantly expands the PNIW green card program to align with the J-1 waiver program by providing benefits to physicians who, while not physically working in a federally designated rural or underserved urban area, provide care to patients who live in federally designated rural or underserved urban areas.[38]

Finally, the Conrad Reauthorization Bill provides "cap gap" relief for J-1 trainees, like that provided to F-1 students working in OPT status, whose work authorization expires before October 1 and whose employers have filed a cap-subject H-1B petition selected in the registration period. Expanding this relief to physicians would provide employers with quicker access to necessary healthcare and allow these foreign national physicians to change status in the United States, without having to depart the United States, obtain a visa, and only be permitted to re-enter the U.S. months later. Cap gap work-authorization for U.S.-trained physicians would add a quarter of a year or more of badly needed physician coverage and is smart immigration reform.

HEALTHCARE WORKFORCE RESILIENCE ACT

The Healthcare Workforce Resilience Act is another key piece of bi-partisan legislation for smart immigration reform. It affords U.S.-trained physicians and desperately needed nurses an immediate and viable pathway to remain in the U.S. permanently. This legislation would recapture 40,000 unused employment-based visas from prior years and reallocate 15,000 visas to physicians and 25,000 visas to nurses to bolster our healthcare workforce and ensure U.S. patients retain access to the care they deserve and continue to need during this unprecedented public health crisis. This will be important especially to our frontline medical workers born in India or China who otherwise are facing a delay of up to 15 years or more to become "green card" holders.[39] Without adding a single new green card number to the overall quota, and instead by recapturing numbers already authorized years ago by Congress but never used, passage of the Healthcare Workforce Resilience Act will bring important relief to physicians and nurses who have been working on our front lines.

While these two bi-partisan bills provide necessary and immediate relief, they are merely necessary short-term enhancements and do not solve the larger issues faced by international physicians and nurses, nor to the U.S. employers trying to employ them to address the U.S. healthcare crisis. Congress can and should do more.

Create a Lasting and Long-term Solution to the Problem of Healthcare Equity for All Americans

[37] Conrad Bill § 3.
[38] Conrad Bill § 6(b).
[39] I provide a more detailed explanation of this delay later in this testimony.

Provide H-1B cap exemption for any IMG or International Nurse working in a Designated Rural or Underserved Urban Area

Congress should amend the INA to provide H-1B cap exemption for physicians working at facilities located in an HHS-designated shortage area. The H-1B is the very same visa competed for each year by software companies in Silicon Valley and hedge funds in New York, and the demand for H-1Bs is growing every year. Indeed, the United States Citizenship and Immigration Services ("USCIS") has reported that for fiscal year 2023 it received more than 480,000 entries in the H-1B lottery for just 85,000 spots, an increase of more than 150,000 entries from the prior year.[40] Many employers seeking to hire an IMG or international nurse in H-1B status to work in a rural or underserved urban area are competing head-to-head with Google, Apple, Microsoft, and other large technology companies. By exempting IMGs and international nurses who choose to work in a designated rural or underserved urban area, we can both provide an important incentive to those doctors and nurses who choose to work in areas that desperately need healthcare, while also providing the hospitals, clinics, and local medical practices with far greater certainty in being able to obtain the necessary physicians and nurses needed to provide care. Providing this common-sense and cost-neutral carve out would provide greater access to health care for patients of international nurses and IMGs who underwent their GME in H-1B status, and it would make choosing to work in an underserved rural or urban area a more attractive choice to those doctors and nurses who don't want to "play the H-1B lottery."

Provide an immigrant visa cap exemption for any IMG or International Nurse working For Five Years in an Underserved Area

The green card process is lengthy and difficult for any high-skilled immigrant. But compound the process with J-1 waivers, licensing issues, and a growing shortage of physicians and nurses generally, and we have an outdated system that does not easily facilitate the transition for needed healthcare workers from temporary work authorization to permanent resident status, or the "green card."

