

Chapter 3E

Workforce Issues at Critical Access Hospitals

With Particular Attention to the Use of International Medical Graduates

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There are close to 800,000 physicians practicing in the U.S. today, of which one-fourth are graduates of medical schools in other countries.¹ Most of these graduates are foreign-born, although a small percentage of them are U.S.-born citizens who graduated from non-U.S. medical schools.

There is a longstanding debate between those who advocate and others who oppose a decrease in the proportion of international medical graduates (IMGs) in the medical workforce (Mullan, 2000). A number of policy-oriented organizations² have long advocated for lowering the number of IMGs, while a variety of interest groups have found IMGs to be willing (or able to be induced) to provide care to underserved poor urban or rural populations. Until recently, the pro-IMG voices have typically prevailed in policy debates.

A prominent issue in these debates is whether IMGs are more likely than their U.S. medical graduate counterparts (USMGs) to contribute to the health care safety net, or whether they simply exacerbate a physician surplus (Mick, 1999; Politzer et al., 1998). In the short run, new IMGs can often be induced to serve in underserved communities for at least three years while they participate in various visa-waiver programs.

Evidence shows IMGs are no more likely to practice in urban poor or rural underserved areas than their USMG counterparts. Nonetheless, about one-quarter of community health centers rely on IMGs to fill physician vacancies (Baer et al., 1999). In addition, it has been estimated that if all IMGs currently in primary care practice were removed, “one out of every five ‘adequately served’ non-metropolitan counties would become underserved and the percentage of rural counties with physician shortages would rise to 44.4 percent” (Baer et al., 2001).

¹ An increase of well over 100% since the start of the 1970s. Medical school enrollment increased by about 50% over that time, and is now at about 16,000 per year, per the U.S. Bureau of Health Professions <<http://bhpr.hrsa.gov/healthworkforce/factbook.htm>> (June 13, 2002).

² The American Medical Association, the Council on Graduate Medical Education, and the American Association of Medical Colleges, to name three.

Federal programs were launched in the 1990s to make IMG practice in the U.S. more accessible. It was considered a reasonable strategy to address the physician maldistribution problem in rural and inner city underserved areas. Many IMGs come to this country to receive residency training on J-1 student visas. One of the requirements of that visa status is that the student return to his or her home country for at least two years before applying for a permanent residency visa to return to the U.S. A “J-1 visa waiver” can be granted by the Immigration and Naturalization Service (INS) and the State Department, however, if it is deemed to be in the national interest. Interested government agencies can recommend that IMGs receive these waivers if they find employers in health professional shortage areas (HPSAs). Most IMGs in the U.S. have already completed their J-1 waiver commitments, however, and are here as permanent residents.

Two of the most significant interested government agencies for placing foreign-born physicians are the Appalachian Regional Commission (ARC), which places between 50 and 75 physicians a year in portions of 13 states,³ and the U.S. Department of Agriculture (USDA). Many rural hospitals, clinics, and private physician offices find IMGs to fill their openings, and sponsor them with the USDA or ARC or a state health department to receive a J-1 visa waiver. The USDA recommended over 3,000 IMGs for rural practice between 1994 and 2001.⁴ After September 11, 2001, however, the agency became reluctant about its role in allowing foreign nationals to stay in the U.S., and announced it would no longer be an interested government agency for the purpose of recommending J-1 visa waivers to the INS. The USDA has announced it will process all requests that were pending before September 11, and a White House Task Force has been assembled to determine the future of the program.

The federal Conrad-20 program was passed as an amendment to immigration legislation sponsored by Senator Kent Conrad (D-ND) in 1997. It allows state health departments to be interested government agencies for the purposes of recommending J-1 visa waivers. Health departments may recommend up to 20 such waivers annually, for any HPSA in its state (rural or urban). Bills before Congress this year⁵ would increase the limit on the number of waivers and extend the sunset provisions of the program. That will not entirely make up the deficit caused by USDA’s exit from the scene, however, for states like Texas, Louisiana, Michigan, California, Florida, New York, Illinois, and others.⁶

³ ARC states include Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia, West Virginia. Numbers reported by Duane J. DeBruyne, Office of the Federal Co-Chairman, Appalachian Regional Commission, Washington, DC, 202-884-7663.

