The Visalaw.com Health Care Newsletter
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Siskind Susser serves immigration clients throughout the world from its offices in the US, Canada, Mexico, Argentina and the People's Republic of China. To schedule a consultation with the firm by telephone or in-person, go to http://www.visalaw.com/intake.html.

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1. Openers

Dear Readers:

After a hiatus, we resume publication of our health care newsletter this month and as you can see from the number of articles, there is much news to report. The major development, of course, since our last publication is the passage of a major health care reform bill this year that will extend insurance coverage to an estimated 30 million more Americans.

There are a number of immigration angles to this story. First, earlier this year, South Carolina Congressman Joe Wilson dramatically drew attention to the question of what eligibility illegally present immigrants will have for benefits under the new bill. The President told a joint session of Congress that such immigrants would not be eligible for benefits. Congressman Wilson yelled back to the President “you lie!” and this, of course, dominated the news for several days.

In fact, the President was telling the truth. Illegally present immigrants are not eligible for any benefits under the new law. Wilson and supporters later said they were talking about the punishment for people falsely claiming to be legal was not harsh enough which is hardly the same thing. Penalties were strengthened in response and that presumably has put the issue to rest. But this is a crazy, hyper-partisan age we live in so who knows?

The other question which has not garnered as much attention, but which is a very serious one is how exactly we’ll be able to provide health care to 30 million new people – the equivalent of the population of Canada – if we already have a severe shortage of doctors and other health care professionals. That question has largely been ignored by the legislation and the role immigration will play in providing these professionals has certainly not been addressed.

Of course, the future of health care reform is still up in the air with many questioning what impact a change in the leadership in either House of Congress could have on reform. That remains to be seen.

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In this issue, I'm including an article I've co-written with my colleague Elissa Taub that will hopefully help doctors who make one of the most critical choices in their American careers even before they arrive in the US – whether to seek an H-1B visa or J-1 for training. For the last few years, the H-1B has been the clearly preferred visa. But is that really the smartest choice today? I hope the article provides food for thought.

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We also include in this issue an article summarizing the immigration options available to nurses. Nursing immigration presents numerous challenges and the number of immigrating nurses to the US has declined in recent years due to problems in immigration law despite an ongoing shortage.

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We remind readers that we do not charge employers and recruiters of health care employees for consultations and that policy extends to individual physicians as well. Please feel free to call our office at 901-682-6455 to arrange for an appointment with me or one of my colleagues.

Kind regards,

Greg Siskind

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2. Ask Visalaw.com for Healthcare Workers

If you have a question on immigration matters, write Ask-visalaw@visalaw.com. We can't answer every question, but if you ask a short question that can be answered concisely, we'll consider it for publication. Remember, these questions are only intended to provide general information. You should consult with your own attorney before acting on information you see here.

Please see our final article which we've included in lieu of Ask Visalaw.com in this issue. The article addresses many of the questions doctors have when trying to decide between entering in J-1 status versus the H-1B.

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3. Health Care News Bytes

In July, the Federal State Boards of Physical Therapy (FSBPT) announced that graduates of physical therapy programs in Egypt, India, Pakistan and the Philippines will no longer be allowed to take the National Physical Therapy Exam (NPTE) due to security breaches. These breaches include sharing and distribution of recalled questions by graduates of programs in these countries, as well as by several exam preparation companies in these countries.

The FSBT is currently in the process of developing a new exam for graduates of physical therapy programs in these countries. The new exam, known as the NPTE-YRLY will be offered only once a year, as opposed to the NPTE. The FSBT plans to have the new test ready by the fall of 2011, but advises those who will need to take the test to check their website for updates at https://www.fsbpt.org/NewsAndEvents/SecurityBreach20100712/.

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On March 5, 2010, the US Department of Labor published a final rule governing the H-1C program as of April 5, 2010. On December 21, 2009 the H-1C nonimmigrant visa category expired. However, there are nurses who will be in H-1C status even after the December 21st date and this rule contains provisions relating to their employment.

The H-1C visa allows up to 500 nurses per year to work in eligible health care facilities. The program was authorized by Congress in 1999 and expired in 2005. In December 2006, Congress reauthorized the program for 3 more years. As of publication, the program still had not been extended.

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The American Association of Colleges of Nursing reported that enrollment in entry-level baccalaureate nursing programs increased for the ninth straight year in 2009. However, approximately 39,423 qualified applications were turned away due to lack of faculty and resources at nursing programs. The association also found that enrollment in master's programs rose by 9.6% and doctoral programs rose by 20.5%.

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The New York Times reported that the president of New York City's Health and Hospitals Corporation, the city's public hospital system, is in support of providing coverage for uninsured immigrants. He encouraged the Senate and House to include language in their respective bills that would lift the five-year ban on federal health benefits for legal immigrants. He also asked the Senate to allow illegal immigrants to buy insurance policies.

Under both the Senate and House health care bills, federal payments to hospitals that handle large numbers of uninsured patients would decrease as more Americans obtained insurance coverage. Both bills would also make insurance mandatory for most people, and the government would subsidize the cost of insurance for those with low incomes. However, illegal immigrants would not be eligible for these subsidies. The House bill would allow illegal immigrants to buy insurance policies, but the Senate's version of the bill would not allow them to buy these policies.

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Diversity in the health care workforce is growing as the percentage of minorities in the US population increases from 30% in 2010 to nearly 50% by 2050. Because of this, hospital administrators are now faced with the task of recruiting medical personnel who are not only qualified in their fields, but also understand cultural differences and can speak a foreign language. Currently, there are approximately 25

million people in the United States who have significantly limited or no ability to speak English.

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In April 2009, sponsors of the USMLE program agreed to waive their fees for eligibility period extensions in response to the swine flu epidemic. This temporary fee waiver was intended to give examinees flexibility in scheduling their USMLE exams during the influenza outbreak.

Because swine flu outbreaks have decreased around the world, applications for eligibility period extensions received after May 31, 2010 will require payment of the extension fee. Additionally, examinees will again be subject to the eligibility period extension restrictions in place prior to April 2009, which means examinees will be permitted only one, three-month eligibility period extension, contiguous with the original eligibility period. The fee and restrictions apply to those who already registered for exams as well as to those who plan to register.

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USCIS is changing the Form N-648, Medical Certification for Disability Exceptions. The revisions to the form clarify the requirements for the exception and the basis for preparing a medical certification for applicants and medical professionals.

Under US immigration law, applicants for naturalization must demonstrate that they can communicate in English and understand US history and government. However, applicants who cannot comply with one or both of those requirements because of a medically determinable physical or developmental disability or mental impairment may request an exemption from either or both of the requirements through submission of a Form N-648 certification, completed by a medical professional.

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4. The ABC's of Healthcare Immigration – Nonimmigrant Visa Options for Nurses

A growing shortage of nurses in the United States has forced many health care employers to look overseas for the nursing talent needed to care for American patients. But bringing those nurses to the US is challenging.

What status can a nurse coming to the US receive?