For IMGs and international nurses born in India or China, this problem is especially vexing. Consider the story of Dr. Pranav Singh, a critical care physician practicing in Mason City, Iowa, a small city with a population of around 27,000 that is nearly a two-hour drive from Des Moines.[41] Dr. Singh arrived in the U.S. in 2006 and has been working his way through the U.S. immigration system ever since. Because of the extensive backlogs experienced by people born in India in the green card process, and with a 16-year-old daughter who would likely lose her ability to remain in the U.S. once she turns 21 (at which time she is no longer considered Dr. Singh's dependent), Dr. Singh made the difficult decision to return to India. Dr. Singh obtained a job with a telemedicine

---

[40] https://www.uscis.gov/working-in-the-united-states/temporary-workers/h-1b-specialty-occupations-and-fashion-models/h-1b-electronic-registration-process, last visited September 5, 2022.

[41] https://www.americanbazaaronline.com/2021/10/24/tired-of-green-card-backlog-indian-doctor-returns-home-447509/, last visited September 5, 2022.

company in India, and Mason City lost a badly needed critical care physician. This happened because Dr. Singh and his family could see no light at the end of the tunnel, and ultimately needed the stability that a constant renewal of temporary visas does not bring. The story of Dr. Singh is just one of thousands of doctors and nurses who are growing weary with the outdated U.S. immigration process and its failure to recognize the essential contributions they make to the United States.

While there are preliminary foundational steps in the green card process, the ability for any high skilled immigrant to file the final step in the green card process is determined by a limited supply and strong demand of the 140,000 employment-based immigrant visa numbers available each year. These are allocated through a complex configuration determined by country of birth and education/training. The U.S. Department of State, through its monthly Visa Bulletin, tells individuals when they may be eligible to file,[42] and then USCIS determines at an even more granular level who can actually file.[43] Because this visa allocation system limits each country in the world to only 7% of the overall available 140,000 numbers, physicians from countries that are our highest contributing sources of high-skilled talent – like India and China – face substantially longer wait times to achieve green card status than their peers from other countries. Considering that physicians born in India comprise almost 22% of the total foreign-born physician community, and physicians born in China comprise over 5%,[44] the significant delays in wait times negatively impact these physicians who face a myriad of issues. These include children who "age out" and are unable to achieve immigration benefits under their parents, instability in their careers and ability to pursue career advancements, inability to independently obtain government research funding so vital for their livelihood, and a variety of other stressful factors, not experienced by their peers born in other countries. Physicians born in India currently will likely need to wait over 10 to 15 years from the time they begin their green card journey to be eligible to file an adjustment of status application within the U.S. and physicians born in China likely need to wait approximately three years.[45]

Congress can solve this problem with a simple, effective, and common-sense change to the law that will help to ensure that underserved rural and urban areas will have greater access to needed medical care. While the Conrad Reauthorization Act referenced above would make certain small carve outs for doctors who qualify for a Physician National Interest Waiver, Congress should solve the broader problem of access in underserved rural and urban areas to both doctors and nurses by amending INA Section 203(b)[46] to create an exemption to the employment-based green card quota for those doctors and international nurses who work for at least five years in

---

[42] https://travel.state.gov/content/travel/en/legal/visa-law0/visa-bulletin.html, last visited September 5, 2022.
[43] https://www.uscis.gov/green-card/green-card-processes-and-procedures/visa-availability-priority-dates/adjustment-of-status-filing-charts-from-the-visa-bulletin, last visited September 5, 2022.
[44] https://research.newamericaneconomy.org/report/immigrant-healthcare-workers-countries-of-birth/, last visited September 5, 2022.
[45] Visa Bulletin for September 2022, https://travel.state.gov/content/travel/en/legal/visa-law0/visa-bulletin/2022/visa-bulletin-for-september-2022.html, last visited September 5, 2022.
[46] 11 USC 1153(b) "Preference allocation for employment-based immigrants."

a designated underserved rural or urban area.[47] This would create the kind of long-term relief necessary to address the serious healthcare shortage these communities are facing.

