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A Supplement

Graduates of Foreign Medical Schools In the United States: A Challenge to Medical Education

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Foreword

In August of 1973 a Task Force on Foreign Medical Graduates was appointed by the Executive Council of the Association of American Medical Colleges with the following membership: Kenneth R. Crispell, M.D., chairman, University of Virginia; Martin S. Begun, New York University School of Medicine; George E. Cartmill, Harper Hospital (Wayne State University), Merlin K. DuVal, M.D., University of Arizona; Rolla B. Hill, Jr., M.D., State University of New York Upstate Medical Center; Robert Q. Marston, M.D., University of Virginia; Max Michael, Jr., M.D., Jacksonville Hospitals Educational Program and University of Florida; Robert J. Weiss, M.D., Harvard University; and Joseph M. White, M.D., University of Missouri at Columbia.

The task force met on four occasions, October 5, November 30, and December 27, 1973, and January 28–29, 1974. In its deliberations the task force was assisted through the participation of Dr. Emanuel Papper, chairman of the AAMC Council of Deans. It also wishes to thank Dr. Betty A. Lockett of the Health Resources Administration (HRA) for her contributions and particularly for providing background documentation for the work of the group. Representatives of the American Hospital Association (Dr. John G. Freymann), the American Medical Association (Dr. Raymond Holden), and the HRA (Dr. Harold Margulies) provided helpful comments and criticism at a crucial stage in the deliberations of the task force.

Statistical data contained in the text and tables were obtained from the following sources: (*a*) *The Foreign Medical Graduate and Physician Manpower in the United States*, BHRD/DMI/OIHMS, Report No. 74-47, prepared by Betty A. Lockett and Kathleen N. Williams, Washington, D.C., DHEW-HRA, BHRD, August 1973; (*b*) The American Medical Association and its published statistics; (*c*) Annual reports and other communications of the Educational Council for Foreign Medical Graduates; (*d*) The National Board of Medical Examiners.

The task force restricted its concern to those problem areas of foreign medical graduates which fall within the sphere of responsibility and authority of the membership of the Association. For this reason the report of the task force intentionally is limited to issues of education and quality of medical services, two areas of particular concern to the AAMC.

The AAMC Executive Council approved the full report on March 22, 1974, and an amendment to the report on June 21, 1974.

Background and Introduction

Throughout the history of the United States immigration has contributed towards the overall development of the work force in the country. The medical profession has been no exception. However, the arrival of physicians educated abroad and their integration in the United States systems of medical education and service have reached unusual proportions in recent years. Furthermore, many American college graduates have sought medical education abroad and are now beginning to return home with a medical degree earned in a foreign country. These students add a domestic dimension to problems which stem from the rapidly increasing number of foreign medical graduates (FMGs)* entering the country and being licensed to practice. The complexity of education, accreditation, and licensure in medicine further complicates the situation.

The Phenomenon

The basic trend of admitting FMGs into the United States is represented in Table 1. It shows that in a little over a decade the rate of increase in the number of FMGs in the United States has been four times greater than the rate of increase in the total physician supply. FMGs are approaching 20 percent of all physicians, and one-third of all internship and residency training posts are filled by them. In 1972 more graduates of foreign medical schools entered the United States than physicians were graduated by our own schools, and 46 percent of all newly licensed physicians in that year were FMGs.

The Immigration and Naturalization Act amendments of 1965 have had a major impact on the migration of FMGs to the United States. Termination of the national origins quota system previously in effect opened avenues of entry to the United States for physicians trained in countries where, even in the face of major unmet health needs, the available physician supply appeared to exceed effective economic demand. In addition, preferential immigration status was assigned to professional and occupational skills presumed to be in short supply nationwide, including medicine and other health skills. The result was that physicians from developing countries began to take advantage of the opportunity to immigrate to the United States regardless of their ability to meet licensure requirements in this country.

Foreign-born FMGs are admitted to the United States both as immigrants (permanent residents) and as nonimmigrants (primarily exchange visitors). In the 11 years ending June 1972, over 50,700 physicians entered this country as exchange visitors, the great majority for graduate medical education. During 1967–1970 about 44 percent of all physicians entering the United States have been immigrants and 52 percent exchange visitors. This has begun to change, however. In 1971 and 1972 more physicians were admitted as immigrants (53 and 63 percent respectively) than as exchange visitors. A major portion of these admitted immigrants, however, were FMGs who converted from nonimmigrant status while residing in this country. Legislation in

* For the purpose of this document a foreign medical graduate is a physician who has completed the requirements for graduation from medical school and for practice in a country outside the United States, Canada, and Puerto Rico.

TABLE 1

TEN-YEAR TREND IN ADMISSION, EMPLOYMENT, AND LICENSURE OF FMGS AND GRADUATES OF DOMESTIC MEDICAL SCHOOLS

	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973
ECFMG Data												
Exams Administered	14,535	19,130	18,511	18,337	18,988	19,188	19,548	22,598	29,950	31,033	32,072	37,023
Candidates Passed	6,054	6,043	6,820	7,724	7,842	8,770	7,774	8,127	11,916	9,693	12,837	12,289
FMGs Certified	*	*	*	*	6,699	5,364	6,142	4,686	5,436	6,886	8,712	6,227
Admission to U S.												
Exchange Visa	3,970	4,637	4,518	4,160	4,370	5,204	5,701	4,460	5,008	4,784	3,935	4,613
Immigrants	1,297	2,093	2,249	2,012	2,552	3,326	3,128	2,756	3,158	5,756	7,143	7,119
Total†	5,767	6,730	6,767	6,172	6,922	8,897	9,125	7,515	8,523	10,947	11,416	12,285
U S Graduates	7,168	7,264	7,336	7,409	7,574	7,743	7,973	8,059	8,367	8,974	9,551	10,391
Graduate Medical Education												
Interns: U.S.	6,900	7,136	7,070	7,296	7,309	7,573	7,506	7,194	7,869	8,213	8,120	7,239
FMG	1,273	1,669	2,566	2,821	2,361	2,793	2,913	3,270	2,939	3,339	3,946	3,924
Total	8,173	8,805	9,636	10,097	9,670	10,366	10,419	10,464	10,808	11,552	12,066	11,163
Residents. U.S.	21,914	22,177	22,433	22,852	22,765	22,548	23,116	23,816	25,013	26,495	28,970	30,610
FMG	7,723	7,062	7,052	8,153	9,133	9,502	10,627	11,231	12,126	12,968	13,543	14,471
Total	29,637	29,239	29,485	31,005	31,898	32,050	33,743	35,047	37,139	39,463	42,512	45,081
Licensed to Practice												
U.S Graduates	6,648	6,832	6,605	7,619	7,217	7,267	7,581	7,671	8,016	7,943	7,815	*
FMGs	1,357	1,451	1,306	1,528	1,634	2,157	2,185	2,307	3,016	4,314	6,661	*
Total	8,005	8,283	7,911	9,147	8,851	9,424	9,766	9,978	11,032	12,257	14,476	*
Physicians in U.S.												
U S Graduates	*	245,550	*	*	*	*	*	271,390	276,811	282,609	288,525	*
FMGs	*	30,925	*	*	*	*	*	53,552	57,217	62,214	68,009	*
Total	268,000	276,475	284,224	292,088	303,375	308,630	317,032	324,942	334,028	344,823	356,534	*

* Figures not available.