Nurses can enter the US in either nonimmigrant or immigrant status. But before reaching the question of whether a nurse is best suited for immigrant or nonimmigrant status, it's best to begin with an overview of immigration principles. "Immigrant" and "Nonimmigrant" are legal terms that have specific meanings. Every person applying for admission to the United States is considered to be an intending immigrant; and it is up to the person seeking admission to prove that they only intend to stay temporarily as a non-immigrant. This question becomes vitally important when a person applies for a visa because a consular officer has complete discretion to deny a request if he or she is not satisfied that the alien will leave the United States when their visa period expires. In short, if the alien is deemed to have immigrant intent when applying for a non-immigrant visa, the application will be denied.

Nonimmigrant visas typically allow foreign nationals for a limited period for a specific purpose. Such purposes include undergraduate or graduate study or employment with a sponsoring company or organization. Nonimmigrant visas are designated by letter, each letter corresponding to a different type of visa (B-2, F-1, H-1B, etc.).

Immigrant visas, on the other hand, permit foreign nationals to enter the US to remain indefinitely as permanent residents. Rather than show that they only intend to stay in the US for a limited time, a person applying for an immigrant visa needs only to prove that they meet the requirements of the visa classification and that they are not "inadmissible". The grounds for inadmissibility include certain criminal convictions, communicable diseases, and terrorist activity.

I've heard that health care workers are barred from entering the US? So how are all these foreign nurses working in the US?

A key aspect of nursing immigration is a bar to the admission of health care workers – including registered nurses – seeking to enter the US. That bar does not apply, however, to health care workers who obtain a certification from an organization approved by USCIS that states that the nurse's education and licensing credentials are equivalent to an American's. Currently, only one organization - the Commission on Graduates of Foreign Nursing Schools – is approved as an agency authorized to issue the certification document for nurses (CGFNS refers to the documents as a VisaScreen certificate).

Non-Immigrant Visa Options

Under current US immigration laws, non-immigrant visa options for nurses are limited, mainly because most employers only require a two year degree rather than four-year bachelor's degree and because most states do not require bachelor's degrees for a nurse license.

During the last nursing shortage, the US Congress carved out a specific non-immigrant visa category, designated H-1A, for registered nurses. This visa type did not become a permanent part of the immigration laws, and was allowed to expire on September 1, 1995, when Congress believed the shortage had subsided. A similar provision, which would provide a new visa category for general registered nurses, is currently under consideration by Congress, and will be discussed separately below.

What is an H-1B non-immigrant visa?

The H-1B "Specialty Occupation" visa is available to individuals who can demonstrate qualification in a "specialty occupation" and who are sponsored by a U.S. employer to work temporarily in the US in a "specialty occupation". The Immigration & Nationality Act defines a specialty occupation as "an occupation that requires (A) theoretical and practical application of a body of highly specialized knowledge, and (B) attainment of a bachelor's or higher degree in the specific specialty (or its equivalent) as a minimum for entry into the occupation in the United States." Persons who typically will be eligible for this visa include members of the professions such as engineers, teachers, lawyers, as well as scientists and other highly qualified persons. Only 65,000 H-1Bs are granted each year. Note that university employees and employees of certain non-profit and government research institutions are

exempt from the cap. That would cover nurses in numerous university and research-oriented hospitals around the country.

Aren't nurses prohibited from getting H-1B visas?

Through policy memos and case decisions, the USCIS has determined that nursing, as a profession, is not per se a specialty occupation, since a bachelor's degree is not generally required to become a registered nurse. This determination is based on the findings of the Department of Labor as to the educational preparation required for most nurses published in the Occupational Outlook Handbook (1995) and the Dictionary of Occupational Titles (1991). Many people have criticized USCIS because many employers have dropped the requirement for a bachelor's degree precisely because of the severe shortage of nurses and not because the ideal nurse does not need such a degree. They argue that if the point of the H-1B visa is to help employers find qualified workers when there may be a shortage, then the USCIS policy totally thwarts the intention of Congress.

The USCIS does acknowledge, however, that there are areas of nursing where the specific duties are so specialized and complex that the knowledge required to perform the duties is usually associated with the attainment of a baccalaureate or higher degree. Late in 2002, the USCIS issued a field memorandum that spelled out for the first time when H-1B visas are appropriate for nurses. Unfortunately, the USCIS has applied the memo with very strict scrutiny.

What kinds of nurses can qualify for H-1Bs?

The USCIS memorandum made it clear that normal RN positions will not qualify for H-1B visas unless the state where the nurse seeks a license requires a bachelor's degree. No state currently requires a bachelor's degree for RNs. The USCIS did, however, list a number of more specialized RN positions that might qualify for an H-1B visa though USCIS has not been consistent in applying this language from the memo..

What are the general requirements for demonstrating that a nurse should qualify for an H-1B visa?

In order to qualify for an H-1B visa, an employer of a nurse must show the following:

1. A bachelor's or higher degree (or its equivalent) is normally the minimum requirement for entry into the position;

2. The degree requirement is common to the industry for parallel nursing positions (i.e., employers in the same industry require their employees to hold the degree when they are employed in the same or a similar position);

3. The employer normally requires a degree or its equivalent for the position or the nature of the position's duties is so specialized and complex that the knowledge required to perform the duties is usually associated with the attainment of a bachelor's or higher degree (or its equivalent).

Employers who can meet these requirements and can show they are paying the prevailing wage for the job can apply for an H-1B visa.

What specific types of nurse positions can qualify?

Advance Practice Registered Nurses

The USCIS 2002 memorandum also discussed specific nurse positions. First, advance practice registered nurses (APRNs) will generally qualify for H-1B visas because these are advanced level positions requiring more education and training than the typical RN. An employer may require that the prospective employees hold advanced practice certification as one of the following: clinical nurse specialist (CNS), certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), or certified nurse practitioner (APRN-certified). If the APRN position also requires that the employee be certified in that practice, then the nurse will be required to possess an RN, at least a Bachelor of Science in Nursing (BSN), and some additional graduate level education.

The USCIS lists the following positions that will normally qualify for an H-1B visa:

• Clinical Nurse Specialists (CNS): Acute Care, Adult, Critical Care, Gerontological, Family, Hospice and Palliative Care, Neonatal, Pediatric, Psychiatric and Mental Health-Adult, Psychiatric and Mental Health-Child, and Women's Health

• Nurse Practitioner (NP): Acute Care, Adult, Family, Gerontological, Pediatric, Psychiatric & Mental Health, Neonatal, and Women's Health.

• Certified Registered Nurse Anesthetist (CRNA); and

• Certified Nurse-Midwife (CNM).

Administrative Positions

The USCIS will also approve H-1B visas for certain administrative nurse positions. According to the USCIS memorandum, "upper level nurse managers" in hospital administration positions may work for H-1B visas since these positions usually require bachelor's degrees. Nursing Services Administrators should work since these positions involve supervisory functions and they typically require a graduate degree in nursing or health administration.