Additional Statutory Fixes to Advance Healthcare Equity through Smart Immigration Reform

There are additional cost-neutral, smart immigration reform steps Congress can and should take to improve health equity in the United States. First, Congress should expand the H-1B U.S. Master's Cap exemption to include ECFMG-certified medical degrees and/or completed U.S. GME programs as qualifying bases for eligibility.[48] The Master's Cap exemption reserves 20,000 H-1B numbers each year for individuals who have completed at least a Master's level educational program at a U.S. college or university.[49] U.S. GME programs are at shortest, three years and at most, eight years of advanced, post-MD training, which is directly in line with policy interests Congress intended when it created the U.S. Master's Cap exemption. By amending INA § 214(g)(5)(C) to clarify that GME programs qualify for the master's Cap exemption, Congress can show that the United States values doctors just as much as it values software engineers.

Additionally, Congress should amend the statute to address the H-1B 6-year limit for physicians undergoing GME training in H-1B status, by tolling the three-year H-1B remainder of the 6-year limit once a physician completes the foundational three-year residency. IMGs who demonstrate acceptance to an ACGME-accredited fellowship program or an ACGME-recognized nonstandard training program and H-1B qualifying employment should be permitted to toll the last three years of H-1B eligibility until they complete the subspecialty training. These physicians would then be eligible for the final three years of the statutory 6-year H-1B status immediately after completing the subspecialty training. This would serve as a necessary bridge for physicians training in H-1B status by eliminating the frequent situation where physicians undergo GME training in H-1B status but run out of time to complete the full course of subspecialty training and still need time to achieve green card status.

REINSTATE AND EXPAND THE H-1C CLASSIFICATION SO INTERNATIONAL NURSES HAVE A VIABLE NON-IMMIGRANT OPTION TO WORK IN THE U.S.

In January 2022, Governors from across the country called in the National Guard to assist health care providers because 1,118 hospitals—more than 1 in 6 hospitals in America[50] —reported serious nursing shortages.[51]

---

[47] I provide details below on additional legislative and administrative reforms that would permit international nurses to work during this five-year period.
[48] This would require amending INA § 214(g)(5)(C), 8 U.S.C. § 1184(g)(5)(C).
[49] INA Section 214(g)(5)(C).
[50] American Hospital Association, "Fast Facts on U.S. Hospitals," available at https://www.aha.org/statistics/fast-facts-us-hospitals (last accessed April 2022). *See also*, https://www.nursingworld.org/practice-policy/workforce/. Further, About 194,500 openings for registered nurses are projected each year, on average, over the decade. Many of those openings are expected to result from the need to replace workers who transfer to different occupations or exit the labor force, such as to retire. https://www.bls.gov/ooh/healthcare/registered-nurses.htm.
[51] Rachael Levy, "Health care workers are panicked as desperate hospitals ask infected staff to return," *Politico*, January 10, 2022, available at https://www.politico.com/news/2022/01/10/doctors-covid-staff-shortage-526842, last visited September 5, 2022.

By March 2022, almost every state in the country had implemented executive actions to address this shortage of nurses.[52] Compounding this issue is the COVID-19 pandemic, as nurses are leaving the profession amid the "extreme and sustained demands of caring for unvaccinated, hospitalized patients during the COVID-19 pandemic."[53] A recent study by American Association of Critical-Care Nurses ("AACN") confirmed that 66% of nurses feel their experiences during the pandemic have caused them to consider leaving nursing.[54]

Smart immigration reform can provide an immediate and cost-neutral approach to solve this problem. In 1999, Congress created, through the Nursing Relief for Disadvantaged Areas Reauthorization Act ("NRDAA"), the H-1C nonimmigrant temporary worker classification specifically to address the shortage of nurses in the U.S. by permitting international nurses coming to the United States to perform services as a registered nurse in a health professional shortage area as determined by the Department of Labor ("DOL").[55] This program required administration and oversight from both DOL and legacy INS. However, on December 21, 2009, the NRDAA sunsetted and has not been reauthorized.