⁴ Per USDA program coordinator, March, 2002.

⁵ S. 1259 for the 107th Congress, introduced July 27, 2001, by Senator Sam Brownback (R-KS) and H.R. 4858, introduced June 20, 2002, by Rep. Jerry Moran (R-KS).

⁶ The USDA sponsored 1,712 J-1 visa waivers in those 7 states alone between 1994 and 2001, per USDA program coordinator, March, 2002.

Research Objective

Against this backdrop, our aim was to determine how reliant America's smallest and most rural hospitals are on IMGs for physician staffing to provide care in their communities, and to describe the chief executive officer's (CEO) perceptions of their roles, quality and interpersonal skills.

Our hypothesis is that, given the difficulty small rural communities have in recruiting physicians to practice in their towns, and the incentives IMGs face to practice in designated HPSAs, critical access hospital (CAH) communities would rely significantly on IMGs for physician staffing. We also hypothesized that IMGs in these remote rural towns would not differ significantly from the national profile of IMGs in terms of specialty, countries of origin or perceived competency.

Study Design and Methods

The University of Minnesota's Rural Health Research Center (UM) coordinated the development of a survey instrument that was administered to eligible administrators of America's smallest, most rural hospitals. The instrument was designed with the three other university-based centers involved in tracking the federal Rural Hospital Flexibility Program (Flex Program). The Flex Program authorizes federal designation of CAHs, a category of hospital licensure in the Medicare program for facilities with 15 or fewer acute care beds. Hospitals elect whether and when to convert to CAH status. CAHs receive cost-based reimbursement from Medicare.

The University of Washington was responsible for the IMG questions in the survey, which we tested on administrators of seven small hospitals in several states (Washington, Montana, New Mexico, and Oregon). The whole questionnaire was tested on ten additional administrators.

Following approval from human subjects review committees, UM staff conducted the survey in the winter of 2002. A letter was mailed to all eligible hospital administrators, introducing the project. In addition to providing background information and contact phone numbers, the mailing included a fact sheet for administrators to complete prior to the phone interview to collect information about hospital bed size, payer mix, nurse staffing volumes, patient days, length of stay, and related statistics.

CEOs of all facilities that had converted to CAH status as of May 1, 2001 (406 hospitals), were asked to answer a 22-page, 55-question telephone survey on a variety of topics in the winter of 2002. The IMG portion of the survey consisted of 10 questions. The response rate was 96 percent, with 388 hospitals responding from 39 states. An additional 234 CAH facilities have been designated as of June 2002.

Findings

Hospitals responding to the survey had an average of 20 beds, including long-term care “swing” beds. Their average length of stay was 3.4 days, with a 25 percent occupancy, and they serve communities with a typical population of approximately 30,000. The average operating margin was a negative 15.3 percent.

Clinical Workforce

The average number of physicians reported to be practicing in each town was 4.8, with a range of 0-35 (median = 4). One in four towns had one or more physician who did not admit to the hospital. Another third of towns had at least one physician who works part time (12% overall have more than one part-time physician).

More than half the hospitals (58%) employ physicians using a payroll mechanism. Of those that do, 34 percent employ just one physician and another 32 percent have two. In addition, the average CAH reported 2.4 nurse practitioners practicing in their towns, with a median of two. We do not know how many of them are part time.

Recruitment and Retention

Physician retention and recruitment to maintain current levels of service is a “major problem” for 42 percent of hospital administrators. For those who might want to expand into new services, 47 percent say recruitment of physicians to fill those needs would be a major problem. Only 27 percent responded that physician retention and recruitment was a major strength for ongoing operations.

Emergency Room (ER) Staffing

Half the hospitals reported that they used their own physician employees to cover the ER at least part of the time, and half contract with local physicians to cover their ERs at least part of the time. About 43 percent use non-physician clinicians to cover ERs at least some of the time.