States that Require Bachelors Degrees

As noted above, the USCIS will consider an H-1B visa to be appropriate for any RN if the state where the nurse's position is requires a bachelor's degree. However, all states had dropped their requirements that nurses have bachelor's degrees.

Specialized Nurse Positions

Aside from the Advanced Practice Registered Nurses noted above, nurses in certain specialized areas may file for H-1Bs. The USCIS specifically cites critical care and peri-operative (operating room) nurses as two examples of positions requiring a higher degree of knowledge and skill than a typical RN or staff nurse position. The USCIS indicates that passing a certification examination for a particular type of

position is an important indicator. Examples of these types of certification examinations are school health, occupational health, rehabilitation nursing, emergency room nursing, critical care, operating room, oncology and pediatrics.

Such nurses should meet the general requirements noted above. Evidence to show these requirements could include affidavits from independent experts or other means showing that the job duties are so specialized and complex that a bachelor's or higher degree is appropriate. The USCIS notes that these cases will be adjudicated on a case-by-case basis so the outcome of such applications is far from certain.

Can Mexican and Canadian nurses qualify for visas under the NAFTA – The North American Free Trade Agreement?

Yes. TN-1 visas are available under the North American Free Trade Agreement ("NAFTA") to Canadian and Mexican citizens for a limited group of specialty occupations. Although not uniformly recognized as a specialty occupation for H-1B purposes, registered nurses were specifically included on the list of professions for which TN visas could be used and any registered nurse position can potentially qualify.

Under NAFTA, the applicant must possess the required credentials to be considered a professional under the TN category. Registered nurses must demonstrate eligibility by providing a provincial or state license or Licenciatura degree. However, in order to be admitted the registered nurse must present a permanent state license, a temporary state license, or other temporary authorization to work as a registered nurse, issued by the state nursing board in the state of intended employment.

Once admitted, a worker is granted an initial stay of one year. Thereafter, a TN professional may seek extensions of stay in one year increments. There is currently no limit on the number of extensions that may be granted.

Canadian nurses applying for TN visas can simply bring the required documentation to a port of entry and enter right away after being inspected by an examiner at the port of entry. A nurse can extend his or her status by mail with the USCIS Nebraska Service Center or by leaving and reentering with the required documents through a port of entry. Mexican nurses go through a similar process. However, they must first apply for a visa at a consulate and cannot simply show up at a port of entry (though the requirement of processing first with the USCIS ended per NAFTA's original provisions after NAFTA's tenth anniversary in January 2004).

Note that unlike H-1B visas, TN visa holders are supposed to be able to demonstrate an intention to leave the US when they complete their TN stay. So nurses who apply for permanent residency while in the US must be very careful about traveling outside the US or applying for a TN extension after a green card application has been submitted.

What is the H-1C visa for registered nurses?

Late in 1999, Congress passed the Nursing Relief for Disadvantaged Areas Act, which called for the creation of a new H-1C visa for nurses going to work for up to three years in health professional shortage areas. Up to 500 nurses per year could get the visa, but each state was limited to 25 H-1C nurses a year. Under the law, facilities interested in sponsoring nurses for H-1C visas would submit documentation

containing a number of attestations regarding the employment of H-1C nurses. This visa was rarely used both because it was weighed down with very strict rules and because so few actual visas were available under the category. In fact, only a small number of H-1C visas had actually ever been issued. While this category expired in December 2009 and new petitions are not being accepted, some nurses remain in the category and Congress could extend the program in the near future.

As with most immigration laws, the statute itself provided very little guidance on how the law would be applied, leaving it to the USCIS (and in most employment visa cases the Department of Labor as well) to develop regulations. The regulations for the H-1C program were released by the Department of Labor last summer, and became effective in September 2000. The USCIS released its regulations in June 2001.

One of the most surprising elements of the Labor Department's regulations is a DOL finding that based on the restrictive definition of "facility" Congress put in the statute, only fourteen hospitals in the country could be initially determined to qualify to apply for H-1C visas. These facilities were:

1. Beaumont Regional Medical Center, Beaumont, TX
2. Beverly Hospital, Montebello, CA
3. Doctors Medical Center, Modesto, CA
4. Elizabeth General Medical Center, Elizabeth, NJ
5. Fairview Park Hospital, Dublin, GA
6. Lutheran Medical Center, St. Louis, MO
7. McAllen Medical Center, McAllen, TX
8. Mercy Medical Center, Baltimore, MD
9. Mercy Regional Medical Center, Laredo, TX
10. Peninsula Hospital Center, Far Rockaway, NY
11. Southeastern Regional Medical Center, Lumberton, NC
12. Southwest General Hospital, San Antonio, TX
13. St. Bernard Hospital, Chicago, IL
14. Valley Baptist Medical Center, Harlingen, TX

Note, however, that there are many more hospitals across the country that could potentially qualify for H-1C visas.

The attestation process was administered by the Employment and Training Administration at the Department of Labor. Enforcement of the attestations was overseen by the Employment Standards Administration's Wages and Hours Division.

The 1999 law was very similar to a 1989 law that created the H-1A visa for nurses. That visa category expired several years ago after unsuccessful efforts to extend its life. The key differences between the two programs are that a much smaller number of H-1C visas have been allocated and that the facility where the nurse will work must be in a health professional shortage area. There were also new requirements which limited a facility's dependence on H-1C nurses (something that is hard to imagine given that only 500 H-1C nurses permitted into the country each year, with no more than 25 allowed to work in a single state).

A qualifying hospital must have met four requirements:

1. The hospital must be located in a Health Professional Shortage Area. You can find out which areas are HPSAs online at http://www.bphc.hrsa.gov/databases/newhpsa/newhpsa.cfm.

2. The facility must have at least 190 acute care beds

3. At least 35% of the facility's acute care inpatient days must be reimbursed by Medicare

4. At least 28% of the facility's acute inpatient days must be reimbursed by Medicaid

The Department of Labor created an attestation form called the ETA 9081 that was submitted as part of the H-1C application process. On the form, the facility would attest to the following:

1. That it is a qualifying facility. If the ETA 9081 is the first one being filed by a facility, then the form must be accompanied by copies of the pages from the paperwork filed with the Department of Health and Human Services showing the number of acute care beds and the percentages of Medicaid and Medicare reimbursed acute care inpatient days. A copy of this paperwork must also be kept in a public access file.

2. That the employment of H-1C nurses will not adversely affect the wages or working conditions of similarly employed nurses.

3. That the facility will pay the H-1C nurse the facility wage rate.

4. That the facility has taken and is taking timely and significant steps to recruit and retain nurses in order to reduce dependence on immigrant nurses. At least two such steps must be taken unless it can show that the second step is not reasonable. Documentation of these steps needs to be included in the facility's public access file for H-1C nurse petitions. Steps which may be taken can include:

a. Operating a training program for registered nurses at the facility or financing or providing participation in a training program elsewhere.

b. Providing career development programs and other methods of facilitating health care workers to become RNs.

c. Paying registered nurses wages at a rate at least 5% higher than the prevailing wage for the area.

d. Providing reasonable opportunities for meaningful salary advancement by registered nurses.

e. Any other steps that would be considered significant efforts to recruit and retain nurses.