† Beginning in 1967 the total includes other categories of nonimmigrant physicians

1970 facilitated this trend by eliminating the requirement that exchange visitors be absent from the United States for a period of two years after ending their studies, provided they were from countries where their special skills are not in short supply.

There is an emerging group of American-born FMGs who seek medical education abroad after failing to gain admission to a medical school in the United States. They request entry into the American medical education system at various stages of their training. Accurate figures regarding these students are not available, but it is estimated that as many as 6,000 students are currently enrolled in medical schools abroad, compared with 50,716 students in American medical schools in September 1973. According to a recent survey carried out by the Division of Manpower Intelligence of the Bureau of Health Resources Development, in 1971–72 medical schools of Latin American universities had 2,045 American students enrolled, 91 percent of whom were at the Universidad Autonoma de Guadalajara in Mexico. In 1970 the AAMC initiated the Coordinated Transfer Application System (COTRANS) which arranges for qualified American students to take Part I of the examination of the National Board of Medical Examiners (NBME) and apply for transfer into a United States medical school. As of May 1973 a total of 442 American students had been admitted through this mechanism to domestic medical schools for advanced standing.

Evaluation of FMGs for Admission

Admission to graduate medical education programs and to state licensure examinations generally is predicated on the fact that the graduate has met the education requirements of an accredited medical school in the United States or Canada. Before 1955 the Council on Medical Education of the AMA attempted to approximate the system of evaluating medical education in the United States by preparing a list of foreign medical schools considered of sufficient quality for graduates to be admitted into domestic graduate medical education programs. Because this practice proved unsatisfactory, the Educational Council for Foreign Medical Graduates (ECFMG) was established as an independent agency sponsored by the AAMC, the American Hospital Association, the Association of Hospital Medical Educators, the American Medical Association, and the Federation of State Medical Boards to develop a system of certifying minimal educational accomplishments of FMGs. For certification the ECFMG uses two criteria—proof that the candidate has fulfilled all requirements of a medical school listed in the *World Directory of Medical Schools* published by the World Health Organization and a satisfactory score on an examination furnished by the National Board of Medical Examiners. The examination is prepared by a test committee from questions provided by the NBME. Eighty percent of the questions are taken from Part II of the NBME examination.

Since its inception in 1958 the ECFMG has organized a worldwide network of 178 examination centers in which a cumulative total of 313,885 examinations has been given to 178,325 candidates. The overall pass rate, including all repeaters, through 1972 is 67 percent. Upon the first try 45 percent obtain a passing score, while a decreasing percentage of those who fail in the first attempt pass in subsequent tries. There is great variation in performance of FMGs from different countries and from different schools within some countries.

Some Characteristics of FMGs

Country of origin—Until recently the majority of FMGs came from European or other countries with standards of medical education similar to those in this country. As a consequence of the amendments to the Immigration and Naturalization Act passed by Congress in 1965, the number of physician immigrants from Asian and other developing countries increased rapidly. As Table 2 shows, 27 and 12 percent of the 2,093 physician immigrants came from Europe and Asia respectively in 1963, while the corresponding figures for 1972 were 13 and 70 percent out of a total 7,143 FMGs. This represents a major shift in nationality of physicians coming to the United States and also in the nature and quality of their medical education because one should not expect medical education offered in developing countries to be the same as that of economically and technically developed nations.

Performance—In objective-type examinations FMGs perform at a lower level than do graduates from American medical schools. Thus, in the past few years the failure rate in the ECFMG examination (score below 75) has varied from 67.4 to 56.9 percent, while students or graduates of American schools have had a failure rate of 14 percent on Part I and 2.5 percent on Part II of the NBME examination. In FLEX (Federation Licensure Examination) 50 percent of FMGs have passed versus 85 percent of graduates from American schools. In specialty board examinations the failure rate in 1972 was 63 percent for FMGs and 27 percent for domestic graduates. It must be emphasized that there is a much wider spread of performance with FMGs and that some perform as well as domestic graduates. It is generally acknowledged, though not proven, that the medical care rendered by some FMGs is of poorer quality than that rendered by graduates from domestic schools. American FMGs have a similar if not greater failure rate in the ECFMG examination than foreign-born FMGs. This suggests that language difficulties do not significantly influence performance in standardized examinations of this kind.

Specialty and geographic distribution—As shown in Table 3, FMGs are distributed by specialty in much the same way as physicians educated in the United States. They are concentrated largely in the five major specialties and general practice chosen by United States graduates. Approximately 52 percent of FMGs versus 57 percent of graduates from domestic medical schools select internal medicine, pediatrics, general surgery, obstetrics and gynecology, psychiatry, and general practice.

Proportionally more FMGs are in specialties such as anesthesiology and physical medicine, while fewer FMGs are in dermatology and orthopedic surgery. In addition, FMGs are disproportionately found in some residency programs.

TABLE 2

COUNTRY OR REGION OF FMGs EMIGRATING TO UNITED STATES, 1963 AND 1972

Year	Europe		Canada		Latin America*		Asia		Other†		Total No
	No	Percent	No	Percent	No.	Percent	No	Percent	No.	Percent	
1963	575	27.5	467	22.3	580	27 7	260	12 4	211	10.1	2,093
1972	911	12.7	439	6.4	372	5.1	4,996	69 9	425	5.9	7,143

* Includes South America, Mexico, and Cuba.

† Includes Africa, Oceania, and selected countries of the Americas.

TABLE 3

SELECTED SPECIALTY DISTRIBUTION OF FMGs AND U.S. MEDICAL GRADUATES AS OF 1970

Specialty	All Physicians		Foreign Medical Graduates*		U S Medical Graduates	
	No	Percent	No	Percent	No.	Percent
Internal Medicine	41,872	12.5	6,894	10.9	34,978	12.9
Pediatrics	17,941	5.4	3,787	6.0	14,154	5.2
General Surgery	29,761	8 9	5,748	9 1	24,013	8.9
Obstetrics-Gynecology	18,876	5 6	3,403	5.4	15,473	5.7
Psychiatry	21,146	6 3	5,588	8.7	15,558	5 8
Subtotal 1	129,596	38.8	25,420	40.1	104,176	38.5
General Practice	57,948	17.3	7,512	11.9	50,436	18.6
Subtotal 2	187,544	56.1	32,932	52.0	154,612	57.1
Other	146,484	43.9	30,459	48.0	116,025	42.9
Total	334,028	100.0	63,391	100.0	270,637	100.0

* Including graduates from Canadian medical schools.