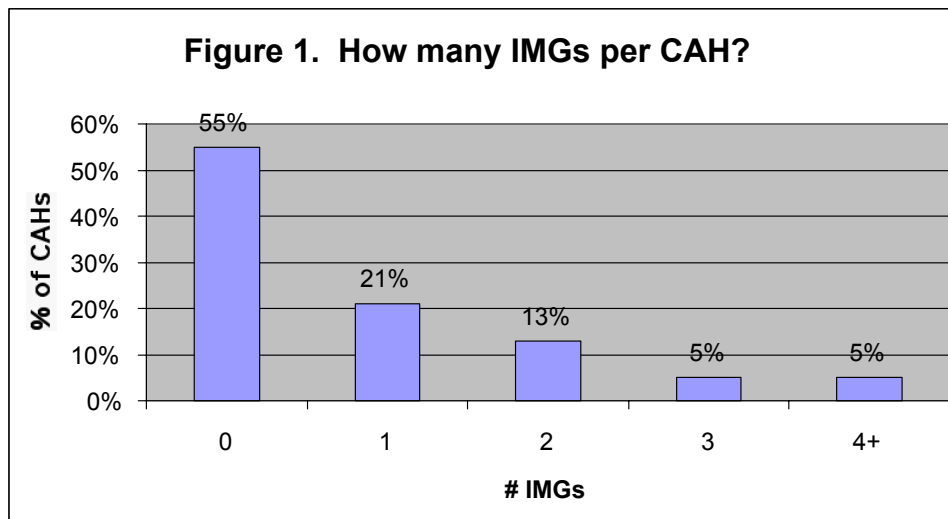
More than one-third of the CAHs in our survey (37%) contracted with an out-of-town entity to cover at least some of the physician staffing in the ER. One previous study on rural ER staffing conducted ten years ago found the number then was substantially higher—59 percent of rural hospitals in Washington State employed external contract physicians to cover their ERs some or all of the time (Williamson et al., 1991).

Of those who contract out ER coverage to an out-of-town entity, about 40 percent also have hospital-employed physicians and/or local physicians who cover some of the ER time. Among those who contract out, about 31 percent also use non-physician clinicians to cover the ER some of the time. CAHs in the smallest and most isolated communities

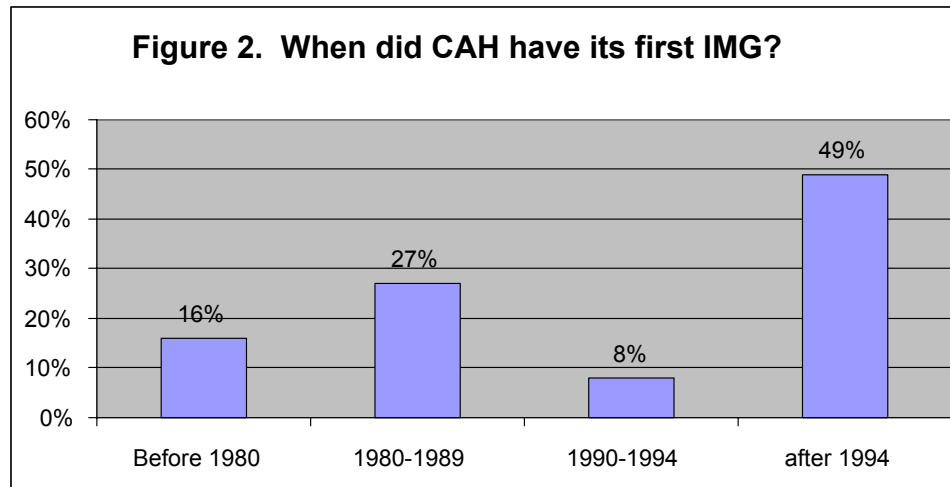
were less likely to contract out ER coverage than the CAHs in closer proximity to urban areas.⁷

International Medical Graduates

Administrators from 167 hospitals (45%) reported they currently had local IMGs admitting to their hospital (see Figure 1). Another 17 percent indicated they had had an IMG in the past, but did not now.



⁷ This analysis used Rural-Urban Commuting Area (RUCA) codes, collapsed into 4 categories; 28% of the hospitals in Category 4—the most isolated hospitals—contracted with an out-of-community entity, compared to 72% that did not have such contracts. In contrast, 53% of those more proximate to urban places used contracted physicians in their ERs, compared to 47% that did not. RUCAs are described in more detail at <<http://www.ers.usda.gov/Briefing/Rural/Data/desc.htm>> (May 30, 2002).



Note: USDA and Conrad-20 programs began in 1994.