5. That there is not a strike or lockout at the facility, that the employment of H-1C nurses is not intended or designed to influence an election for a union representative at the facility and that the facility did not lay off and will not lay off an RN within the 90 day period and 90 day period after the date of filing an H-1C petition.

6. That the employer will notify other workers and give a copy of the attestation to every nurse employed at the facility within 30 days of filing. E-mail attachments are acceptable.

7. That no more than 33% of the nurses employed by the facility will be H-1C non-immigrants.

8. That the facility will not authorize H-1C non-immigrants to work at a worksite not under its control and will not transfer an H-1C nurse from one worksite to another.

The paperwork must also have been accompanied by a filing fee. After the Attestation was approved by the Labor Department and used in support of an H-1C petition approved by the USCIS, the employer was required to send a copy of the H-1C petition and USCIS approval to the Labor Department. Also, as noted above, the employer must have created a public access file that includes the Attestation and its supporting documentation. The file must have been produced for any interested party within 72 hours upon written or oral request.

Under the USCIS regulations, there were three primary eligibility requirements for foreign nurses who wish to work in the US on an H-1C visa:

• They must have an unrestricted license to work as a professional nurse in the country where they received their nursing training, or have received that training in the US;
• They must pass an examination approved by the Department of Health and Human Services or have a license to work as a professional nurse in the state where they will work; and
• They must be eligible to work as a registered nurse under both the laws of the state where they will work and the regulations of the facility where they will work. Currently, the acceptable examination is that offered by the Commission on Graduates of Foreign Nursing Schools (CGFNS). CGFNS certifies that the foreign nurse's training and license are equivalent to a similarly situated US nurse, that all their documents are authentic, that the foreign nurse has an unrestricted license, that the foreign nurse is sufficiently proficient in written and spoken English, and that the foreign nurse has in fact passed a state licensing exam. Questions about the exam may be directed to CGFNS through its website at http://www.cgfns.org.

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5. DHS Continues Investigation of Alleged Violations of J-1 Visa Waiver Program in Las Vegas

For close to two years, the US Department of Homeland Security (DHS) has been investigating alleged violations of the J-1 visa waiver program in the Las Vegas, Nevada area.

The purpose of the J-1 visa waiver program is to provide physicians in areas of the US that have been designated as a shortage area; in return for their service in a medical shortage area, foreign physicians have their two-year home residency requirement waived, and are allowed to remain in the United States. However, according to DHS, participants in the program serving in the Las Vegas area were not actually working in designated shortage areas.

The DHS investigation was initiated due to several articles in Las Vegas newspapers alleging that Las Vegas employers were taking advantage of the J-1 visa waiver program. According to the news reports, employers of foreign physicians assigned the doctors to work in locations other than those listed on the waiver application in order to bill more charges.

In response to the articles, the Nevada Health Division increased its oversight of the visa waiver program in the state and began to conduct periodic site visits to ensure that the physicians were physically working at the location listed on the waiver application. As a result, the state found that 6 employers were in violation of the program.

According to the foreign physicians, they could not complain about their work location assignments for fear of being fired and losing their visa status.

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6. Nursing Schools Short on Faculty to Train Additional Nurses

A recent story by *CNNMoney.com* declared that the United States will be facing a nursing shortage that will continue to increase as the baby boomer population ages.

While the United States has had a nursing shortage for some time, it is expected that within the next 15 years the country will need an additional 260,000 nurses. This is attributed to an aging population with a longer life expectancy who need more medical care as they age and aging nurses seeking to retire.

The problem is further exacerbated by the fact that nursing schools do not have the faculty and facilities to train enough nurses to fill the void.

The economic recession did help the field of nursing by encouraging more students to register for nursing schools and fewer nurses to retire. However, nursing schools still were not able to accommodate all the applicants, and the trend in increased nursing students is not expected to continue as the economy improves.

However, a shortage of nursing instructors is seen as the biggest impediment to addressing the nursing shortage. Nursing schools have difficulty recruiting and retaining nursing instructors since these same nurses can earn larger salaries working in hospitals than they can earn teaching.

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7. Foreign Medical Grad Considered an Expert in his Field

A recent article published in the *New York Times* told the story of Dr. Tomoaki Kato, one of the few surgeons in the United States who an expert in ex vivo resection. Dr. Kato is a foreign medical graduate currently working at New York-Presbyterian Hospital/Columbia University Medical Center.

Ex vivo resection is a surgical procedure where organs are removed and operated on outside the body in order to remove tumors that cannot be treated in any other way, and then sewing the organs back in. The procedure is a long one, that can last over

30 hours, involves several surgeons and anesthesiologists, and is highly expensive. Dr. Kato has lead 16 such surgeries and assisted in several more.

Dr. Kato received his medical degree from Osaka University in Japan and then trained and worked for 12 years in Miami. In 2008, Dr. Kato began working at Columbia University Medical Center in New York City as a professor of surgery and the surgical director for liver and gastrointestinal transplantation.

The article can be found at http://www.nytimes.com/2010/02/23/health/23liver.html .

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8. US Army Halts Program that Accelerates Naturalization for Medical Personnel

A recent article in the *New York Times* reported on the discontinuation of the Defense Department's Military Accessions Vital to the National Interest (MAVNI) pilot program. Under the program, up to 1,000 foreign nationals without permanent resident status could join the US Army or other armed forced sectors per year if they had necessary medical or foreign language and cultural expertise. The pilot program provided successful applicants with a way to accelerate naturalization.

Army officials said it had to stop accepting applications for the program because the Pentagon had not completed a review required to keep the program running.

Over 1,000 immigrants enlisted in the various armed forces sectors through the program, and over 14,000 more immigrants have contacted Army recruiters to see if they qualify for the program. Recruiting officials say the armed forces attracted a large number of unusually qualified candidates, including doctors, dentists and native speakers of Arabic, Urdu, Hindi, Punjabi, Korean and other languages from strategic regions where United States armed forces are currently stationed.

The program was originally set to end at the end of 2009. When the Army filled all of its 890 slots, the program was extended through February. The Army was granted an additional 120 slots, but those were filled by mid-January.

To date, 129 recruits have become US citizens as a result of the MAVNI program. As of publication, the Army web site is telling applicants that the program is still on a temporary hold and is requesting information from potential applicants.

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9. Survey Find Half of Nurses Are Planning a Career Change

A recent AMN Healthcare survey of registered nurses found that almost half of all nurses plan to make a career change over the course of the next three years. The survey asked questions regarding job satisfaction and the effect of the economic recession on nursing career plans.