For example, residencies in general practice, physical medicine, colon and rectal surgery, anesthesiology, and pathology are more than 50 percent filled by FMGs. This may imply in the future a smaller supply of physicians born and educated in the United States for these specialties.

Therefore, in the aggregate FMGs are distributed along the same lines as our own graduates, although for certain specialties there is a differential distribution between FMGs and graduates from domestic medical schools. It remains to be seen whether this differential in enrollment in residency programs will have any impact on specialty distribution in practice at a later time.

The participation of FMGs in the practice of medicine has further distorted the geographic distribution of physician manpower in this country. It has been shown that they follow a similar pattern as that of physicians educated in the United States and tend to concentrate in cities.

State institutions—In many states the demand of public institutions for physicians is accommodated by special licensure provisions for FMGs not fully qualified to practice. The extent to which these FMGs are employed and the impact of their activities on medical care are not known. However, anecdotal evidence suggests that much health care delivery in the public sector depends on physicians not fully qualified but willing to accept working conditions and income levels qualified physicians will not accept.

Academic medicine—Many FMGs have entered careers in academic medicine in this country. Usually these are physicians who either already have established a reputation in their home country and found the working conditions more attractive in an American institution or have demonstrated unusual capabilities within an American graduate program and entered into an academic career in this country. In 1970 there were 4,291* FMGs in academic positions (including medical education and research) representing 7.5 percent of all FMGs in the United States at that time. This percentage is slightly greater than that of United States medical graduates (about 5 percent). In 1971-72 our medical schools had 4,165 FMGs out of a total of 22,611 salaried physicians on their full-time and part-time academic staff. The contribution of FMG scientists to American medical science has been substantial.

* This figure includes U. S. born FMGs.

Dual Standards

The present policy for certifying FMGs has led to a system of dual standards for admission to graduate medical education in this country. To illustrate, Figure 1 gives a graphic representation of the three programs in the continuum of medical education offered in the United States. It shows that the quality of the student's educational experience and performance is ascertained by the following:

1. Accreditation on a national or regional basis of the three required education programs offered consecutively by a college or university, a medical school, and a teaching hospital.

2. Selection of students for each program on the basis of performance in the previous program or scores obtained in national entrance examinations and broader judgment by a selection committee of the institution.

3. Internal evaluation of the student by the faculty in a continuing fashion and final certification by the faculty for awarding the degree.

4. External evaluation of the student by Parts I and II of the NBME examina-

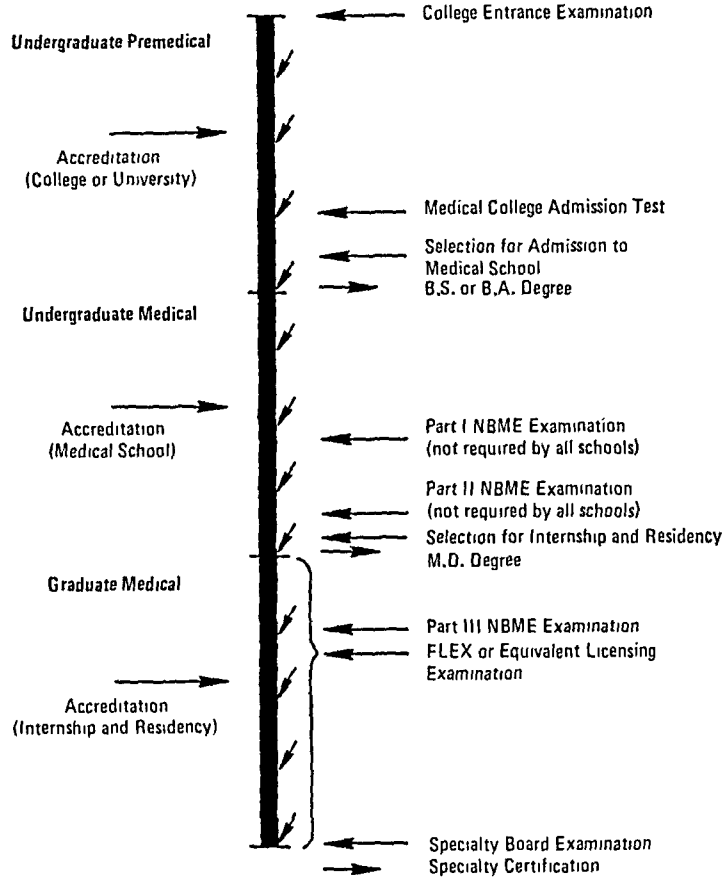

FIGURE 1
Continuum of medical education. The points at which selection and internal and external evaluation of the student occur are indicated at right. Accreditation of the programs is indicated at left. The arrows on the bar indicate internal evaluation.

tion (83 of 116 medical schools require the student to take the NBME examination, while 26 of these schools make a passing score a requirement for promotion or graduation).

5. External evaluation for licensure through FLEX (unless the candidate has already received a passing score on the NBME examination) and for specialty certification by specialty board examination.

The majority of FMGs now applying for admission to graduate medical education has not been screened by equivalent selective internal and external evaluation processes. Furthermore, with notable exceptions, in most countries there is no accreditation system similar to our system. In general, the intensity and quality of the learning experience in the United States are attained by a high faculty student ratio, adequate educational and clinical resources, a competitive situation, and the exposure of the student to the institution's research atmosphere. Finally, by incorporating the student into the medical care programs of the teaching hospital, U.S. medical schools guarantee the American student a participatory role in clinical medicine, while in most schools abroad the clinical student is an onlooker. It may be concluded that while many medical schools abroad are outstanding and excel in many of these same features, the U.S. medical school provides a more intensive learning experience to the student than those institutions from which a large proportion of the FMGs have graduated. Beginning with the extensive premedical education in colleges, the U.S. educational continuum results in a physician-graduate of considerable personal maturity and professional sophistication in the art and science of medicine.

The present mechanism by which FMGs are admitted into graduate medical education programs implies that the ECFMG examination is a substitute for assessing the quality of the educational process over a period of four to six years and for selecting and evaluating the student for admission and promotion during this period. In reality, there is no examination available for measuring professional competence. Hence, we are faced with dual standards for admission and are condoning the evolution of a dual system of graduate medical education. Currently, a little over one-half of the physicians entering the American system are products of accredited U.S. medical schools, while the balance for the most part represents products of unaccredited education systems. This double standard results in wide disparity in the quality of the physicians admitted to deliver care in the United States. It undermines the process of quality medical education in this country and ultimately poses a threat to the quality of care delivered to the people.

Problems Facing FMGs

The notion that American medical education is rendering a service to foreign doctors by permitting them to enter our system in large numbers must be challenged on several counts. The FMG coming to this country faces difficult and disadvantageous conditions which in many instances offset the potential benefits to be gained from entering the education system. Some of these problem areas are: (*a*) differences in culture and daily life resulting in isolation; (*b*) learning of a new language; (*c*) acceptance into a setting which imposes excessive responsibility for patient care without adequate supervision and educational content; (*d*) general stigma associated with the status of being an FMG and, therefore, lack of full acceptance on a professional basis; (*e*) need to accept positions under un-

favorable working conditions and with relatively low salary; (*f*) acceptance of lower performance level; (*g*) fear and threat of failure.