Almost half of the CAHs with an IMG (48%) admitting to the hospital reported having only *one* IMG, while 11 percent had four or more. Fifteen percent of CAHs reported at least half their admitting physicians were IMGs. About one in four (24%) of the physicians admitting to CAHs are reported to be IMGs. Hospitals with fewer than five total admitting physicians reported that 28 percent of those physicians are IMGs, compared to only 17 percent for towns with five or more physicians.

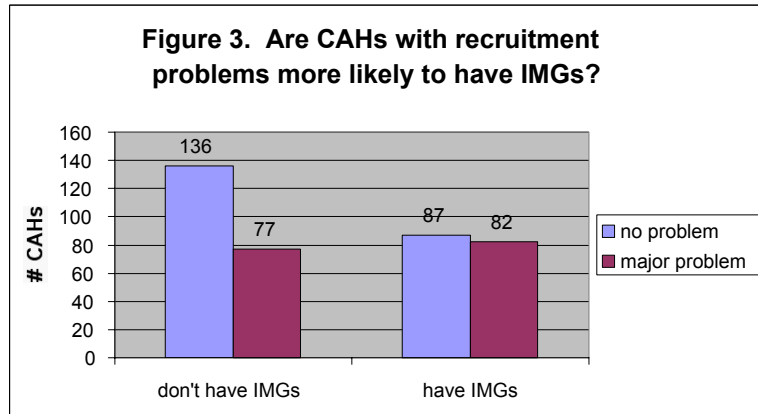
The role of IMGs seems to be increasing, as 49 percent of CAH administrators reported their communities had their first IMGs during or after 1994 (see Figure 2). Some communities, though, have relied on IMGs for more than 20 years—16 percent of hospital administrators indicated they had an IMG before 1980.

Almost half (49%) of IMGs admitting patients to CAH facilities had been in their communities three years or fewer. Three years is the typical obligation period for Conrad-20, USDA and other interested government agency sponsors of J-1 visa waivers. Seventy percent of these IMGs had been in their communities six years or fewer.

Administrators who reported that ongoing physician recruitment was a “major problem” were significantly more likely to have IMGs at their facilities than those for whom recruitment was either a strength or not a problem ($p=.015$). (See Figure 3.)

42% of communities reported problems with physician recruitment.

Communities with ongoing physician recruitment problems have a larger proportion of IMGs.



Hospitals east of the Mississippi River are more heavily reliant on IMGs than hospitals in the west. Indeed, IMG dependence is highly differentiated by region of the country, with the mid-Atlantic region 35 times more likely to have IMGs in its CAHs as the Pacific Northwest region. Of the states with five or more responding CAHs in our study, we found the portion with one or more IMGs to be highest in North Carolina, Kentucky, New York, West Virginia, Illinois, Indiana, and Georgia (70% or more of the hospitals in those states had one or more IMGs). The states with the most hospitals where two-thirds or more of the admitting physicians were IMGs included Florida, New Mexico, Louisiana, North Carolina and Tennessee. The distribution of IMGs did not seem to vary by the degree of rural remoteness of CAH communities.

Of the 388 hospitals in our study, 53 are located in “persistent poverty” rural counties as defined by the USDA’s Economic Research Service. Thirty-three of these hospitals, or 62 percent, have one or more IMGs, compared to 42 percent of non-metropolitan counties that are not classified as persistently poor.

The majority of IMGs admitting patients to CAHs are internists (59%). (See Figure 4.) Another 26 percent are family practitioners, with 6 percent each working as surgeons or pediatricians. Obstetric (OB) services were significantly less likely to be found in hospitals with one or more IMGs than in hospitals with no IMGs (69% versus 31%, $p=.000$). This may be because IMGs are more likely to be internists who do not perform OB services.

The majority of IMGs in CAHs (61%) come from the same three countries that supply most of the U.S.’s IMGs: India, the Philippines and Pakistan. Two-thirds of the 89 CAH physicians from India were internists and 22 percent family practitioners. There were only two family practitioners among the 44 CAH physicians from Pakistan, while a third of the 62 physicians from the Philippines were family practitioners. The longest-tenured IMGs were largely from the Philippines and India, while Pakistani physicians tended to be newer. (See Table 1.)