More specifically, the survey found that 15% of nurses plan to find a new employer if the economy improves within the next year, 28% said they would not be working in their same position within one year, 46% worried that their current jobs were affecting their health, 29% planned to quit nursing either through retirement or

finding a job in another field, 55% believe that the quality of nursing has declined since they started working as nurses, 36% said they would not recommend nursing as a career.

The survey also asked nurses to comment on the nursing shortage over the past five years: 33% said the shortage has worsened, 28% said they have seen no change, and 39% said the shortage is not a bad as it was five years ago.

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10. Patient May Not Receive Transplant Due to Illegal Status

The *Boston Globe* reported on Marcelo Alves, a Brazilian national suffering from cardiomyopathy, a weakening of the heart that is slowly eroding the rest of his body. Mr. Alves is in need of a transplant, but his chances of obtaining one are slim because he is an illegal immigrant.

While it is legal for illegal immigrants to receive organ donations, many say it is wrong to give priority to an illegal immigrant when there are over 2,700 US citizens waiting to receive a new heart. Mr. Alves is not yet on a waiting list for a heart transplant because the hospital treating him, Beth Israel in Boston, refused to consider a transplant because of his immigration status.

According to the United Network for Organ Sharing, the Virginia-based federal contractor that manages organ allocations throughout the United States, organ donations can be provided to illegal immigrants. However, it is up to individual hospitals to establish organ donation policies.

Mr. Alves was later admitted to Massachusetts General, where physicians will determine whether he meets the medical criteria for a transplant. The hospital has agreed that if necessary, they will perform the transplant regardless of Mr. Alves's immigration status.

http://www.boston.com/news/local/massachusetts/articles/2010/01/10/immigration_status_creates_complications_for_heart_patient/

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11. Nurse Unions Try to Address Shortage Concerns

A new trend is becoming common in the health care workforce: unionization. According to the US Bureau of Labor Statistics, the number of health care medical workers represented by some form of collective bargaining agreement or registered as union members is increasing. This trend is in response to hospital cutbacks on expenses in response to the economic downturn as well as uncertainty about health care reform.

In general, union membership in the United States has been declining, according to data collected by the Bureau of Labor Statistics. In 1979, union membership peaked at nearly 21 million members, or 24.1% of workers. By 2009, union membership dropped 15.3 million members, or 12.3% of all employees.

However, union membership in the category of "Healthcare Practitioner and Technical Occupations" is growing instead. This category includes physicians, dentists, veterinarians and various categories of therapists and technicians. Within this category, registered nurses and other non-physician field have seen the most unionization.

In 2000, about 12.9% of the health care workforce, or 693,000 workers, were union members. In 2009, these number of health care worker union members rose to 13.6%, or 962,000 workers. Most unionization is among hospital employees; there are almost no union members in physician offices.

Unionization seems to be especially popular with nurses as the nursing shortage continues to grow, and nurses face longer hours and increased patient loads. In December 2009, the California Nurses Association, the National Nurses Organizing Committee, the Massachusetts Nurses Association, and United American Nurses merged to become the 150,000-member National Nurses United; this is the largest registered nurse union in the country. The organization is affiliated with the AFL-CIO.

Because of the economic recession, hospital CEOs tried cutting costs, which included hiring freezes and layoffs. The field most affected by the cost-cutting was nursing. Nursing unions, therefore, pay close attention to maintaining staff-patient ratios so that patients do not suffer and nurses are not overworked.

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12. Primary Care Physician Shortage

The *Pittsburgh Tribune-Review* reports that according to the Association of American Medical Colleges, by the year 2025, there will be a shortage of 46,000 primary care physicians in the United States. This shortage is due to many factors, including lower salaries than specialist physicians, disinterest by medical students, and retiring primary care physicians. Primary care physicians include those practicing Internal Medicine, Family Medicine, Pediatric Medicine, and Geriatric Medicine.

The shortage may turn out to be even higher than predicted when the new healthcare legislation takes effect, adding 32 million people to the insurance rolls over the next few years.

Resolving the shortage may mean that primary care physicians receive higher salaries comparable to other medical specialties. A recent medical school graduate can have over $100,000 in debt for school loans. A primary care physician will generally earn around $150,000 per year, while a specialist can earn around $300,000 or more per year, thus making medical specialties more attractive to new physicians.

Other ways to resolve the shortage include increasing medical school admissions, increasing residency openings at teaching hospitals and allowing more foreign physicians to work in the U.S. Other medical industry experts advocate transferring many of the duties performed by a Family Medicine physician to a nurse practitioner.

http://www.pittsburghlive.com/x/pittsburghtrib/business/s_679113.html

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13. States Try to Expand Nursing School Capacity

A report by the Robert Wood Johnson Foundation describes the efforts taken by 12 states to expand capacity at their nursing schools. Within the next 15 years, the current nursing shortage in the United States will grow to over 260,000 unless nursing schools improve efforts to educate more nurses. Each year, thousands of nursing school applicants are rejected due to lack of nursing faculty, clinical placements, and other lacks in student capacity. According to the report, in 2008, 41,385 qualified applicants were rejected to capacity issues; in 2009, the number of qualified applicants rejected by nursing schools grew to 42, 981.

Texas reported a nursing shortage of 22,000 in 2009. This number is predicted to grow to 70,000 by 2019. To address the shortage, Texas must double the number of graduates of nursing programs by 2013. It was found that Texas nursing programs had high enrollment numbers, but low a low number of graduates. The Texas Workforce Shortage Coalition categorized all of Texas's nursing schools into two categories: those who had 70% or more graduates and those who had below 70% graduates. The schools with a higher percentage of graduates are to focus on increasing enrollment, while those schools with a low percentage of graduates must improve their graduation rates. Schools who do not meet target percentages set by the state legislature will have to return state appropriated funds.

Michigan had a projected shortage of 18,000 nurses by 2015. The governor of Michigan therefore made increasing the number of nurses in the state a high priority. She appropriated $30 million in grants to partnerships among nursing schools, hospitals and the Regional Skills Alliance to provide accelerated second degree programs. These programs attracted unemployed auto workers, engineers, lab technicians, and architects. These programs have produced an additional 4,000 nurses and 277 new clinical faculty members. The governor also saw the need to increase nursing faculty, and further appropriated $6.8 million quickly train clinical and classroom faculty. This has resulted in 150 new faculty-in-training.

In Virginia, a group of nursing leaders has developed ideas for increasing nursing students. The group created a nursing policy agenda that is presented to Virginia legislators before elections. Through their effective policy, the group has achieved among other things, a 10% pay raise for nursing school faculty, which resulted in a 50% increase in nursing graduates.

Competitive tensions between Associate Degree and Bachelor's Degree nursing programs in both New York and North Carolina led the two states to create RIBN, Regionally Increased Baccalaureate Nurses, whose purpose is to increase and encourage students to earn a baccalaureate nursing degree. RIBN combines the strengths of community colleges, such as larges diverse classes, supportive learning environments, and focus on practical skills, with the baccalaureate degree's significance to allow one to pursue graduate education and faculty roles. Schools participating in RIBN will begin classes in 2010. Students will spend 3 years at a community college and then a fourth year at a university, after passing the NCLEX. Students in the North Carolina program will receive full scholarships, while those in the New York program will pay community college tuition for all four years.

