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ABSTRACT

Congressional hearings on H.R. 7118, a bill to amend the Immigration and Nationality Act with respect to the admission of foreign medical graduates for graduate medical education, are presented. The bill would allow an extension of the time by which hospitals are required to reduce their reliance on foreign medical graduates. In particular the bill would authorize: a two-year extension of the substantial disruption waiver authority for those hospitals that make a clear showing by means of a comprehensive plan that they are phasing down reliance on foreign medical graduates by recruiting U.S. medical graduates, improving the quality of the program, and attempting to use alternative health care providers. The bill suggests that the National Health Service Corps should play a prominent part in providing medical services while hospitals and programs develop and implement their plans. Testimony by representatives of the federal government, the City and State of New York, and the medical community are presented. Statements regarding the bill and alternative proposals are appended (SW)

ADMISSION OF ALIEN PHYSICIANS FOR GRADUATE MEDICAL EDUCATION

HEARING

BEFORE THE

SUBCOMMITTEE ON IMMIGRATION, REFUGEES, AND INTERNATIONAL LAW

OF THE

COMMITTEE ON THE JUDICIARY HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

H.R. 7118

A BILL TO AMEND THE IMMIGRATION AND NATIONALITY ACT WITH RESPECT TO THE ADMISSION OF ALIEN PHYSICIANS FOR GRADUATE MEDICAL EDUCATION

MAY 14, 1980

Serial No. 38

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ADMISSION OF ALIEN PHYSICIANS FOR GRADUATE MEDICAL EDUCATION

WEDNESDAY, MAY 14, 1980

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON IMMIGRATION,
REFUGEES, AND INTERNATIONAL LAW
OF THE COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met at 2:07 p.m. in room 2237 of the Rayburn House Office Building; the Hon. Elizabeth Holtzman (chairwoman of the subcommittee) presiding.

Present: Representatives Holtzman, Hall, Butler, and Lungren.

Also present: Arthur P. Endres, Jr., counsel; James B. Schweitzer, assistant counsel, and Alexander B. Cook, associate counsel.

Ms. HOLTZMAN. The subcommittee hearing on H.R. 7118, relating to the admission of foreign medical graduates will commence. My opening statement will be incorporated at this point in the record.

[Material referred to follows:]

OPENING STATEMENT OF HON. ELIZABETH HOLTZMAN

Today's hearing has been called to consider legislation (H.R. 7118), which I have introduced relating to the admission of foreign medical graduates (FMG's) to the United States.

Almost 4 years have passed since Congress passed legislation to insure that only medically and English-language qualified FMG's could enter the U.S. as immigrants or nonimmigrants. Because it was anticipated that the legislation would abruptly reduce the available supply of FMG's that has served many public hospitals for years, the 1976 law attempted to provide a reasonable and orderly transition period. In particular, it authorized a waiver of the Visa Qualifying Examination (VQE) until December 1980 for those institutions which would experience a substantial disruption of health services if FMG's were not available.

Regrettably, many municipal and voluntary hospitals did not take advantage of this grace period and as a result continue to rely heavily—if not exclusively in some instances—on FMG's for house staffing and patient care. The underlying purpose of the 1976 law was to upgrade the educational standards for FMG entry to this country and I do not believe that we can indefinitely postpone the achievement of that objective. Likewise, we cannot continue a system of "second class" medical care for the poor and disadvantaged in our inner-city neighborhoods, who are in many cases totally dependent on FMG's for primary medical care.

On the other hand, I am troubled by the findings contained in a report recently issued by Carol Bellamy, President of the New York City Council to the effect that failure to extend the substantial disruption waiver authority could seriously disrupt medical care in New York City's public hospitals. The report also notes that "FMG's now make up 93 percent of the Health and Hospital Corporation pediatricians in Brooklyn and that new policy could leave the Borough without any children's services in its municipal hospitals."

and complex problem I have introduced a bill (H.R. 7118)
extension of the transition period but at the same time re-
y the hospitals to reduce their reliance of FMG's. In par-
uthorize: A 2-year extension of the substantial disruption
hose hospitals which make a clear showing by means of a
t they are phasing down reliance on FMG's by (1) recruit-
uates; (2) improving the quality of the program; (3) and
ernative health care providers. An additional one year exten-
stantial progress has been made by the institution during

I firmly b[illegible]ve [illegible]at a longer period—as proposed by some—will unduly delay
talled plan[illegible]and active recruitment on the part of municipal hospitals.
The [illegible]em must be addressed quickly and we must—as my bill does—
requi[illegible]ensive planning and rigid reporting on the efforts that are being
ade to [illegible]d for all terminate dependency on FMG's.
[illegible]o reflects my view that the National Health Service Corps should
ay a prom[illegible]nent part in providing medical services while hospitals and programs
[illegible]implement their plans. By deeming hospitals receiving waivers as
[illegible]npower Shortage areas and allowing National Health Services Corps
[illegible], to count residence toward their service obligation, we could insure
or[illegible]ly and smooth phase out of FMG reliance.
[illegible]der to discuss the difficult issues surrounding the FMG problem and to
[illegible]nt on my proposal, I have invited officials from the Federal Government.
[illegible]ity and State of New York and the medical community to testify today
b[illegible]re the Subcommittee. We welcome our witnesses here today and we anxi-
o[illegible]ly await your testimony.