The present system of accepting FMGs into the United States and incorporating them into our medical education and care systems has created a category of second-class physicians. From an educational and ethical point of view, this is undesirable.

The Task Force's Response

In reviewing the benefits and problems which accompany the admission of FMGs to the United States, the task force considered many approaches. Although the prohibition of medical practice by FMGs could be considered a possible solution, the long history and ideals of the United States regarding immigration policy make this unacceptable. It was agreed that any recommendations should be in accord with two major considerations, namely that:

1. Medical schools in the United States presently are able to identify outstanding candidates for educational programs which prepare physicians, provide programs of quality medical education to students of medicine, and deliver highly qualified physicians in sufficient numbers into the medical care system of this country. With the rapid increase of enrollment by students in our medical schools (15,000 by September 1975), it is anticipated that our basic need for physicians in the 1980s presumably can be satisfied from domestic sources. If the anticipated number of graduates is insufficient to meet our nationally conceived need for physicians, adequately planned and financed programs should be initiated to increase further the class size of domestic medical schools. It seems inappropriate that the United States with its existing resources should depend to any significant degree on physicians supplied by education systems of other countries.

2. The dual standards in admission of U.S. and foreign medical graduates must be reduced in the interest of quality of medical education and care as well as for the benefit of foreign graduates who come to this country to achieve medical excellence. Ultimately nobody can gain from the continued existence of two classes of physicians.

The task force is aware of the consequences that corrective measures may have on the number of FMGs gaining admission to graduate medical education in the United States. Because the implications of the present trend are so vast, it recommends that steps be taken to minimize the difference in admission standards between graduates of domestic and foreign medical schools, in spite of the fact that complete equality cannot be achieved rapidly and that some hospitals will be faced with a shortage of house staff during an intermediary period of time. The recommendations do not address themselves to the licensing process except for the loopholes which permit unqualified FMGs institutional medical practice without adequate supervision.

The task force recognizes the similarity between these recommendations and those made by the National Advisory Commission on Health Manpower in 1967 (*Report of the National Advisory Commission on Health Manpower* [Vol. II]. Washington, D.C.: U.S. Government Printing Office, 1967, Pp. 71–81). For their implementation, close collaboration among concerned government and private agencies is required. The task force urges the AAMC to initiate such concerted action.

Recommendations

The task force recommends the following policies to the AAMC for adoption and implementation by the constituency in collaboration with related agencies:

1. *Physician manpower*—Medical schools of the United States must become the major source for educating physicians to satisfy the need for physician services to the American people. This country should not depend for its supply of physicians to any significant extent on the immigration of FMGs or on the training of its own citizens in foreign medical schools. If the anticipated need for physicians exceeds present or future enrollment in our medical schools, appropriate measures including adequate funding must be taken to enlarge the student body accordingly. Since there is a delay of seven to 10 years until a corrective increase in first-year medical school admissions first becomes manifest in terms of physician manpower, a continuing analysis of our physician needs is called for.

2. *Admission criteria*—The process of certifying FMGs for admission to graduate medical education programs in the United States is inequitable and inadequate. In order to apply the same standards to all medical graduates, it is recommended that a generally acceptable qualifying examination be developed as rapidly as possible and be made a universal requirement for admitting all physicians to approved programs of graduate medical education. Until such an examination becomes available, Parts I and II of the NBME examination or the FLEX examination should be required. FMGs can register for these examinations only after having demonstrated an acceptable command of spoken and written English.

3. *Approval of programs of graduate medical education*—In order to ensure all medical graduates of a continuing exposure to quality education, regulations for the approval of programs of graduate medical education must be strictly enforced. The regulations should emphasize the educational function of these programs. In addition, the relative number of FMGs permitted in any program should be limited and geared to the educational resources of the program. Effective adaptation and enculturation cannot be expected unless special efforts are made and there is a balance between American and foreign graduates in the program. Since undergraduate and graduate medical education are considered integral parts of an educational continuum, it is also recommended that the number of first-year positions in approved programs of graduate medical education be adjusted gradually so as to exceed only slightly the expected number of graduates from domestic medical schools and to provide sufficient opportunities to highly qualified FMGs.

4. *Pilot project*—Because examinations to determine the professional competence of the physician are still in a developing stage, it is recommended that a pilot project be initiated for the enrollment of a limited number of FMGs as students in modified undergraduate medical education programs in U.S. institutions. The objectives of this project to be undertaken by the AAMC and interested medical schools are to identify the educational deficiencies of FMGs and provide supervised learning experiences to correct these deficits with the goal of bringing the FMG to a level of professional com-

petence similar to that reached by graduates of domestic schools. In this project preference should be given to U.S. citizens and may include American students enrolled in foreign medical schools qualified for participation in the COTRANS program.

5. *Loopholes*—On the basis of temporary licenses or exemptions from licensure provisions, a large but unknown number of FMGs are delivering medical services in institutional settings such as state institutions and other medical service organizations. They are active in this capacity without having qualified either for graduate medical education or licensure. The indefinite continuation of unsupervised medical practice on this basis without involvement in approved graduate medical education should be discontinued. It is recommended that the AAMC join with the American Hospital Association, the American Medical Association, and other agencies to bring this problem to the attention of the Federation of State Medical Boards in a concerted effort to seek and implement appropriate solutions.

6. *Hospital patient care services*—These recommendations when implemented undoubtedly will reduce the number of FMGs qualified for appointment to positions in graduate medical education. Therefore, new methods must be developed to ensure patient care services in many hospitals. The task force believes that other health care personnel can be trained to provide under physician supervision many of the services now required to be rendered by physicians. Projects to study and demonstrate the engagement of such personnel in institutional care settings should be undertaken immediately. Ultimately, the efficient utilization of such personnel depends on appropriate education of the health care team, particularly physicians, and thus is a conjoint responsibility of medical and other health profession faculties.

7. *Special categories*—The task force recognizes two categories of FMGs which require special consideration. The first category includes FMGs who are seeking limited educational objectives in this country with the full intent of returning to their home country. They may be accepted into special programs without the qualifications contained in the second recommendation of this report, provided these trainees are not permitted to assume any independent patient care obligations and provided the training thus obtained is not credited towards specialty board qualification in this country.

The second group encompasses FMGs who have established reputations as medical academicians and are appointed by medical schools as visiting scholars. Unless the respective state licensing boards prescribe differently, temporary exemptions from the requirement specified under recommendation two should be accorded these FMGs provided they are visiting members of a medical faculty and their involvement in the practice of medicine is limited to patient care related to their teaching obligations. The granting of these exemptions should be based on a policy agreed upon nationally and should cover a delimited period of time. FMGs who serve on medical faculties as teachers and scientists without patient obligations including supervision of those who render patient care do not fall within the purview of these recommendations.