In Oregon, the Oregon Consortium for Nursing Education (OCNE) created a partnership of eight community colleges and the five Oregon Health and Science University campuses. These schools now share common admission procedures and other educational resources. Associate and bachelor's degree programs have also collaborated to improve education standards and create a common curriculum. This has resulted in an increase in the number of nurses pursuing baccalaureate degrees in the state. Also, nurses in Oregon who become faculty can make use of a loan repayment program for their nursing education.

Massachusetts created the Nurse of the Future Core Nursing Competencies in order to increase the number of nursing school graduates and see what competencies they need to care for patients. Several nursing programs in the state have received funding to develop nursing curriculum models to produce more efficient nurses.

In California, several regional collaborations have resulted in increased clinical placements, recruitment of additional faculty, and increased access to higher education for nursing students.

Hawaii has been using innovative education techniques, such as distance learning and simulation, to make up for faculty shortages and lack of classroom space. These techniques allow instructors to reach more students, thereby resulting in more students in Hawaii's nursing programs. Four groups in Hawaii have contributed over $1 million to the Hawaii Nursing Simulation Center Fund. The center will connect existing campus and hospital simulation laboratories across the state.

Mississippi is one of the state with the highest nursing shortage due to nursing students dropping out of their programs prior to graduation. The Mississippi Office of Nursing Workforce conducted a number of surveys to determine why students did not finish their nursing education. The surveys found that lack of finances, inability to balance family and school, and inability to simultaneously work and attend school all contributed to the high number of drop-outs. In response, the group created the Mississippi Student Navigator, which provided students with information on financial assistance, legal services, child care, stress management, and academic preparation. This caused the number of nursing graduates in Mississippi to double.

Florida is facing an expected shortage of 52,200 registered nurses by the year 2020. The Florida Center for Nursing (FCN) has found that shortages are caused by a lack of faculty and limited clinical training sites. FCN plans to address these issues by using grant money for simulation training. More use of simulation could reduce the need for clinical sites.

In North Dakota, three programs are working on increasing the number of nurses and nursing education in small rural communities in the state. The Dakota Nursing Program (DNP) is an association of five community colleges that use a common curriculum to educate those pursuing an Associate's Degree in nursing. Graduates are encouraged pursue a Bachelor's Degree at two cooperating universities. Those who receive a Bachelor's Degree are then encourages to pursue higher nursing education and to teach for the DNP. This allows the nurses to have increased job prospects while remaining in their rural communities. The Nurse Faculty Intern Program (FNI) was launched by the State Board of Nursing to allow registered nurses with a Bachelor's Degree and at least two years of clinical experience to teach in nursing schools while pursuing graduate degrees. These faculty interns are supervised by a faculty member and a consulting PhD-level educator. The third

program is the RAIN Program – Recruitment and Retention of American Indians into Nursing. North Dakota has over 30,000 Native American residents and five reservations, but only 19 Native Americans earned Bachelor's Degrees in nursing from the University of North Dakota since 1990. RAIN offers cultural and emotional support for Native American students, as well as special scholarships, orientation, mentors, free taxi service, and other financial assistance. Since its inception, RAIN has helped 149 graduates with Bachelor's Degrees and 39 with Master's Degrees.

The report can be found at http://www.rwjf.org/files/research/20100608cnf.pdf.

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14. Recruitment of Foreign-Born Nurses Analyzed

The *American Journal of Nursing* recently ran a research article about the recruitment of foreign-born nurses. The article found there is a large number of companies that specialize in recruitment of foreign nurses, most nurses are recruited from the Philippines and India, and that many foreign-born nurses feel the recruitment companies do not treat them fairly.

In the last 20 years, the number of recruitment companies that specialize in bringing foreign-born nurses to the United States has greatly multiplied. In 2000, the foreign-born nurse recruitment industry consisted of around 30-40 firms. In July 2007, there were 273 firms. In January 2010, due to the economic crisis, the number of recruitment firms dropped to 211. A survey of the recruitment firms found that most of them focus mainly on the Philippines and India. However, the firms surveyed said they plan to expand their recruitment to other countries such as the United Kingdom, Israel, China, Poland, Russia, Ukraine, Norway, Sweden, Colombia, Brazil, Argentina, the Czech Republic and South Korea.

The surveyed recruitment firms range in size from small outfits that bring in only a few foreign nurses each year, to large companies that bring in hundreds of nurses. The firms stated that the number of nurses brought in over the last couple of years has decreased due to the economic recession; however, most thought that the number of nurses brought in each year would increase by 2011.

Foreign-born nurses were also surveyed for the article through focus groups in New York City. While the nurses generally felt positively towards the recruiters for helping them come to the United States, half of the nurses surveyed felt their rights as workers were not respected. Nurses stated that recruiters did not always provide enough information about the recruitment and immigration to the US. They also said that not all recruiters would let them have a copy of their contracts and that some of them had to pay fees to recruiters who then disappeared. Nurse also complained that they did not always receive the salary they had been promised by recruiters, and their American counterparts were paid more.

[Note: A new association, the Association for International Health Care Recruitment (http://www.aaihr.org/) was recently formed by recruiting companies interested in promoting ethical practices in the field. The organization has developed a new code of ethics for recruiters.]

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15. IMG Physicians Can Receive Special License to Work at Children's Research Hospital

A recent bill unanimously passed by the Tennessee legislature will allow foreign-trained physicians to work at St. Jude Children's Research Hospital without having completed a U.S. residency program. The bill allows foreign physicians to be licensed to work at St. Jude only.

The St. Jude Children's Research Hospital Global Collaboration License can be issued by the Tennessee Board of Medical Examiners to physicians who meet all qualifications for licensure other than a U.S. residency program approved by the American Medical Association. This license is non-transferable; if the physician is no longer employed by St. Jude, the license is void.

According to St. Jude, the hospital sought this legislation in order to lower restrictions it has faced in recruiting physicians from outside the United States. St. Jude routinely recruits physicians from around the world who have an expertise needed by the hospital. The purpose of the bill is not to find minimally trained physicians who can now have an easier time working in the U.S., but to find world medical experts who can maintain St. Jude's reputation of providing the best medical care for children.

Note that the new law does not affect the requirements for a US visa which, in the case of an H-1B visa, requires passage of all three parts of USMLE 3.

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16. Unemployment High Among Filipino Nurses

An article published by *Feet in 2 Worlds* discusses that even though most foreign-born nurses in the U.S. hail from the Philippines, Filipino nurses are having trouble finding employment in the U.S. due to the economic recession and a shortage of visas. In the 1980s and 1990s, Filipino nurses were persuaded to come work in the United States with perks such as free housing, free airfare to the U.S., a signing bonus, and a green card for the nurse and his or her family members. Now nursing jobs for these nurses are so hard to find, even with a nursing shortage, that the nurses have to pay recruiters to find them work.