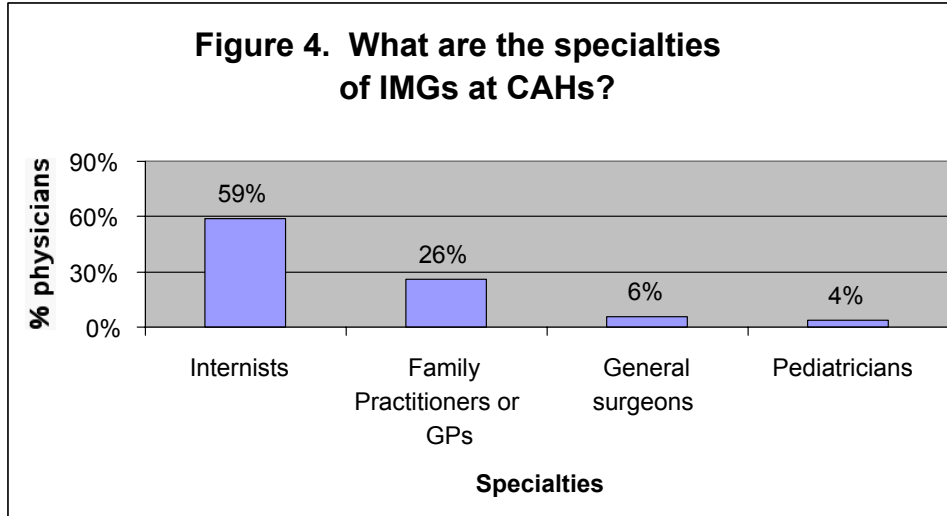
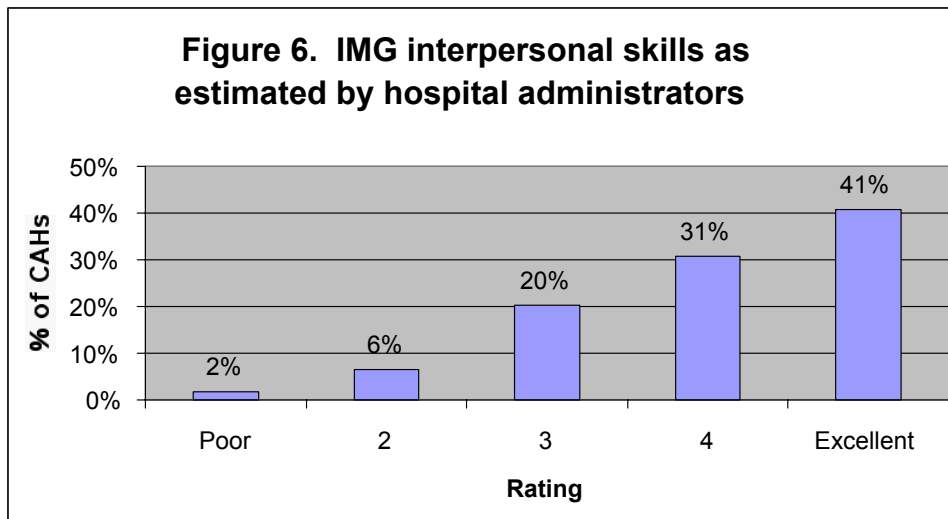
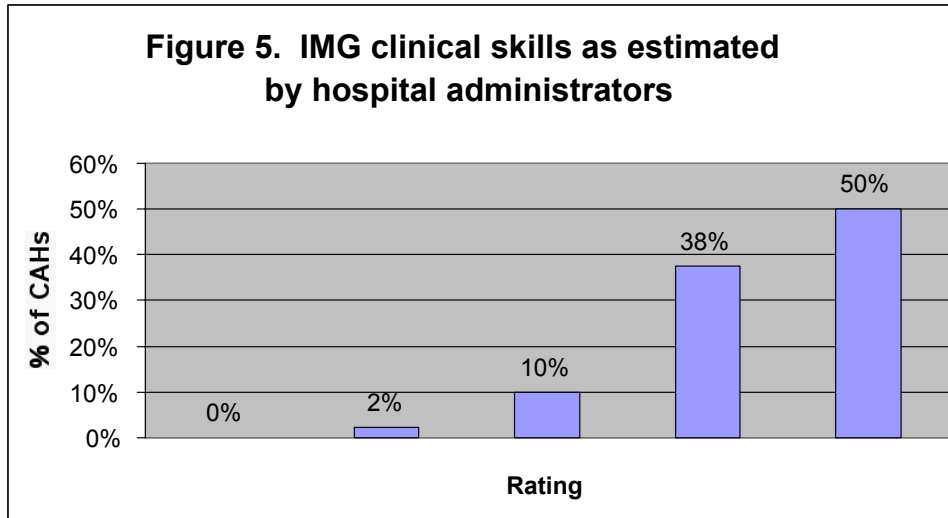