8. *Timetable*—In establishing a timetable for implementation of these recommendations, considerations must be given to a broad range of consequences, including educational policies of our medical schools, maintenance of undisrupted patient care services within and without teaching hospitals, and cost.

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Throughout the history of the United States immigration has contributed toward the overall development of the work force in the country. The medical profession has been no exception. However, the arrival of physicians educated abroad and their integration in the United States systems of medical education and service have reached unusual proportions in recent years. Furthermore, many American college graduates have sought medical education abroad and are now beginning to return home with a medical degree earned in a foreign country. These students add a domestic dimension to problems which stem from the rapidly increasing number of foreign medical graduates (FMGs)* entering the country and being licensed to practice. The complexity of education, accreditation, and licensure in medicine further complicates the situation.

The Phenomenon

The basic trend of admitting FMGs into the United States is represented in Table 1. It shows that in a little over a decade the rate of increase in the number of FMGs in the United States has been four times greater than the rate of increase in the total physician supply. FMGs are approaching 20 percent of all physicians, and one-third of all internship and residency training posts are filled by them. In 1972 more graduates of foreign medical schools entered the United States than physicians were graduated by our own schools, and 46 percent of all newly licensed physicians in that year were FMGs.

The Immigration and Naturalization Act amendments of 1965 have had a major impact on the migration of FMGs to the United States. Termination of the national origins quota system previously in effect opened avenues of entry to the United States for physicians trained in countries where, even in the face of major unmet health needs, the available physician supply appeared to exceed effective economic demand. In addition, perferential immigration status was assigned to professional and occupational skills presumed to be in short supply nationwide, including medicine and other health skills. The result was that physicians from developing countries began to take advantage of the opportunity to immigrate to the United States regardless of their ability to meet licensure requirements in this country.

Foreign-born FMGs are admitted to the United States both as immigrants (permanent residents) and as nonimmigrants (primarily exchange visitors). In the 11 years ending June 1972, over 50,700 physicians entered this country as exchange visitors, the great majority for graduate medical education. During 1967-1970 about 44 percent of all physicians entering the United States have been immigrants and 52 percent exchange visitors. This has begun to change,

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* For the purpose of this document a foreign medical graduate is a physician who has completed the requirements for graduation from medical school and for practice in a country outside the United States, Canada, and Puerto Rico.

however. In 1971 and 1972 more physicians were admitted as immigrants (53 and 63 percent respectively) than as exchange visitors. A major portion of these admitted immigrants, however, were FMGs who converted from nonimmigrant status while residing in this country. Legislation in 1970 facilitated this trend by eliminating the requirement that exchange visitors be absent from the United States for a period of two years after ending their studies, provided they were from countries where their special skills are not in short supply.

There is an emerging group of American-born FMGs who seek medical education abroad after failing to gain admission to a medical school in the United States. They request entry into the American medical education system at various stages of their training. Accurate figures regarding these students are not available, but it is estimated that as many as 6,000 students are currently enrolled in medical schools abroad compared with 50,716 students in American medical schools in September of 1973. According to a recent survey carried out by the Division of Manpower Intelligence of the Bureau of Health Resources Development, in 1971-1972 medical schools of Latin American universities had 2,045 American students enrolled, 91 percent of whom were at the Universidad Autonoma de Guadalajara in Mexico. In 1970 the AAMC initiated the Coordinated Transfer Application System (COTRANS) which arranges for qualified American students to take Part I of the examination of the National Board of Medical Examiners (NBME) and apply for transfer into a United States medical school. As of May 1973 a total of 442 American students had been admitted through this mechanism to domestic medical schools for advanced standing.

Evaluation of FMGs for Admission

Admission to graduate medical education programs and to state licensure examinations generally is predicated on the fact that the graduate has met the education requirements of an accredited medical school in the United States or Canada. Before 1955 the Council of Medical Education of the AMA attempted to approximate the system of evaluating medical education in the United States by preparing a list of foreign medical schools considered of sufficient quality for graduates to be admitted into domestic graduate medical education programs. Because this practice proved unsatisfactory, the Educational Council for Foreign Medical Graduates (ECFMG) was established as an independent agency sponsored by the AAMC, the American Hospital Association, the Association of Hospital Medical Educators, the American Medical Association, and the Federation of State Medical Boards to develop a system of certifying minimal educational accomplishments of FMGs. For certification the ECFMG uses two criteria -- proof that the candidate has fulfilled all requirements of a medical school listed in the *World Directory of Medical Schools* published by the World Health Organization and a satisfactory score on an examination furnished by the National Board of Medical Examiners. The examination is prepared by a test committee from questions provided by the NBME. Eighty percent of the questions are taken from Part II of the NBME examination.

Since its inception in 1958 the ECFMG has organized a worldwide network of 178 examination centers in which a cumulative total of 313,885 examinations has been given to 178,325 candidates. The overall pass rate including all repeaters through 1972 is 67 percent. Upon the first try 45 percent obtain a passing score, while a decreasing percentage of those who fail in the first attempt pass in subsequent tries. There is great variation in performance of FMGs from different countries and from different schools within some countries.

Some Characteristics of FMGs

Country of Origin -- Until recently the majority of FMGs came from European or other countries with standards of medical education similar to those in this country. As a consequence of the amendments to the Immigration and Naturalization Act passed by Congress in 1965, the number of physician immigrants from Asian and other developing countries increased rapidly. As Table 2 shows, 27 and 12 percent of the 2,093 physician immigrants came from Europe and Asia respectively in 1963, while the corresponding figures for 1972 were 13 and 70 percent out of a total 7,143 FMGs. This represents a major shift in nationality of physicians coming to the United States and also in the nature and quality of their medical education because one should not expect medical education offered in developing countries to be the same as that of economically and technically developed nations.

Performance -- In objective-type examinations FMGs perform at a lower level than do graduates from American medical schools. Thus, in the past few years the failure rate in the ECFMG examination (score below 75) has varied from 67.4 to 56.9 percent, while students or graduates of American schools have had a failure rate of 14 percent on Part I and 2.5 percent on Part II of the NBME examination. In FLEX (Federation Licensure Examination) 50 percent of FMGs have passed versus 85 percent of graduates from American schools. In specialty board examinations the failure rate in 1972 was 63 percent for FMGs and 27 percent for domestic graduates. It must be emphasized that there is a much wider spread of performance with FMGs and that some perform as well as domestic graduates. It is generally acknowledged, though not proven, that the medical care rendered by some FMGs is of poorer quality than that rendered by graduates from domestic schools. American FMGs have a similar if not greater failure rate in the ECFMG examination than foreign-born FMGs. This suggests that language difficulties do not significantly influence performance in standardized examinations of this kind.