To qualify for an H-1C visa, RNs had to possess full and unrestricted nursing license in the country where the nursing education was obtained or must have received a nursing education and license in the United States. They were also required to be licensed in the State in which they sought to practice and to have passed the Commission on Graduates for Foreign Nursing Schools ("CGFNS") exam, or have held a full and unrestricted license to practice as a registered nurse in the state where they were to work, or have held full and unrestricted registered nurse's licensure in any state and have received temporary authorization to practice as a registered nurse in the state where they were to work. Employers were required to: be a "subpart D" hospital under the Social Security Act; be in a HPSA; have at least 190 acute care beds; have a Medicare population of no less than 35%; have a Medicaid population of no less than 28%; and, be certified by the DOL.[56]

Congress could, and should, immediately reauthorize the NRDAA to facilitate the ability for Employers to hire and employ RNs. Congress should also raise the annual numerical limit beyond the historical 500 to a more reasonable number such as 20,000 per year, to meet real-world, current nursing shortages in the United States.

Bring the Two-year Home Residence Requirement for Physicians in line with all other J-1 Occupations

The concern about IMGs taking jobs away from U.S. physicians was the impetus of Congress legislating the two-year home residence requirement for all clinical IMGs who receive GME in J-1 status in the U.S. This concern has not only since disappeared, but it is also at this point well-established that the U.S. simply cannot train enough

[52] National Council of State Boards of Nursing, "State Response to COVID-19," available at https://www.ncsbn.org/State_COVID-19_Response.pdf.
[53] https://www.aacn.org/newsroom/hear-us-out-campaign-reports-nurses-covid-19-reality, last visited September 5, 2022.
[54] *Id*.
[55] https://www.uscis.gov/archive/h-1c-registered-nurse-working-in-a-health-professional-shortage-area-as-determined-by-the-department, last visited September 5, 2022.
[56] https://www.uscis.gov/archive/h-1c-registered-nurse-working-in-a-health-professional-shortage-area-as-determined-by-the-department#:~:text=To%20qualify%20for%20an%20H,to%20practice%20within%20the%20state, last visited September 5, 2022.

physicians to meet our current need. Nevertheless, despite this perpetual shortage, Congress still *de facto* subjects IMGs to the two-year home residence requirement at INA Section 212(e). All other J-1 occupations are subject only after the U.S. Department of State's Waiver Review Division, Visa Office, Bureau of Consular Affairs, consults with foreign governments and overseas posts to determine if the country has a shortage of a particular occupation.[57] Given that the United States is suffering from an acute, decades-long shortage of physicians, and that the HPEAA was passed largely due to the fact that there were more IMGs than the U.S. population needed at that time, Congress should now modernize INA section 212(e) to bring it in line with all other J-1 occupations. If a physician can show that their home country does not object to the physician being granted a waiver of the 2-year home residence requirement, it should be waived. This is the same approach taken with engineers, teachers, finance professionals, and all other J-1 professions. It should be applied to doctors as well, rather than treating them differently and more strictly.

Administrative Actions to Improve the Provision of Health Care in Rural and Underserved Urban Areas

While the legislative changes noted above are exceptionally important to a long-term solution to ensure access to basic medical care for all Americans, Congress can also effectuate necessary relief through highlighting and supporting administrative and regulatory changes to the relevant federal agencies. There are several smart, cost-neutral, and effective administrative actions that would greatly improve access to urgently needed healthcare in rural and underserved urban communities, without the need for the passage of legislation.

EXPAND THE HHS CLINICAL J-1 WAIVER PROGRAM

The HHS clinical J-1 waiver program is an effective way for primary care physicians to practice in rural and underserved urban areas. This program has no statutory annual limit but limits eligibility to facilities located in the most acute underserved rural and urban America and only permits primary care physicians in Internal Medicine, Family Practice, OB/GYN, Psychiatry, Pediatrics, and Hospitalists to apply.