The current economic climate has forced many U.S. hospitals to close or to reduce the number of beds, forcing Filipino nurses to look for non-hospital jobs like caregiving, or go back to school for higher education. The nurses also must compete with American nurses for existing positions, and the number of American nurses has grown as unemployed Americans chose nursing as a second career.

According to the American Nursing Association, there is still a demand for Filipino nurses, but because of the decline in available visa numbers, American nursing graduates are filling positions normally filled by foreign-born nurses.

Currently, availability of visa numbers for green cards for Filipino nurses is extremely low. Foreign nurses, professionals and other skilled workers compete for 40,000 employment-based visa numbers each year in the third category of employment-based green cards. Out of these 40,000 visa numbers, Filipinos can receive only 7

percent; this means that out of the available 40,000 visa numbers, only 2,800 green cards per year can be issued to Filipino nurses. And currently, there are more Filipino nurse applicants than there are available green cards.

Nursing has become a popular career choice in the Philippines, with thousands of nurses becoming licensed every year. In 2009 alone, over 95,000 nurses were licensed. However, with this high number of nurses, there is an excess of nurses in the Philippines, so the nurses look to other countries, like the U.S., for career opportunities.

http://news.feetintwoworlds.org/2010/04/14/filipino-nurses-immigration/

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17. WHO Institutes Guidelines for Recruitment of Foreign Health Care Workers

In May, international health leaders at the annual World Health Assembly in Geneva endorsed new guidelines relating to foreign health care workers that are designed to help countries strike a balance between meeting the health care needs of patients in developed economies with negative impacts such migration might have on health care systems in the home countries. The migration rights of individual health care workers also need to be addressed.

The document doesn't seek to end migration, but instead to encourage recipient countries to work with source countries to ensure that the needs of both societies are being addressed. That might include providing development assistance to ensure that enough workers are being trained in the source country to meet domestic needs as well as the needs of people in the recipient country.

The code can be found at http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R16-en.pdf

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18. Foreign Educated Physicians Have Fewer Patient Deaths

The August issue of *Health Affairs* included a report on physicians educated outside the United States. The report, which tracked the performance of primary care physicians and cardiologists, found that physicians trained outside the U.S. had lower patient death ratios than those physicians who were trained in the U.S. The report separated out Americans educated at foreign medical schools from immigrant doctors educated abroad and trained in the US.

The study found that foreign doctors performed somewhat better than US doctors educated in the US and substantially better than Americans educated overseas who had a 16 percent higher mortality rate. The study also found that physicians who have been certified in medical specialty have lower patient mortality rates than those who have only been certified in primary care, regardless of whether or not they were educated in the United States.

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19. Chart Of Pharmacist Licensing Requirements By State

Linked at http://www.visalaw.com/IMG/charts.html.

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20. State 30 Physician Waiver Chart

Linked at http://www.visalaw.com/IMG/state30.html.

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21. Physician National Interest Waiver Chart

Linked at http://www.visalaw.com/IMG/NIW.html.

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22. The J-1 and the H-1B Visas: Which is the Best Choice for Graduate Medical Training?

By Greg Siskind and Elissa Taub

International Medical Graduates typically have to make the difficult choice of entering the United States on either a J-1 or an H-1B visa to pursue graduate medical training. To some extent, the decision regarding which visa to pursue also depends on the residency program. Though most programs accept either the J-1 or the H-1B, some will only accept one or the other.

In years past, the J-1 was the dominant visa category. This started to change in the mid-1990s as programs became more open to sponsoring H-1B visas. From the institution's perspective, the J-1 application process is far less expensive and burdensome because the J-1 program sponsor is actually the Educational Commission on Foreign Medical Graduates and not the residency program itself. H-1B visas require an institution to be the petitioner, comply with various legal requirements and pay government filing fees and attorney fees (if the application process is handled by an outside firm).

Programs responded to pressures from competing institutions and most have become much more willing to go the H-1B route. But the attractions of the H-1B visas are perhaps not as great as they once were, and many of the drawbacks of the J-1 visa for graduate medical trainees have been lessened considerably. This article discusses the current environment and compares the advantages and disadvantages of each category for the international medical graduate.

The J-1 Visa

The J-1 Visa is an exchange visitor visa. Consequently, under Section 212(e) of the Immigration and Nationality Act, most J-1 visa holders coming to pursue graduate medical training are subjected to a foreign residence requirement upon conclusion of the J-1 program. That requirement essentially means that a doctor must return to

his or her home country or country of last residency for two years or face the following three consequences:

1. J-1s subject to 212(e) may not change non-immigrant categories within the US (i.e. applications to change categories must be made at US consulates abroad);
2. J-1 visa holders subject to 212(e) are ineligible to receive an H-1B or L-1 visa stamp at a US consulate;
3. J-1s subject to 212(e) may not obtain permanent residency.

Physicians typically have three options when they complete their programs:

1. Go back to their home countries or countries of last residence for two years and then reenter the US on a work visa;
2. Pursue a waiver of 212(e) by receiving the support of a federal agency or a state health agency (typically based on an agreement to work in a medically underserved community), obtain a waiver based on an exceptional hardship to a US citizen or permanent resident spouse or child, or obtain a waiver based on demonstrating that the applicant will be subjected to persecution (similar to an asylum claim). Most waivers are based on working in medically underserved communities.
3. Leave the US and reenter on a visa, like an O-1 visa for physicians with extraordinary ability in the sciences (note that this really only postpones the need to satisfy or waive 212(e)'s foreign residence requirement).

Applicants for J-1 visas must have their educational credentials certified as being equivalent to or greater than a US medical degree by the Educational Commission on Foreign Medical Graduates (ECFMG). Applicants must also pass parts 1 and 2 of the US Medical Licensing Examination (USMLE), which includes passing the Clinical Skills assessment. That assessment requires a physician applicant to go through a series of interactions with actors playing the parts of patients and health care professionals in order to test the communications skills of a doctor. English examination passage is also required. Because the clinical skills part of USMLE is only offered in the US, physicians typically need to come to the US first as visitors before coming on a J-1.

Once a physician is admitted to a training program at a teaching hospital and ECFMG has issued its certificate and a DS-2019 exchange visitor participant form, the doctor can apply for a J-1 visa at a US consulate abroad.

The H-1B Visa

H-1B physicians coming to the US to train are petitioned by the teaching hospitals rather than ECFMG. Teaching hospitals must demonstrate that they are paying the physicians the higher of the prevailing wage in the community or the actual wage paid to similarly positioned physicians at the hospital.

H-1B physicians must pass all three parts of USMLE before they can obtain an H-1B visa and must demonstrate that they have whatever type of license is required in the particular state where the training will take place. The doctor typically needs an ECFMG certification for licensure.