Table 1. Number of IMGs by County of Origin and Discipline

	India	Philippines	Pakistan	Totals
Internal medicine	58	34	36	128
Family Practice	19	20	2	41
Surgery	3	5	1	9
Pediatrics	3	1	1	5
Ob/Gyn	0	1	1	2
Totals	83	61	41	

The hospital administrators rate IMG clinical skills highly (50% said excellent on a 5-point scale), and their interpersonal skills only slightly lower (41% said excellent). (See Figures 5 and 6.) Only four administrators reported that their IMGs, on average, had very low clinical skills. Of those four, two were said to also have low interpersonal skills. Of the 14 with low reported interpersonal skills, 86 percent were reported to have adequate or better clinical skills.



We asked administrators to tell us about their experience with IMGs in an open-ended question. When categorized, we found half of the 115 administrators who wrote comments had unreservedly positive comments about the IMGs in their communities, 27 percent gave their IMGs mixed reviews, and 23 percent had strictly negative comments. (See Table 2.) Many of the positive comments were duplicates of each other, so they are not repeated here, whereas there was more variety among those who were dissatisfied.

Table 2. Sample of Positive and Negative Comments about IMGs*A few of the positive comments included:*

- Very hard workers, and both are kind and compassionate.
- Current doctor has integrated into the community beautifully, speaks language well.
- Dr. from Ghana is awesome.
- We are very fortunate. They are very knowledgeable and embrace the community. The community embraces them too.
- We lucked out; very well assimilated, adored by the population. He is a gem!
- They have been our life saver. Only reason we are in existence today.
- They work hard and are willing to take call.
- Dr. is excellent to work with, willing to take the time needed with patients.
- We've had a great experience. Even after 9/11, there was no fallout from the community.
- I could use a couple more.

Some of the negative or mixed comments included:

- The feeling I have is that most IMGs are wonderful with patients, but difficult to work with.
- Sometimes there is a lack of business knowledge, policies and procedures of the hospital, which makes it more difficult to get them to understand what we have to do as a rural hospital.
- IMGs are mostly internal medicine; do not have good skills with general medicine, pediatric, ortho, ER, general trauma.
- Frustrating to get them legal. Took them nine months to get one certified and he was already here.
- Not had very good luck with J-1 program. It's hurt the hospital's reputation, the high turnover rate.
- They never stay past the required time.
- Not a good experience—cultural aspect—rural folks have a problem with foreign physicians, especially female doctors.
- Total disaster. Local population was very intolerant. Doctors were very abusive to nursing staff. We spent thousands on sensitivity and training—all to a disastrous end.
- Difficult for rural community to accept foreign graduates. Right now, it is especially difficult with the current world situation.
- Heart of redneck country and many people won't give him a chance.

Limitations

A limitation of this report is that the source of information is entirely from the point of view of the CEO, who may have had a short tenure at the facility (average tenure is under six years) or may have limited knowledge.

Discussion

America's critical access hospitals are significantly reliant on foreign-born graduates of non-U.S. medical schools. More than half the CAHs currently have (or recently had) at least one IMG on the active medical staff, and in 15 percent of the hospitals more than half the physicians are IMGs. In half the states, at least half the hospitals had IMGs. Furthermore, their role seems to be increasing.

Given the apparent importance of IMGs in CAHs, recent and proposed changes to immigration policy may have significant implications. The USDA's decision to stop serving as an interested government agency for purposes of sponsoring J-1 visa waiver requests could reduce the number of IMGs in rural areas, as would the possible sunset of the Conrad-20 program. Increasing constraints on immigration generally, and especially from South Asia and the Middle East because of concerns about national security, will affect the significant physician immigration stream from those areas. All these issues are highly fluid and subject to rapid change as we write this chapter.