[A copy of H.R. 7118 follows:]

96TH CONGRESS
2D SESSION

H. R. 7118

To amend the Immigration and Nationality Act with respect to the admission of certain aliens for graduate medical education or training programs.

IN THE HOUSE OF REPRESENTATIVES

APRIL 22, 1980

Ms. HOLTZMAN introduced the following bill; which was referred jointly to the Committees on the Judiciary and Interstate and Foreign Commerce

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A BILL

To amend the Immigration and Nationality Act with respect to the admission of certain aliens for graduate medical education or training programs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 212 of the Immigration and Nationality Act (8 U.S.C. 1182) is amended by striking out the semicolon at the end of paragraph (32) of subsection (a) and inserting in lieu thereof a period and the following: "For the purpose of this paragraph and subsection (j)(1)(B), an alien who is a graduate of a medical school shall be considered to have

passed parts I and II of the National Board of Medical Examiners examination if the alien was fully and permanently licensed to practice medicine in a State on January 9, 1977, and was practicing medicine in a State on that date;".

(b)(1) Subsection (j) of such section is amended by striking out "Commissioner of Education" and "Secretary of Health, Education, and Welfare" each place it appears and inserting in lieu thereof "Secretary of Education" and "Secretary of Health and Human Services", respectively.

(2) Paragraph (1)(B) of such subsection is amended—

(A) by striking out "(ii)" and inserting in lieu thereof "(ii)(I)"; and

(B) by inserting "(II)" before "has competency", "(III)" before "will be able to adapt", and "(IV)" before "has adequate prior education".

(3) Such subsection is further amended—

(A) by striking out "(including any extension of the duration thereof under subparagraph (D))" in paragraph (1)(C);

(B) by amending subparagraph (D) of paragraph (1) to read as follows:

"(D) The duration of the alien's participation in the program of graduate medical education or training for which the alien is coming to the United States is limited to the time typically required to complete such

program, as determined by the Director of the International Communications Agency at the time of the alien's entry into the United States, based on criteria established in coordination with the Secretary of Health and Human Services; except that the alien may, once and not later than two years after the date the alien enters the United States as an exchange visitor or acquires exchange visitor status, change the alien's designated program of graduate medical education or training if the Director approves the change and if a commitment and written assurance with respect to the alien's new program have been provided in accordance with subparagraph (C)."; and

(C) by striking out "December 31, 1980" in paragraph (2)(A) and inserting in lieu thereof "December 31, 1982 (an additional one-year extension may be granted, until December 31, 1983, in the case of a program which the Secretary of Health and Human Services finds has substantially reduced its reliance on aliens who are graduates of foreign medical schools and has made substantial progress in carrying out its plan as described in clause (ii) in 1981 and 1982)".

(4) Paragraph (2)(A) of such subsection is amended—

(A) by striking out "and (B) of paragraph (1)" and inserting in lieu thereof "and (B)(ii)(I) of paragraph (1)";

(B) by inserting after "if" the following: "(i) the Secretary of Health and Human Services determines, on a case-by-case basis, that"; and

(C) by striking out the period at the end and inserting in lieu thereof the following:

", and (ii) the program has a comprehensive plan to reduce reliance on alien physicians, which plan the Secretary of Health and Human Services finds, in accordance with criteria published by the Secretary, to be satisfactory and to include the following:

"(I) A detailed discussion of specific problems that the program anticipates without such waiver and of the alternative resources and methods (including use of physician extenders and other paraprofessionals) that have been considered and have been and will be applied to reduce such disruption in the delivery of health services.

"(II) A detailed description of those changes of the program (including improvement of educational and medical services training) which have been considered and which have been or will be applied which would

make the program more attractive to graduates of medical schools who are citizens of the United States.

"(III) A detailed description of the recruiting efforts which have been and will be undertaken to attract graduates of medical schools who are citizens of the United States.

"(IV) A detailed description and analysis of how the program, on a year-by-year basis, has phased down and will phase down its dependence upon aliens who are graduates of foreign medical schools so that the program will not be dependent upon the admission to the program of any additional such aliens after December 31, 1982.".

(5) Paragraph (2)(B) of such subsection is amended by inserting at the end the following: "The Secretary of Health and Human Services, in coordination with the Attorney General and the Secretary of State, shall (i) monitor the issuance of waivers under subparagraph (A) and the needs of the communities (with respect to which such waivers are issued) to assure that quality medical care is provided, and (ii) review each program with such a waiver to assure that the plan described in subparagraph (A)(ii) is being carried out and that participants in such program are being provided appropriate supervision in their medical education and training.

"(C) The Secretary of Health and Human Services, in coordination with the Attorney General and the Secretary of State, shall report to the Congress at the beginning of each fiscal year (beginning with fiscal year 1981) on the distribution (by geography, nationality, and area of specialty) of foreign medical graduates in the United States who have received a waiver under subparagraph (A), including an analysis of the dependence of the various communities on aliens who are in medical education or training programs in the various medical specialties.".

(c)(1) The amendments made by subparagraphs (A) and (B) of subsection (b)(3) shall apply to aliens entering the United States as exchange visitors (or otherwise acquiring exchange visitor status) on or after January 10, 1978.