A petitioning employer must first file and receive approval for a Labor Condition Application (LCA) from the US Department of Labor. Once the LCA is certified, the employer files an H-1B petition with a US Citizenship and Immigration Services

(USCIS) service center. Once the H-1B petition is approved, USCIS cables its approval to the State Department, and the case soon makes it to a US consulate overseas. The physician then applies for the visa at the consulate before coming to the US. Employers must demonstrate that they will pay the prevailing wage in the community for GMEs and maintain public access files. The hospital must typically also demonstrate that it is exempt from the annual H-1B quota of 65,000 visas because those visas are typically not available in July, when residency and fellowship programs typically begin. Most training programs are exempt because they are either run by universities or non-profit hospitals affiliated with universities.

Pluses and Minuses of the J-1 and H-1B visas

1. *Training periods*

J-1 physicians can remain on the visa for up to seven years while pursuing graduate medical education. H-1B physicians can only be in that status for six years. Furthermore, if a J-1 physician obtains a waiver of 212(e), he or she can get an additional six years of H-1B training. For physicians in long subspecialty training programs, this can be critical.

2. *Exam requirements*

J-1 physicians are only required to pass the first two parts of USMLE. The third part can be dealt with after the physician is already in the US as a J-1. H-1B doctors, however, must pass all three parts of USMLE prior to getting the visa.

3. *H-1B requirements*

The H-1B cap noted above is a serious problem for many H-1B physicians in graduate medical training. While doctors are usually not subject to the quota when they enter training programs, because the programs are run by universities or non-profit employers affiliated with universities, doctors do become subject to the cap when they find their first post-training job. Often, there are no visas available at that time, and in years when demand for H-1Bs is especially strong, cap-subject H-1Bs may not be available for as long as 15 months after completing training. That can result in physicians having to limit their job search to positions at non-profit employers and university hospitals.

4. *Costs*

While physicians don't have to bear the filing costs for H-1B petitions, the employing petitioner typically needs to consider costs, particularly during this time of tight budget constraints. H-1B USCIS filing fees are typically anywhere from $820 to $3320 depending on the type of employer and the speed of processing chosen and a few hundred dollars for the visa fee at the consulate. Outside attorneys are often needed for H-1Bs and this can add a few thousand dollars to the process as well. There is a significantly lower price tag for J-1 visas. For J-1s, hospitals typically do not need to use an outside law firm, and the government filing fees are just a few hundred dollars for the consular visa fee.

5. *For-profit training programs*

As noted above, for-profit hospitals running training programs are not exempt from the H-1B cap. The J-1 visa does not restrict for-profit employers and they are eligible to hire doctors using that visa.

6. Ease of administration

Hospitals hiring J-1 doctors do not have to sponsor the doctors for their visas. That is ECFMG's task. While hospitals need to comply with ECFMG rules for their doctors to get ECFMG sponsorship, this is generally not as onerous as the requirements that apply to H-1B employers. Hospitals using the H-1B category to hire a physician must file a LCA with the Department of Labor and then an I-129 petition with USCIS.

7. J-1 Waiver headaches

The chief reason doctors used to avoid the J-1 in years past was the need to get a waiver of the two year home residency requirement to remain in the US. That meant finding a qualifying job in a shortage location, finding a waiver program willing to sponsor (and most were only willing to sponsor primary care doctors), having a waiver slot available and having an H-1B number available to convert to after the waiver was approved. The environment has changed considerably over the last decade. A much larger number of communities qualify as shortage areas eligible for J-1 sponsorship, states can now sponsor up to ten doctors a year working on "flex" slots in non-shortage area locations, most state and federal waiver programs now sponsor specialists for waivers, and H-1B cap exemptions are available to J-1 doctors receiving waivers based on working in shortage areas or VA hospitals.

Nevertheless, if a physician is interested in working for an H-1B cap exempt employer and is not running out of H-1B time, being free of the J-1 home residency requirement is an advantage.

8. Spouses and children

J-2 spouses of J-1 physicians can receive an employment authorization document that allows most types of employment as long as the J-1 spouse remains in J-1 status. H-4 spouses are not granted employment authorization.
J-2 spouses and children are subject to a home residency requirement along with the J-1. That means that even if the J-1 goes home, the J-2 is not off the hook for the home residency requirement until the J-1 has finished meeting the residency test.

9. Timing

Physicians looking to remain in the US following their training can face challenges switching in a timely matter to their first post-training position, depending on the visa chosen. Those on J-1 visas need to get a waiver of the home residency requirement and then switch in to H-1B status and that process can often take well over six months to complete (though it is also possible to get it done a few months fast than this depending on the government agency sponsoring the waiver and how quickly the State Department is approving its recommendations.

H-1B transfers can often be done in a matter of weeks. The key factor is usually whether an H-1B visa quota number is available. If not, doctors may end up waiting many additional months.

H-1B doctors running short on time left in H-1B status may also need to find post-training employers willing to start green card processing shortly after starting those jobs or even, when possible, while the doctor is still in training (this assumes that the doctor qualifies for the job based on training already completed before the green card process begins). If a doctor has more than a year of his or her six years of H-1B time left when the PERM labor certification application or the I-140 immigrant visa petition is filed, it may be possible to extend H-1B status as needed until green card processing is finished. If less than a year remains, the doctor could face having to stop work for several months.

J-1 doctors are also restricted in how much of the green card process can progress while they are in their J-1 waiver service period. They can go through the PERM labor certification process and also file an I-140 petition. They cannot file for adjustment of status until their three year service period is completed. H-1B track physicians can file for permanent residency as soon as they have their license in place and are qualified to begin the post-training job.

10. Dual Intent

H-1Bs are “dual intent” visas, and a consular officer or USCIS official cannot deny the petition because of concerns that the doctor will immigrate to the US. That is not the case for J-1s. In reality, most J-1 applications are not denied over this issue, but physicians still need to make the case that they intend to leave the US when their J-1 time is over.

11. Contracts

J-1 waiver programs come with numerous contract requirements that some physicians and employers may find onerous. Contracts need to be for three years or more, specify that the physician will be employed at least forty hours per week in an underserved area. Many programs also require employers to strip out restrictive covenants, agree to post sliding fee scales and drop “without cause” termination clauses. Doctors may also have to sign liquidated damages provisions that require the payment of financial penalties if a doctor leaves the underserved community. H-1B cases do not require contracts at all and other than the requirement to pay the prevailing wage, employers and doctors have a lot of flexibility in structuring the employment relationship.

Conclusion

There is no clear winner in the bout between the J-1 and the H-1B visa, but the J-1 visa has certainly made a comeback in recent years as many of the worst problems with the J-1 waiver program have been addressed. But the H-1B still has attractions that may make it the logical choice for some doctors. The unknown question at this point is how changes being considered by Congress would affect the decision-making process. Those changes might include providing H-1B cap exemptions for doctors taking jobs in shortage areas and providing more J-1 slots. Furthermore, the H-1B program in general is under attack, and USCIS and Congress are imposing more and more restrictions on the category. How these changes will affect doctors is not yet entirely clear, but will certainly bear close monitoring.