Specialty and Geographic Distribution -- As shown in Table 3, FMGs are distributed by specialty in much the same way as physicians educated in the United States. They are concentrated largely in the five major specialties and general practice chosen by United States graduates. Approximately 52 percent of FMGs versus 57 percent of graduates from domestic medical schools select internal medicine, pediatrics, general surgery, obstetrics and gynecology, psychiatry, and general practice.

Proportionally more FMGs are in specialties such as anesthesiology and physical medicine, while fewer FMGs are in dermatology and orthopedic surgery. In addition, FMGs are disproportionately found in some residency programs. For example, residencies in general practice, physical medicine, colon and rectal surgery, anesthesiology, and pathology are more than 50 percent filled by FMGs. This may imply in the future a smaller supply of physicians born and educated in the United States for these specialties.

Therefore, in the aggregate FMGs are distributed along the same lines as our own graduates, although for certain specialties there is a differential distribution between FMGs and graduates from domestic medical schools. It remains to be seen whether this differential in enrollment in residency programs will have any impact on specialty distribution in practice at a later time.

The participation of FMGs in the practice of medicine has further distorted the geographic distribution of physician manpower in this country. It has been shown that they follow a similar pattern as that of physicians educated in the United States and tend to concentrate in cities.

State Institutions -- In many states the demand of public institutions for physicians is accommodated by special licensure provisions for FMGs not fully qualified to practice. The extent to which these FMGs are employed and the impact of their activities on medical care are not known. However, anecdotal evidence suggests that much health care delivery in the public sector depends on physicians not fully qualified but willing to accept working conditions and income levels qualified physicians will not accept.

Academic Medicine -- Many FMGs have entered careers in academic medicine in this country. Usually these are physicians who either already have established a reputation in their home country and found the working conditions more attractive in an American institution or have demonstrated unusual capabilities within an American graduate program and entered into an academic career in this country. In 1970 there were 4,291* FMGs in academic positions (including medical education and research) representing 7.5 percent of all FMGs in the United States at that time. This percentage is slightly greater than that of United States medical graduates (about 5 percent). In 1971-72 our medical schools had 4,165 FMGs out of a total of 22,611 salaried physicians on their full-time and part-time academic staff. The contribution of FMG scientists to American medical science has been substantial.

Dual Standards

The present policy for certifying FMGs has led to a system of dual standards for admission to graduate medical education in this country. To illustrate, Figure 1 gives a graphic representation of the three programs in the continuum of medical education offered in the United States. It shows that the quality of the student's educational experience and performance is ascertained by the following:

1. Accreditation on a national or regional basis of the three required education programs offered consecutively by a college or university, a medical school, and a teaching hospital.

2. Selection of students for each program on the basis of performance in the previous program, or scores obtained in national entrance examinations and broader judgement by a selection committee of the institution.

3. Internal evaluation of the student by the faculty in a continuing fashion and final certification by the faculty for awarding the degree.

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* This figure includes U.S. born FMGs.

4. External evaluation of the student by Parts I and II of the NBME examination (83 of 116 medical schools require the student to take the NBME examination, while 26 of these schools make a passing score a requirement for promotion or graduation).

5. External evaluation for licensure through FLEX (unless the candidate has already received a passing score on the NBME examination) and for specialty certification by specialty board examination.

The majority of FMGs now applying for admission to graduate medical education has not been screened by equivalent selective internal and external evaluation processes. Furthermore, with notable exceptions, in most countries there is no accreditation system similar to our system. In general, the intensity and quality of the learning experience in the United States are attained by a high faculty student ratio, adequate educational and clinical resources, a competitive situation, and the exposure of the student to the institution's research atmosphere. Finally, by incorporating the student into the medical care programs of the teaching hospital, U.S. medical schools guarantee the American student a participatory role in clinical medicine, while in most schools abroad the clinical student is an onlooker. It may be concluded that while many medical schools abroad are outstanding and excel in many of these same features, the U.S. medical school provides a more intensive learning experience to the student than those institutions from which a large proportion of the FMGs have graduated. Beginning with the extensive premedical education in colleges, the U.S. educational continuum results in a physician-graduate of considerable personal maturity and professional sophistication in the art and science of medicine.

The present mechanism by which FMGs are admitted into graduate medical education programs implies that the ECFMG examination is a substitute for assessing the quality of the educational process over a period of four to six years and for selecting and evaluating the student for admission and promotion during this period. In reality, there is no examination available for measuring professional competence. Hence, we are faced with dual standards for admission and are condoning the evolution of a dual system of graduate medical education. Currently, a little over one-half of the physicians entering the American system are products of accredited U.S. medical schools, while the balance for the most part represents products of unaccredited education systems. This double standard results in wide disparity in the quality of the physicians admitted to deliver care in the United States. It undermines the process of quality medical education in this country and ultimately poses a threat to the quality of care delivered to the people.

Problems Facing FMGs

The notion that American medical education is rendering a service to foreign doctors by permitting them to enter our system in large numbers must be challenged on several counts. The FMG coming to this country faces difficult and disadvantageous conditions which in many instances offset the potential benefits to be gained from entering the education system. Some of these problem areas are: *(a)* differences in culture and daily life resulting in isolation; *(b)* learning of a new language; *(c)* acceptance into a setting which imposes