HHS' authorizing regulations are much broader, however, and would permit primary care physicians to carry out their service in any "primary care Health Professional Shortage Area ("HPSA") or Medically Underserved Area or Population ("MUA/P")," and psychiatrists to work in any Mental Health HPSA, with no specification as to a minimum score.[58] As these are all areas that HHS itself has already designated as shortage areas, as a matter of policy, HHS should expand its clinical J-1 waiver program to the fullest extent of the current regulations. Additionally, the program could readily be expanded beyond the current primary care fields, so long as the healthcare service would be rendered in an HHS-designated shortage area. There is a pervasive shortage of medical specialists in rural and underserved urban areas and yet medical specialists are unable to utilize the HHS J-

[57] 74 FR 20107, https://www.federalregister.gov/documents/2009/04/30/E9-9657/2009-revised-exchange-visitor-skills-list, last visited September 5, 2022.
[58] 45 C.F.R. § 50.5(c).

1 waiver program.[59] Because HHS is eligible under the statute to recommend J-1 waivers as an Interested Federal Agency, it should revise its regulations to expand J-1 waiver eligibility to medical specialists.[60]

Encourage All Federal Regional Commissions to Enact J-1 Waiver Programs

Congress has authorized seven federal regional commissions and authorities to address instances of major economic distress in certain defined socioeconomic regions, including improving access to critically needed healthcare. Five of these seven are currently active, yet only three of these seven have active J-1 waiver programs. Congress should encourage the remaining regional commissions and authorities to actively create and administer J-1 waiver programs to ensure the neediest Americans have access to primary healthcare.

Add Medical Doctor and Bachelor of Science in Nursing to the STEM OPT List of Occupations

Another smart and simple administrative reform that would provide significant relief is to revise the rules governing work authorization for students who graduate from a U.S. university. In 2016, the Department of Homeland Security ("DHS") updated the regulations governing post-completion Optional Practical Training ("OPT") to provide an additional 24 months of work authorization for students who graduate from a U.S. college or university with a STEM degree, as long as their employer participates in the E-Verify program.[61] This regulation recognized the tremendous importance to the United States of students with education in science, technology, engineering, and math, and has allowed engineers, computer scientists, physicists, and others with a STEM degree to remain in the U.S. for a longer amount of time applying their skillsets to the benefit of the U.S.[62] However, despite the fact that a Bachelor of Science in Nursing ("BSN") and a Doctor of Medicine ("MD") both involve extensive study of science, neither a BSN nor a U.S. MD are designated as STEM fields eligible for the 2 year extension of OPT.[63] By simply treating these educational programs in the U.S. as the scientific disciplines that they are, these students can be provided with an opportunity to work and receive additional on-the-job training while also providing badly needed medical care to Americans who need it. This would not require the passage of any new statute by Congress and could be effectuated through a simple change to the administrative rules governing a program that is already in place.

Designate IMGs Working in a federally qualified underserved area as a "DOL Schedule A" occupation

Dr. Daniel Dahle is a physician in Bieber, California. At age 71, he has delayed retirement for years

[59] See, https://www.aamc.org/data-reports/students-residents/interactive-data/table-c2-number-individuals-who-completed-residency-and-are-practicing-medically-underserved-areas.
[60] *See* INA § 214(l)(c); INA § 214(l)(D). See also, 45 CFR Part 50.5(b), https://www.govinfo.gov/content/pkg/CFR-2009-title45-vol1/pdf/CFR-2009-title45-vol1.pdf. Last visited September 5, 2022.
[61] 8 CFR 214.2(f)(10)(ii)(C).
[62] https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/optional-practical-training-extension-for-stem-students-stem-opt, last visited September 5, 2022.
[63] https://www.ice.gov/doclib/sevis/pdf/stemList2022.pdf, last visited September 5, 2022.

because it is so difficult to recruit new family practitioners to come to rural California for their medical careers. By 2030, the state of California will be in dire need of primary care doctors, and the problem will be particularly difficult in agricultural areas like the Central Valley. This is the kind of shortage that has caused Dr. Dahle to delay retirement again and again. [64]

However, despite this known shortage, and despite the fact that HHS already designates specific areas in each state as underserved shortage areas, most employers seeking to obtain a green card for a foreign-national doctor for one of those small towns or underserved urban areas are required to first complete a 16 to 18 month long process known as PERM labor certification.[65] In essence, those employers have to go through a lengthy process just to show what they and HHS already know – that there aren't enough U.S. doctors in the community.