If the IMG pipeline were to dry up without a replacement source of physicians, CAHs would lose a substantial portion of their physician workforce. Current U.S. policy on IMGs is murky. The USDA has ceased to serve as an interested government agency for purposes of sponsoring J-1 visa waiver physician applicants in rural areas. Additionally, the Conrad-20 program has begun to sunset, as the authorizing legislation⁸ declared foreign doctors who enter the U.S. or change status to J-1 after June 1 are no longer eligible to participate in a state Conrad-20 program when they graduate.⁹ Without a renewal of the legislation, in three years the program would be virtually over.

The nationality and specialty profile of IMGs in CAHs is similar to IMGs nationally. Most are internists, and many of these internists have likely been trained in a sub-specialty area, either in their home countries or in the U.S., although they may be acting as primary care physicians while they fulfill their periods of obligation in rural settings. This can be problematic, as sub-specialists have different practice styles than generalists and have a more limited scope of practice, especially for pediatric and obstetrical care.

⁸ Section 622 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRAIRA), 8 C.F.R. § 212.7(c)(9)(i)(A).

⁹ Federal Register: 4/16/97: 62(73), final rule on 8 CFR parts 212, 245 and 248.

Indeed, we found hospitals with IMGs were less likely to offer obstetrical services, although this may be confounded by other issues. Additionally, the skills mismatch between a sub-specialty level of training, and the primary care scope of services to be offered during the period of obligated service, may reduce the probability that the physician will remain in the position or the community when the period of obligation is completed.

The nationalities of physicians in CAH communities are similar to the backgrounds of IMGs generally in the U.S. India, the Philippines and Pakistan contribute the largest numbers of IMGs. While IMGs generally tend to be internists, the chances of finding family practitioners from India and the Philippines are higher than from Pakistan.

In open-ended comments, hospital administrators expressed concern about the amount of turnover among IMGs in their rural communities. We do not know the number of IMGs who were fulfilling J-1 visa waiver obligations by serving in rural HPSAs, but we do know that half the physicians in these communities had been there only three or fewer years. Rural communities rely on a small number of physicians, and continual turnover within that group can be disruptive and weaken the hospitals.

Six states in the U.S. host 73 percent of all immigrant population, both skilled and non-skilled: California, Texas, Florida, New York, New Jersey and Illinois (Money, 1997). IMGs are also substantially more likely to settle in a handful of states. In general, the percentage of post-residency primary care IMGs in HPSAs is highest in Florida, West Virginia, North Dakota, and Illinois (Baer et al., 1998). The presence of fellow nationals likely contributes to a continually increasing number of immigrants in some locations, in a phenomenon known as “chain migration” (Foulkes & Newbold, 2000). In these data limited to the experience of CAHs, we did not see the same amount of clustering as occurs with immigration patterns nationally. While there was more IMG experience east of the Mississippi region, and while the odds of having an IMG were highest in the mid-Atlantic states, there was still a considerably wide distribution of IMG experience across the states.

CEOs reported high satisfaction with the clinical skills of the IMGs practicing in their hospitals, but somewhat lower satisfaction with their interpersonal skills. This is consistent with the literature. Half of the 115 administrators who commented had unqualified positive remarks about the IMGs admitting to their hospitals. In the communities where it is working well, it seems IMGs have adapted well socially, have good English skills, are willing to work hard (perhaps harder than would be expected of USMGs), and have been accepted by the community. Not all communities have been welcoming, however, and in some places where the administrators expressed concern it seemed the community was not adapting to the idea of a non-U.S. medical graduate.

Conclusions

Evidence exists in our study that IMGs are located in areas of higher stress than communities without any IMGs. These are communities with fewer physicians, more recruitment problems, and no outside contracts for emergency room coverage. Additionally, the non-metropolitan counties classified “persistently poor” by the USDA are significantly more likely to have IMGs than other rural counties.

Given the heavy dependence of U.S. critical access hospitals on graduates of non-U.S. medical schools, policy makers who advocate reducing the number of IMGs must consider alternative strategies to meet the physician workforce needs of America’s smallest rural hospitals. It is ironic that America’s poorest and most rural communities rely on physicians trained in some of the world’s poorest countries.

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