(2) Section 602 of the Health Professions Educational Assistance Act of 1976 (Public Law 94–484), added by section 307(q)(3) of Public Law 95–83, is amended by striking out subsections (a) and (b).

(3) The Secretary of Health and Human Services, after consultation with the Attorney General, the Secretary of State, and the Director of the International Communications Agency, shall evaluate the effectiveness and value to foreign nations and to the United States of exchange programs for the graduate medical education or training of aliens who are graduates of foreign medical schools, and shall report to Con-

gress, not later than two years after the date of the enactment of this Act, on such evaluation and include in such report such recommendations for changes in legislation or regulations as may be appropriate.

SEC. 2. (a) Section 332 of the Public Health Service Act (42 U.S.C. 254e) is amended by adding at the end the following new subsection:

"(i)(1) Any public or private nonprofit hospital with an accredited residency training program for which a waiver has been granted (within the previous 12 months) under section 212(j)(2)(A) of the Immigration and Nationality Act shall be deemed to be a health manpower shortage area described in subsection (a)(1).

"(2) For the purpose of assignment of Corps members under sections 333 and 752(d), a hospital described in paragraph (1) shall be considered among the facilities with the greatest health manpower shortage, and assignment of Corps members shall, whenever possible, reduce the number of alien graduates of foreign medical schools in residency training programs in such hospitals.".

(b) Section 334(b) of such Act (42 U.S.C. 254g(b)) is amended by inserting after paragraph (3) the following new paragraph:

"(4) In the case of one or more Corps members assigned to a hospital described in section 332(i)(1), if the hospital can

demonstrate to the satisfaction of the Secretary that the position available for the Corps member or members (whether in a residency training program pursuant to section 752(d)(2) or as a practitioner pursuant to section 333) is attributable to the termination of one or more positions filled by an alien graduate of a foreign medical school in a residency training program within the previous 12 months, the Secretary shall waive the application of the requirement of subsection (a)(3) to the extent that the rate of payment otherwise required to be paid to the United States under such subsection exceeds the rate of payment made by the hospital to such alien.".

(c)(1) Subsection (a) of section 752 of such Act (42 U.S.C. 294u) is amended by inserting "subsection (d)(2) and" after "Except as provided in".

(2) The third sentence of subsection (b)(5)(A) of such section is amended by striking out "No period" and inserting in lieu thereof "Except as provided in subsection (d)(2), no period".

(3) Subsection (d) of such section is amended by inserting "(1)" after "(d)" and by adding at the end the following new paragraph:

"(2) An individual may choose to perform such individual's residency as a member of the Corps in a hospital's program described in section 332(i)(1), and the period in such residency shall be counted toward satisfying the individual's period of obligated service under this subpart.".

Ms. HOLTZMAN. Our first witnesses are a panel of Government witnesses: Michael Glass, General Counsel, the International Communication Agency; and Henry Foley, Administrator, Health Services Administration.

TESTIMONY OF MICHAEL A. GLASS, GENERAL COUNSEL, UNITED STATES INTERNATIONAL COMMUNICATION AGENCY, ACCOMPANIED BY JOSEPH A. BLUNDON, ASSISTANT GENERAL COUNSEL, AND MARY HITT, WAIVER REVIEW OFFICER; AND HENRY FOLEY, ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY FITZHUGH MULLAN, DIRECTOR, NATIONAL HEALTH SERVICE CORPS, AND KEN MORITSUGU, DIRECTOR, DIVISION OF MEDICINE, HEALTH RESOURCES ADMINISTRATION

Mr. GLASS. I would be happy to start by making a suggestion, Ms. Holtzman. I am Michael Glass. My colleague, Mr. Joseph Blundon, Assistant General Counsel, and Mrs. Mary Hitt, one of our waiver review officers, are with me today.

If it fits with your way of proceeding, if we could have about 4 minutes to highlight our particular concerns, we could then answer questions.

Maybe Dr. Foley——

Ms. HOLTZMAN. Dr. Foley, would you identify the people with you?

Dr. FOLEY. The person on my immediate right is Dr. Fitzhugh Mullan. To his immediate right is Dr. Moritsugu, Director of the Division of Medicine in the Health Resources Administration.

Ms. HOLTZMAN. Thank you very much. Without objection, the statement of Mr. Glass and the statement of Mr. Foley will be included in the record at this point.

[The complete statements follow:]

PREPARED STATEMENT OF MICHAEL A. GLASS, GENERAL COUNSEL, U.S. INTERNATIONAL COMMUNICATION AGENCY

Madam Chairwoman, members of the subcommittee: I am pleased to testify before this subcommittee on a matter which I regard as most important from the point of view of the public health, commercial interests and, particularly from the point of view from which I will be speaking, the foreign relations of the United States. I am General Counsel of the United States International Communication Agency ("USICA") and am accompanied by Joseph A. Blundon, Esq., Assistant General Counsel. USICA, is comprised of the former United States Information Agency ("USIA") and the Bureau of Educational and Cultural Affairs of the Department of State, which were consolidated into a single agency by Reorganization Plan No. 2 of 1977. Among its activities, USICA operates the Voice of America, and a network of libraries and information centers around the world designed to inform the peoples of other nations about the United States of America, its people and its policies. USICA also has primary responsibility within the Executive Branch for international educational and cultural exchange programs, including those programs under which alien graduates of foreign medical schools come to the United States as exchange visitors to receive advanced medical education or training and then return to their native countries to use the skills acquired here to improve the health and welfare of their fellow citizens.