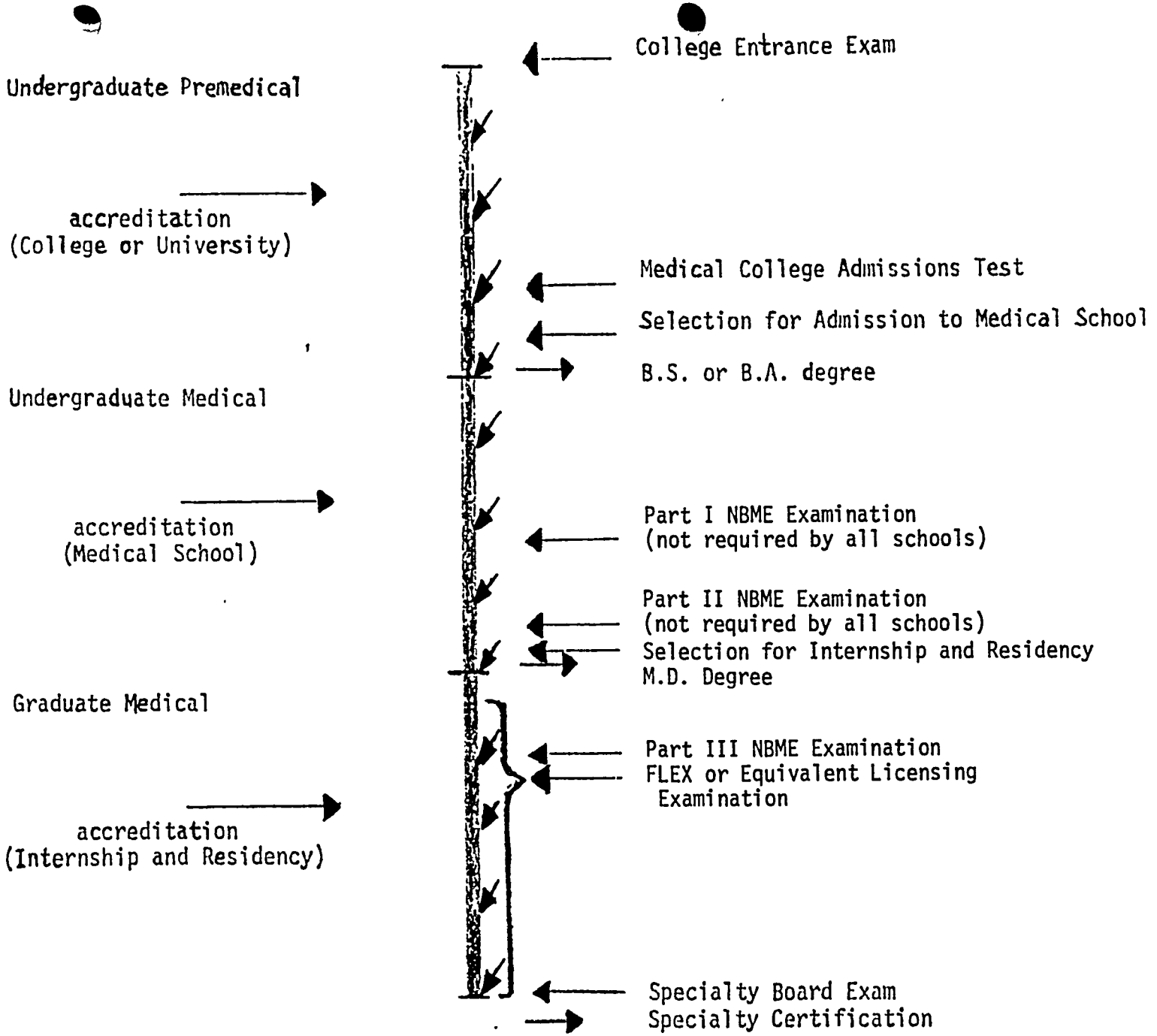

FIGURE 1

Continuum of medical education. The points at which selection and internal and external evaluation of the student occur are indicated at right. Accreditation of the programs is indicated at left. The arrows on the bar indicate internal

excessive responsibility for patient care without adequate supervision and educational content; *(d)* general stigma associated with the status of being an FMG and, therefore, lack of full acceptance on a professional basis; *(e)* need to accept positions under unfavorable working conditions and with relatively low salary; *(f)* acceptance of lower performance level; *(g)* fear and threat of failure.

The present system of accepting FMGs into the United States and incorporating them into our medical education and care system has created a category of second-class physicians. From an educational and ethical point of view, this is undesirable.

The Task Force's Response

In reviewing the benefits and problems which accompany the admission of FMGs to the United States, the task force considered many approaches. Although the prohibition of medical practice by FMGs could be considered a possible solution, the long history and ideals of the United States regarding immigration policy make this unacceptable. It was agreed that any recommendations should be in accord with two major considerations, namely that:

1. Medical schools in the United States presently are able to identify outstanding candidates for educational programs which prepare physicians, provide programs of quality medical education to students of medicine, and deliver highly qualified physicians in sufficient numbers into the medical care system of this country. With the rapid increase of enrollment by students in our medical schools (15,000 by September 1975), it is anticipated that our basic need for physicians in the 1980s presumably can be satisfied from domestic sources. If the anticipated number of graduates is insufficient to meet our nationally conceived need for physicians, adequately planned and financed programs should be initiated to increase further the class size of domestic medical schools. It seems inappropriate that the United States with its existing resources should depend to any significant degree on physicians supplied by education systems of other countries.

2. The dual standards in admission of U.S. and foreign medical graduates must be reduced in the interest of quality of medical education and care as well as for the benefit of foreign graduates who come to this country to achieve medical excellence. Ultimately nobody can gain from the continued existence of two classes of physicians.

The task force is aware of the consequences that corrective measures may have on the number of FMGs gaining admission to graduate medical education in the United States. Because the implications of the present trend are so vast, it recommends that steps be taken to minimize the difference in admission standards between graduates of domestic and foreign medical schools, in spite of the fact that complete equality cannot be achieved rapidly and that some hospitals will be faced with a shortage of house staff during an intermediary

period of time. The recommendations do not address themselves to the licensing process except for the loopholes which permit unqualified FMGs institutional medical practice without adequate supervision.

The task force recognizes the similarity between these recommendations and those made by the National Advisory Commission on Health Manpower in 1967 (*Report of the National Advisory Commission on Health Manpower* [Vol. II]. Washington, D.C.: U.S. Government Printing Office, 1967, Pp. 71-81). For their implementation, close collaboration among concerned government and private agencies is required. The task force urges the AAMC to initiate such concerted action.

RECOMMENDATIONS

The task force recommends the following policies to the AAMC for adoption and implementation by the constituency in collaboration with related agencies:

1. *Physician manpower* -- Medical schools of the United States must become the source for educating physicians to satisfy the need for physician services to the American people. This country should not depend for its supply of physicians to any significant extent on the immigration of FMGs or on the training of its own citizens in foreign medical schools. If the anticipated need for physicians exceeds present or future enrollment in our medical schools, appropriate measures including adequate funding must be taken to enlarge the student body accordingly. Since there is a delay of seven to 10 years until a corrective increase in first-year medical school admissions first becomes manifest in terms of physician manpower, a continuing analysis of our physician needs is called for.

2. *Admission criteria* -- The process of certifying FMGs for admission to graduate medical education programs in the United States is inequitable and inadequate. In order to apply the same standards to all medical graduates, it is recommended that a generally acceptable qualifying examination be developed as rapidly as possible and be made a universal requirement for admitting all physicians to approved programs of graduate medical education. Until such an examination becomes available, Parts I and II of the NBME examination or the FLEX examination should be required. FMGs can register for these examinations only after having demonstrated an acceptable command of spoken and written English.

3. *Approval of programs of graduate medical education* -- In order to ensure all medical graduates of a continuing exposure to quality education, regulations for the approval of programs of graduate medical education must be strictly enforced. The regulations should emphasize the educational function of these programs. In addition, the relative number of FMGs permitted in any program should be limited and geared to the educational resources of the program. Effective adaptation and enculturation cannot be expected unless special efforts are made and there is a balance between American and foreign graduates in the program. Since undergraduate and graduate medical education are considered integral parts of an educational continuum, it is also recommended that the number of first-year positions in approved programs of graduate medical education be adjusted gradually so as to exceed only slightly the expected number of graduates from domestic medical schools and to provide sufficient opportunities to highly qualified FMGs.