There is, however, a sensible and easy-to-implement solution to this problem that doesn't require any new legislation. The DOL's Office of Foreign Labor Certification ("OFLC") has pre-certified certain occupations as having a severe shortage of U.S. workers, referred to as "Schedule A occupations."[66] Currently, registered nurses and physical therapists are classified as such.[67] However, given the documented U.S. physician shortage spanning more than two decades, DOL could simply add physicians working in HHS-designated shortage areas to the list of shortage occupations. This would help employers more quickly sponsor physicians for permanent resident status, without having to expend significant time, money, and resources to test a local labor market that already evidences current and significant shortages. Permitting employers to skip entirely a labor market test through DOL's designation of physicians working in HHS-designated shortage areas as a Schedule A occupation would be smart immigration reform that will help the U.S. retain foreign national physicians by providing them with means to adjust to lawful permanent resident status, or "green card" status, more quickly.

Conclusion

IMGs and international nurses are not only a short-term solution to help solve the lack of access to medical care in the United States, but they are also a long-term solution. Beyond the urgent need for more physicians based on these pervasive shortages, IMGs positively impact the communities in which they work. J-1 waivered physicians are more likely to remain in medically underserved areas after program completion than U.S. medical graduates participating in the National Health Service Corps. Twenty-eight percent (28%) of foreign national physicians who obtain J-1 waivers continue to practice in their underserved locations after five years, as compared with a retention rate of 11% for U.S. medical graduates participating in the NHSC.[68] In fact, it is often

---

[64] https://calmatters.org/projects/californias-worsening-physician-shortage-doctors/?smid=nytcore-ios-share, last visited September 5, 2022.
[65] https://www.dol.gov/agencies/eta/foreign-labor/programs/permanent, last visited September 5, 2022.
[66] https://www.ecfr.gov/current/title-20/chapter-V/part-656/subpart-B/section-656.5, last visited September 5, 2022.
[67] *Id*.
[68] American Medical Association (AMA)-International Medical Graduate (IMG) Section Governing Council, International Medical Graduates in American Medicine: Contemporary Challenges and Opportunities-15 (2010), https://www.slideshare.net/drimhotep/internationalmedicalgraduatesinamericanmedicinecontemporarychallengesandopportunities, last visited September 5, 2022.

IMGs who are the only qualified, U.S.-trained physicians providing care in their area, seeing patients who drive for hours to access care.[69] Access to healthcare in rural America is vital to stabilizing and ensuring the viability of many rural U.S. communities. Given that many IMGs remain in these communities long-term, they are essential to ensuring viability in rural and underserved urban communities.

Through targeted, simple, and smart immigration reform, Congress can help solve the problem of access to medical care in the United States. The U.S. is facing an ongoing and pervasive shortage of physicians and nurses, and the integral role IMGs and international nurses play in the delivery of basic and acutely needed healthcare is documented. I have outlined several legislative and administrative actions that I urge Congress to immediately pursue to ensure these IMGs and international nurses are able to continue to provide desperately needed medical care in the U.S. The U.S. needs to be bold and swift in enacting these modest, bi-partisan, budget-neutral enhancements to our existing immigration laws. This is smart immigration policy.

[i] While this testimony is my own, I gratefully acknowledge the support of SPS Immigration team members Elizabeth Storey, Jenny Patrias, and Yer Vang for their assistance with related research and preparation.

[69] https://money.cnn.com/2018/06/08/news/economy/immigrant-doctors-green-card-backlog/index.html, last visited September 5, 2022.