Immediately after acquiring responsibility for the exchange visitor programs, USICA became aware that Public Law 94-484, which included an amendment to § 212 of the Immigration and Nationality Act (8 U.S.C. § 1182), and as amended

by Public Law 95–83, was having a deleterious effect on the role of the United States as the recognized leader among nations in providing advanced medical education. Public Law 94–484, as amended, reduced to a maximum of three years the length of time a foreign medical graduate could remain in the United States as an exchange visitor pursuing a program of advanced medical education or training. This, in most cases, involves a residency or fellowship program designed to qualify such a foreign medical graduate to take the examination required to become a certified medical specialist.

At the present time, we are told, only three medical specialty certifying boards (those in internal medicine, general practice and pediatrics) will examine doctors for certification after as little as three years of residency or equivalent fellowship training. The average training time requirement for all medical specialties is four and one-half years, and the maximum (psychiatry with a sub-specialty in psychoanalysis) is twelve years. As a result of the enactment of Public Law 94–484, since January 10, 1978, all foreign medical graduates interested in studying in the United States with a view to becoming specialists—except for those in internal medicine, general practice or pediatrics—have been told at the outset that they will not be allowed to remain here long enough to complete the required training. Under prior law, the permitted visit was limited to five years, with provision for extension in appropriate cases.

The United States has for many years been the recognized leader in providing advanced medical training to the physicians and surgeons of the world. They have come here, studied, qualified as specialists, and gone home to contribute to the development of their native countries and to become prominent and influential citizens, and, in many cases, officials in hospitals, universities and governments. They and the institutions with which they have become affiliated, as can be reasonably inferred, have proved to be good customers for American medical and scientific equipment and pharmaceuticals. Equally important, they constitute a reservoir of public opinion and political influence favorable to the United States in their home countries.

Since the effective date of Public Law 94–484, the number of foreign medical graduates in the United States pursuing advanced medical education and training has decreased from 5,090 on January 10, 1977, to 2,578 on January 10, 1979, and about 2,000 on January 10, 1980. That number is continuing to go down. Further, USICA has received numerous expressions of anxiety and distress from other nations, notably Saudi Arabia, Venezuela, Mexico, Ecuador, Bolivia, Panama, Iceland, Egypt and Cyprus, all of which have in the past relied primarily on the United States for the advanced medical training of their doctors. At the same time we have become aware that the Soviet bloc is taking advantage of the situation by sharply increasing recruiting efforts among doctors, particularly in developing countries, offering liberal scholarships and fellowships for full-term graduate medical education and training. In 1978, from Panama alone, more than one hundred persons who in the past would have normally come to the United States have gone to communist countries to pursue their medical studies.

This unfortunate trend will continue until the Congress acts to amend Section 212(j) of the Immigration and Nationality Act along the lines set forth in section (b)(3)(B) of H.R. 7118. The first foreign medical graduates who came to the United States as exchange visitors after January 10, 1978, will be reaching their mandatory return dates around July 1990. All who are required to leave then will not be eligible to re-apply for admission until they have spent at least two years in their home countries; meanwhile, the flow of new medical exchange visitors will continue to decrease. The only results can be a retreat from the premier position America has held in worldwide medical education and training, a diminution of American assistance to developing nations and to the health of the peoples of the world. The need for such legislation is immediate and urgent, and USICA strongly supports enactment of section (b)(3)(B) of H.R. 7118, with a minor amendment which I will mention presently.

It has also been called to USICA's attention that Public Law 94–484 has cut off a major source of the resident physicians and surgeons to hospitals who, in the course of pursuing their advance medical education and under supervision by fully certified specialists, provide much of the day-to-day medical care provided to the U.S. public. The foreign medical graduate residents who were already here when the new law took effect are gradually being required to return home pursuant to Section 212(e) of the Immigration and Nationality Act, and very few new ones are coming in because, except for internists, pediatricians and general practitioners, they cannot stay long enough to complete a certification program.

Under H.R. 7118, all foreign medical graduates pursuing programs of graduate medical education or training would continue to be tested for English language fluency and medical competence by means of the Visa Qualifying Examination as they now are. They continue to be screened for eligibility and be sponsored as exchange visitors by the Educational Commission for Foreign Medical graduates, under contract with the International Communication Agency. This section permits a foreign medical graduate, with the approval of the Director of USICA, to change his or her designated program of study no more than once and no later than the end of the first two years following entry into the United States. This section should, however, be amended so as to apply to all foreign medical graduates entering the United States as exchange visitors to pursue programs of graduate medical education for training on and after January 10, 1978 (the effective date of the three-year limitation of Public Law 94–484, as amended). Otherwise, those who came in since that date and before this Bill takes effect will be unfairly discriminated against.

I have discussed section (b)(3)(B) of H.R. 7118 first, because, of all the provisions of the Bill, it is the most important to the International Communication Agency. However, I would also like to express a few observations and comments as to other provisions of the Bill.