4. *Pilot project* -- Because examinations to determine the professional competence of the physician are still in a developing stage, it is recommended that a pilot project be initiated for the enrollment of a limited number of FMGs as students in modified undergraduate medical education programs in U.S. institutions. The objectives of this project to be undertaken by the AAMC and interested medical schools are to identify the educational deficiencies of FMGs and provide supervised learning experiences to correct these deficits with the goal of bringing the FMG to a level of professional competence similar to that reached by graduates of domestic schools. In this project preference should be given to U.S. citizens and may include American students enrolled in foreign medical schools qualified for participation in the COTRANS program.

5. *Loopholes* -- On the basis of temporary licenses or exemptions from licensure provisions, a large but unknown number of FMGs are delivering medical services in institutional settings such as state institutions and other medical service organizations. They are active in this capacity without having qualified either for graduate medical education or licensure. The indefinite continuation of unsupervised medical practice on this basis without involvement in approved graduate medical education should be discontinued. It is recommended that AAMC join with the American Hospital Association, the American Medical Association and other agencies to bring this problem to the attention of the Federation of State Medical Boards in a concerted effort to seek and implement appropriate solutions.

6. *Hospital patient care services* -- These recommendations when implemented undoubtedly will reduce the number of FMGs qualified for appointment to positions in graduate medical education. Therefore, new methods must be developed to ensure patient care services in many hospitals. The task force believes that other health care personnel can be trained to provide under physician supervision many of the services now required to be rendered by physicians. Projects to study and demonstrate the engagement of such personnel in institutional care settings should be undertaken immediately. Ultimately, the efficient utilization of such personnel depends on appropriate education of the health care team, particularly physicians, and thus in a conjoint responsibility of medical and other health profession faculties.

7. *Special categories* -- The task force recognizes two categories of FMGs which require special consideration. The first category includes FMGs who are seeking limited educational objectives in this country with the full intent of returning to their home country. They may be accepted into special programs without the qualifications contained in the second recommendation of this report, provided these trainees are not permitted to assume any independent patient care obligations and provided the training thus obtained is not credited toward specialty board qualification in this country.

The second group encompasses FMGs who have established reputations as medical academicians and are appointed by medical schools as visiting scholars. Unless the respective state licensing boards prescribe differently, temporary exemptions from the requirement specified under recommendation two should be accorded these FMGs provided they are visiting members of a medical faculty and their involvement in the practice of medicine is limited to patient care related to their teaching obligations. The granting of these exemptions should be based on a policy agreed upon nationally and should cover a delimited period of time. FMGs who serve on medical faculties as teachers and scientists without patient obligations including supervision of those who render patient care do not fall within the purview of these recommendations.

8. *Timetable* -- In establishing a timetable for implementation of these recommendations, considerations must be given to a broad range of consequences, including educational policies of our medical schools, maintenance of undisrupted patient care services within and without teaching hospitals, and cost.

Ten-Year Trend in Admission, Employment and Licensure of FMGs and Graduates of Domestic Medical Schools

	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973
ECFMG												
Exams Administered	14,535	19,130	18,511	18,337	18,988	19,188	19,548	22,598	29,950	31,033	32,072	37,023
Candidates Passed	6,054	6,043	6,820	7,724	7,842	8,770	7,774	8,127	11,916	9,693	12,837	12,289
FMGs Certified	°	°	°	°	6,699	5,364	6,142	4,686	5,436	6,886	8,712	6,227
Admission to U.S.												
Exchange Visa	3,970	4,637	4,518	4,160	4,370	5,204	5,701	4,460	5,008	4,784	3,935	4,613
Immigrants	1,297	2,093	2,249	2,012	2,552	3,326	3,128	2,756	3,158	5,756	7,143	7,119
Total*	5,767	6,730	6,767	6,172	6,922	8,897	9,125	7,515	8,523	10,947	11,416	12,285
U.S. Graduates	7,168	7,264	7,336	7,409	7,574	7,743	7,973	8,059	8,367	8,974	9,551	10,391
Graduate Medical Education												
Interns:												
U.S.	6,900	7,136	7,070	7,296	7,309	7,573	7,506	7,194	7,869	8,213	8,120	7,239
FMG	1,273	1,669	2,566	2,821	2,361	2,793	2,913	3,270	2,939	3,339	3,946	3,924
Total	8,173	8,805	9,636	10,097	9,670	10,366	10,419	10,464	10,808	11,552	12,066	11,163
Residents:												
U.S.	21,914	22,177	22,433	22,852	22,765	22,548	23,116	23,816	25,013	26,495	28,970	30,610
FMG	7,723	7,062	7,052	8,153	9,133	9,502	10,627	11,231	12,126	12,968	13,543	14,471
Total	29,637	29,239	29,485	31,005	31,898	32,050	33,743	35,047	37,139	39,463	42,512	45,081
Liscensed to Practice												
U.S. Graduates	6,648	6,832	6,605	7,619	7,217	7,267	7,581	7,671	8,016	7,943	7,815	°
FMGs	1,357	1,451	1,306	1,528	1,634	2,157	2,185	2,307	3,016	4,314	6,661	°
Total	8,005	8,283	7,911	9,147	8,851	9,424	9,766	9,978	11,032	12,257	14,476	°
Physicians in U.S.												
U.S. Graduates		245,550						271,390	276,811	282,609	288,525	°
FMGs		30,925						53,552	57,217	62,214	68,009	°
Total	268,000	276,475	284,224	292,088	303,375	308,630	317,032	324,942	334,028	344,823	356,534	°

* Beginning in 1967 the total includes other categories of non-immigrant physicians.

° Figures not available.

TABLE 2

Country or Region of FMGs Emigrating to United States, 1963 and 1972

Year	Europe		Canada		Latin America *		Asia		Other °		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	No.
1963	575	27.5	467	22.3	580	27.7	260	12.4	211	10.1	2093
1972	911	12.7	439	6.4	372	5.1	4996	69.9	425	5.9	7143

* Includes South America, Mexico and Cuba.
° Includes Africa, Oceania, and selected countries of the Americas.

TABLE 3

Selected Specialty Distribution of FMG's and U.S. Medical Graduates as of 1970

Specialty	All Physicians		Foreign Medical Graduates *		U.S. Medical Graduates	
	Number	Percent	Number	Percent	Number	Percent
Internal Medicine	41,872	12.5	6,894	10.9	34,978	12.9
Pediatrics	17,941	5.4	3,787	6.0	14,154	5.2
General Surgery	29,761	8.9	5,748	9.1	24,013	8.9
Obstetrics-Gynecology	18,876	5.6	3,403	5.4	15,473	5.7
Psychiatry	21,146	6.3	5,588	8.7	15,558	5.8
Subtotal 1	129,596	38.8	25,420	40.1	104,176	38.5
General Practice	57,948	17.3	7,512	11.9	50,436	18.6
Subtotal 2	187,544	56.1	32,932	52.0	154,612	57.1
Other	146,484	43.9	30,459	48.0	116,025	42.9
Grand Total	334,028	100.0	63,391	100.0	270,637	100.0

* Including graduates from Canadian medical schools.