Section (a) of the Bill repeals a provision of Public Law 94–484, as amended, which requires any alien graduate of a foreign medical school who was lawfully practicing medicine under the laws of a state as of January 9, 1977, if the doctor desires to retain the status he or she holds under the Immigration and Nationality Act, to become certified by some recognized medical specialty certifying board. Among other things, this would require such a doctor to take and pass the Visa Qualifying Examination ("VQE"), administered by the Educational Commission for Foreign Medical Graduates ("ECFMG") pursuant to Title 8, United States Code, § 1182(a)(32), and to pursue such studies as might be required by a medical specialty certifying board even if the doctor desired only to engage in the general practice of medicine.

USICA understands the unanimous position of various professional medical groups to be that these requirements of Public Law 94–484 are unnecessary and unfair ex post facto burdens on foreign doctors resident in the United States and lawfully practicing medicine under the laws of a state at the time Public Law 94–484 took effect. These groups also feel that licensure of the medical profession is and ought to be a function of the several states, in which the Federal government should intervene only to further some compelling national interest not present here, and therefore support and urge the enactment of section (a) of this Bill.

Section (b) of H.R. 7118 makes further changes in Public Law 94–484 as amended (22 U.S.C. § 1182(j)). One pertains to: (1) the length of time an alien graduate of a foreign medical school may remain in this country as an exchange visitor, which I have already discussed. The other pertains to the standards to be applied in granting "substantial disruption" waivers to hospitals and medical schools enabling them to bring in foreign medical graduates to serve in residency programs without having first passed the VQE, and the time period within which such waivers may be granted.

Section (b)(3)(C) amends Public Law 94–484 as amended by imposing more stringent requirements which would have to be met before a hospital or medical college could be granted a waiver of certain requirements of Public Law 94–484 (*e.g.*, the VQE) in utilizing exchange visitor foreign medical graduates where neccessary to avoid substantial disruption of medical services to the public. It extends to December 31, 1983 the time during which such waivers could be granted. It also requires that the requesting institution file comprehensive and detailed plans for reduction of reliance on alien physicians, and, in seeking waivers after December 31, 1982, demonstrate substantial progress in actually reducing such reliance.

An inter-agency Substantial Disruption Waiver Appeal Board has been in existence for more than a year, under the Chairmanship of the Administrator of the Health Resources Administration ("HRA"), Department of Health and Human Services ("HHS"). It includes members from HHS, the Immigration and Naturalization Service, the Department of State, and the International Communication Agency, and has developed its own guidelines and standards based on the statute for approving "substantial disruption" waivers. Those guidelines and standards already mandate most, if not all, of the things which Section (b)(3)(C) and succeeding sections would require, and the Board, with the

assistance of HMA and ECFMG, has been highly successful in monitoring compliance by hospitals and medical colleges with the requirements of Title 8, United States Code, § 1182(j)(2)(A), and in ensuring that the overall purposes of the medical exchange visitor programs are carried out. For these reasons, the provisions of sections (b) (3) and (4) of the Bill are redundant to present practice and may be unnecessary.

Section (b)(5) would direct that: "The Secretary of Health and Human Service in coordination with the Attorney General and *the Secretary of State*, shall (i) monitor the issuance of waivers under subparagraph (A) and the needs of the communities (with respect to which such waivers are issued) to assure that quality medical care is provided, and (ii) review each program with such a waiver to assure that the plan described in subparagraph (A)(ii) is being carried out and that participants in such program are being provided appropriate supervision in their medical education."

And that: "The Secretary of Health and Human Services, in coordination with the Attorney General and *the Secretary of State*, shall report to the Congress at the beginning of each fiscal year (beginning with fiscal year 1981) on the distribution (by geography, nationality, and area of specialty) of foreign medical graduates in the United States who have received a waiver under subparagraph (A), including an analysis of the dependence of the various communities on aliens who are in medical education or training programs in the various medical specialties."

I suggest that because primary responsibility for international educational and cultural exchange visitor programs, including those involving foreign medical graduates, was transferred to the International Communication Agency from the Department of State by Reorganization Plan No. 2 of 1977, the words "the Director of the International Communication Agency" should be substituted for the words "the Secretary of State" in these two paragraphs. With that substitution, USICA would have no objection to these provisions of Section (b)(5).

Section (c)(3) of the Bill would provide as follows:

"The Secretary of Health and Human Services, after, consultation with Attorney General, the Secretary of State, and the Director of the Internation Communications [sic] Agency, shall evaluate the effectiveness and value to foreign nations and to the United States of exchange programs for the graduate medical education or training of aliens who are graduates of foreign medical schools and shall report to Congress, not later than two years after the date of the enactment of this Act, on such evaluation and include in such report such recommendations for changes in legislation or regulations as may be appropriate."

USICA agrees that such a study and evaluation of exchange visitor programs for foreign medical graduates is desirable and supports enactment of this section. As I already mentioned, however, the Secretary of State no longer has any function or responsibility for exchange visitor programs, and I suggest that participation in such a study and evaluation would impose an unnecessary burden on the Secretary. As to those provision of H.R. 7118 not specifically commented on above, the International Communication Agency defers to the views of the Secretary of HHS.

Madam Chairwoman, I shall be happy to respond to any questions which you or other members of the Subcommittee may have.

PREPARED STATEMNT OF HENRY A. FOLEY, PH. D., ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Madam Chairwoman and members of the subcommittee: I am pleased to have the opportunity to appear before you today to discuss the provisions of H.R. 7118, which would amend the Immigration and Nationality Act with respect to the admission of certain aliens for graduate medical education and make other legislative changes relating to the utilization in the United States health-care system of foreign medical graduates (FMGs).

The immigration of FMGs to the United States began in earnest in 1948 with the passage of the U.S. Education and Information (Smith-Mundt) Act. This educational exchange Act facilitated the coming of FMGs to the United States for medical residency training at a time when the number of residency positions

available in this country was increasing more rapidly than the number of U.S. trained physicians. Many FMGs who came as exchange visitors later altered their immigration status to become full immigrants and stay beyond the length of their educational program.

By the mid-1970s, the growing number of FMG exchange visitors and immigrants was giving rise to major concerns. There was considerable variation in the quality of medical training among countries. Testing by the Educational Commission for Foreign Medical Graduates (ECFMG) was believed to establish only a minimal level of medical competence. Many FMGs also had minimal fluency in the English language. As American medical schools expanded their enrollments, the need for FMGs to fill residency positions was declining. Finally, FMGs often were not returning home to allow their country to benefit from their American education, which meant that, from an international perspective, there was a "skill drain" of valuable medical talent from foreign countries into the United States.

Title VI of the Health Professions Educational Assistance Act of 1976, Public Law 94–484, mandated a number of changes in policies relating to the issuance of exchange visitors and selected immigrant visas to FMGs. Under current requirements, alien physicians wishing to enter the United States as immigrants on the basis of their skills (under preference categories 3 or 6) or as nonpreference immigrants must pass Parts I and II of the National Board of Medical Examiners' (NBME) examination (or an equivalent examination as determined by HHS, such as the Visa Qualifying Examination) and be competent in written and oral English. The Secretary of Labor must provide certification for alien physicians wishing to immigrate under other than family-related preference.

Alien physicians may no longer enter the United States as exchange visitors (J visa) to obtain graduate medical education or training unless:

A school of medicine (or other accredited health professions school) and affiliated hospital have agreed in writing to provide the training or to assume responsibility for arranging for the training by an appropriate public or private nonprofit institution or agency;

The alien has passed Parts I and II of the NBME examination (or the equivalent), is competent in written and spoken English, will be able to adapt to the educational and cultural environment, and has adequate prior training;

The alien is committed to return to his country and his country has given written assurance that there is a need for persons with the skills being acquired in the U.S. training program; and

The alien will stay no more than two years unless additional training (one year maximum) is requested specifically by his country.

Two of the exchange visitor requirements (relating to school affiliation and passage of examinations) may be waived for an alien until December 31, 1980, if otherwise there would be a "substantial disruption" in the health services provided by the graduate medical education program in which the alien seeks to participate. In granting waivers, the Attorney General must assure that the total number of aliens participating in graduate medical programs at any time does not exceed the number of aliens participating on January 10, 1978, when the new J-visa requirements took effect.

Alien physicians who are in the United States as exchange visitors and who wish to apply for permanent resident status are no longer eligible, simply on the basis of permission from their country, for a waiver of the requirement that they first return to their country for a two-year period.

Alien physicians are no longer allowed to enter the United States as persons "of distinguished merit and ability" coming to perform "services of an exceptional nature requiring such merit and ability" (H–1 visa) unless they have a specific invitation from a public or nonprofit private educational or research entity to teach or conduct research or do both. H visas are no longer available to aliens coming to the United States to perform temporary services as members of the medical profession (H–2 visa) or to receive graduate medical education or training (H–3 visa).

Madam Chairwoman, H.R. 7118 would attempt to ameliorate several problems that have arisen in the application of these new FMG requirements. First, the bill would amend existing legislative restrictions on the entry of alien physicians to make it unnecessary for a physician who was fully and permanently licensed and practicing in a State before January 10, 1977 (the effective date of the new examination requirement for foreign physicians) to have also held on that date

a specialty certificate, in order to be exempt from the requirement of passing Parts I and II of the National Board of Medical Examiners' Examination or an equivalent examination.

We favor on equity grounds the provision for a "grandfather clause" for physicians who were in active practice in the United States when the new restrictions went into effect. Under current law such physicians are exempt from the examination requirement only if they were Board certified specialists on that date. A specialty certificate has never been needed to practice medicine in this country. We would like to make it clear, however, that State licensure in itself would not be regarded as equivalent to passage of Parts I and II of the National Board of Medical Examiners' Examination for aliens entering the country after the effective date of the new requirements. The Visa Qualifying Examination has been determined to be the equivalent examination for this purpose.

Second, the bill would relax the present strict limit on the number of years an FMG exchange visitor may stay in the United States to complete residency training. The bill would allow participants in graduate medical education programs to remain in the U.S. for "the time typically required to complete such program, as determined by the International Communications Agency (ICA), based on criteria established in coordination with the Secretary of the Department of Health and Human Services." In addition, the exchange-visitor would be able to change his/her program once, but not later than two years after entry.

Because many FMG exchange visitors need more than the existing maximum of 3 years to complete needed graduate medical education, we favor an extension in the length of stay allowed. The Administration's bill on this matter, H.R. 7058, specifies that the time limits for any individual would be determined on the basis of the published requirements of officially recognized medical specialty certifying boards and criteria established in coordination with the Secretary of Health and Human Services. For aliens not pursuing full medical specialty certification programs, the determination would be made on such other basis as the Director of the International Communications Agency and the Secretary of HHS found to be in the public interest.

Third, the bill proposes to extend the "substantial disruption" waiver authority through December 31, 1982, with a possible one-year extension to December 31, 1983, for programs which have substantially reduced their reliance on alien foreign medical graduates (FMGs). In addition, there are requirements placed on the Department of HHS to coordinate, monitor, publish regulations and submit reports to Congress on various aspects of the waiver provisions.

The waiver provision mechanism, i.e., review of applications by the Educational Commission for Foreign Medical Graduates (ECFMG) and by the Federal-level Substantial Disruption Waiver Appeal Board, has been operational for two years (calendar years 1978 and 1979). Applications have been submitted from all regions of the Nation, although the Northeast and Central Northeast have been most heavily represented in the applicant pool.

Criteria for implementation of the program were developed after extensive analysis of the expected national and regional impact of the amendments of 1976. During the two years it has been possible to make approval/disapproval decisions at the Tier I level (ECFMG-review level which does not require departmental action) in sufficient numbers (70 program requests) to reduce the load at the Federal level to a manageable number (50 program requests). This has allowed the waiver provision to be implemented efficiently, equitably, and effectively.

The administration of the current waiver provision has included stringent requirements for detailed narratives on (1) the service-related problems associated with a potential reduction in FMGs; and (2) the plans for reducing dependence on FMGs. However, this requirement has been placed on Tier II level applications.

Fourth, H.R. 7118 would require that any public or private nonprofit hospital which has received a "substantial disruption" waiver for alien FMGs during the previous 12 months be automatically designated a heath manpower shortage area. The bill further would provide that such areas automatically be considered among the areas with the greatest need for placement of National Health Service Corps personnel.

The designation of areas, population groups and facilities as health manpower shortage areas is based on objective criteria with the involvement of local health planning and other agencies knowledgeable of particular local circumstances.

The purpose of this process is to determine areas, population groups, and facilities which have the greatest need for National Health Service Corps personnel in order that we may best deploy our limited resources.

The criteria now used to demonstrate "substantial disruption" are of two types. Those used for Category A and C waivers depend only on the percentages of the training program slots which were occupied by foreign physicians on January 10, 1978. Those used for Category B and D waivers also involve indicators that the facility involved is serving a shortage area or underserved population; specifically, that the facility is located in a primary medical care manpower shortage area designated under Section 332 of the Public Health Service Act, or had more than 25 percent Medicaid patients.

It should be emphasized that public and nonprofit hospitals themselves may be designated as shortage areas and of course may be serving shortage areas (although they do not necessarily do so, even when they are located near underserved populations). It should also be pointed out that alien FMGs who do not have a permanent resident visa and who are employed by hospitals are excluded from the physician count in the designation process. Thus, hospitals do not face an impediment in being designated by reason of having large numbers of alien FMGs. This existing provision is sufficient to enable hospitals with waivers to fully and fairly compete for the limited resources of the National Health Service Corps.

Within the limits of our resources, we support the placement of fully qualified National Health Service Corps personnel in hospitals which have qualified as health manpower shortage areas under the present law. For the same reason, we oppose the approach used in H.R. 7118. Additional special considerations are unwarranted and could result in the diversion of significant numbers of National Health Service Corps personnel from areas more in need. Moreover, we believe that the primary purpose of the NHSC is the placement of primary care physicians in medically underserved areas and the highest priority areas are those with no primary care physicians.

The fact that the bill proposes that, by law, hospitals with waivers be among those with the "greatest need," could, in practical effect, give such hospitals priority for placements over, among others, remote Indian reservation sites, prisons, and mental health facilities. We believe, as in the case of other facilities, population groups or areas, that the hospitals in question should earn their relative priority based on their actual circumstances and not by operation of a special law.

While the number of hospitals from which waiver applications have been received in the two calendar years has not been large (i.e., 57), the extent to which the applicant pool will expand in the future is not known. A recently completed study confirmed the apparent serious situation in the Northeast, particularly in New York City, but found no major concern in other parts of the Nation. However these findings were based on a small sample of hospitals. There is some concern that the New York City situation will soon be repeated in several other urban areas.

The bill is not clear as to whether it is meant that a hospital which receives a "substantial disruption" waiver for, say, its anesthesiology program, would be designated as a shortage area for anesthesiologists only, for primary care physicians as well, or for any and all specialties.

If the intent or the effect were to be to consider such a hospital as a shortage area for all specialties because of a problem identified for one specialty, this would be even more damaging to the National Health Service Corps Scholarship and placement programs.

Fifth, the bill would allow the assignment of Corps physicians to residency positions in "waivered" hospitals, with each year of residency training to be credited as a year of obligated service for Corps Scholarship recipients. Madam Chairwoman, this provision raises problems in respect to quality of care provided under the Corps program and to equity in the application of service obligation requirements.

Many hospitals that have developed a dependency on alien FMG residents use them in large part for providing ambulatory primary health care to the population of the area it serves. Before we assign a NHSC provider to an area we require that they complete at least one year of clinical training, and we are required by law to defer those who wish to seek advance training for up to three years and

in certain cases even longer. We believe these provisions enable us to insure that, when the National Health Service Corps assigns physicians to an area or facility, the assignees will furnish high quality health care. Currently, two-thirds of NHSC physicians have completed residency training and are board eligible or board certified. The practice of relying on residents, be they domestic graduates or alien FMGs, for primary care is not in the interest of optimal medical care.

We believe that there is an important distinction between backfilling residency positions and placing fully qualified primary care physicians in a hospital. The latter, which we support, requires organizational and other institutional changes to see that a proper and high quality ambulatory primary health care setting is in place.

We understand that the transition from dependence on alien FMGs to structuring residency programs attractive to American graduates is difficult and time consuming. And, for this reason, we support the extension of waivers and the Administration has submitted legislation to provide a simple extension of the waiver authority (H.R. 6800).

We also believe the elements of the plan required for such hospitals to decrease their dependence on alien FMGs under H.R. 7118 has merit. The plan will require that they explore other alternatives such as appropriate use of physician assistants, and describe changes in their program designed to attract domestic graduates and institute active recruitment efforts to attract these graduates. A well developed and executed plan of this nature will not be easy but should be sufficient to enable hospitals to reduce the number of their alien FMG residents. Such a plan goes to the root problem and is the appropriate course of action for these hospitals and should govern Federal Government intervention. Reliance on special legislation to secure NHSC personnel, often at the expense of more worthy areas, does not address the causes of the problem and may be detrimental to the overall aims of the NHSC Program.

The proposed provision would have the effect of considerably diffusing the NHSC's current focus on primary care, since the residency training programs heavily filled by alien FMGs include not only general practice, pediatrics, psychiatry, and child psychiatry, but also such specialties as anesthesiology, pathology, physical medicine, nuclear medicine, and therapeutic radiology. Also, if NHSC Scholarship recipients were to be allowed to fulfill their obligations by residency in these fields, this would tend to shift them away from the primary care orientation which the NHSC Scholarship Program and many other programs authorized under the Health Professions Educational Assistance Act of 1976 have been promoting.

The most disruptive aspect of the provision in H.R. 7118 for assigning Corps physicians to hospitals as residents, however, is that it would establish a basic inequity in the National Health Service Corps. Some scholarship obligees—those serving in hospitals with waivers—would have the opportunity of fulfilling their residency training while at the same time serving their scholarship obligation. We would be expending approximately $60,000 to train a physician so that we could be repaid by that physician's entering and serving in a training program. It should be noted that under H.R. 7118 the residency training need not even involve direct patient care. Other obligees serving residencies and who may be providing primary care to needy patients would be denied this benefit.

This "double credit" has the potential of being so attractive that it may frustrate our matching efforts—which hopefully lead to retention—and thwart an appropriate rural/urban balance. This is particularly true when the attractiveness of the "double credit" is coupled with the statutory "need" priority for those hospitals and with the fact that service as a resident would be at the choice of the scholarship recipient. We know from experience under prior legislation that such an inequity can cause serious difficulties and morale problems with little benefit to the National Health Service Corps.

Finally, the bill provides that if an NHSC assignment to a waivered hospital is due to termination of positions filled by alien physicians, the hospitals will only owe the Federal Government the amount they would have paid the alien FMGs.

All entities that have the benefit of NHSC personnel are subject to repay the Federal Government for the salary and proportionate share of scholarship costs for each assignee. Currently that is approximately $39,000 per physician assignee per year. We do not believe hospitals with waivers for alien FMGs should be given special consideration.

Again, we should stress that we have no difficulty in granting waivers of repayment to hospitals or other entities when conditions warrant. Indeed, as a consequence of our efforts to place NHSC personnel in the most needy areas, our collections for salary and scholarship costs have been low.

One exception is that of State and local entities. It is the Administration's policy that the National Health Service Corps should not be used to subsidize functions such as prison health and the operation of mental health institutions which traditionally have been the function of State and local governments.

In brief, the National Health Service Corps is available and should be used to assist in ameliorating the many difficulties of hospitals still dependent on alien FMGs. The National Health Service Corps can be of significant assistance to these institutions. Other programs such as the Community Health Center program and the Hospital-Affiliated Primary Care Center program can also be of great help in addressing the problems of these hospitals. We stand ready to aid these hospitals, but firmly believe they must compete for Federal resources on the same footing as other entities.

Madam Chairwoman, this concludes my testimony. I would be happy to answer any questions.

Ms. HOLTZMAN. Mr. Glass, perhaps you ought to briefly summarize the contents of your testimony.

Mr. GLASS. Certainly. The first point we would like to make is in our area of expertise, communicating the foreign policy of the United States abroad. Doctors in other countries—especially in developing countries—whether or not they make their living in intergovernment service, always become centers of community leadership and influence. If we can favorably impress the medical community abroad, we have achieved a very significant foreign policy objective.

The present law is, one might say, goring the foreign policy of this country increasing a barrier to reaching doctors. It imposes a 2-year limitation, with the possibility of a 1-year extension on the length of time alien graduates of foreign medical schools may spend here pressuring advanced medical training leading to anticipation as a specialist.

I think all specialties require more than 3 years of sustained study in this country; and, therefore, most foreign doctors, who came here for advanced training know that they will have to interrupt their careers by changing horses in midstream. This is a disincentive to both them personally as well as to the government which—in most cases—are providing some sort of support for their studies.

Therefore, there has been—as one can expect—a significant falloff in the number of foreign medical graduates coming here. Two years ago there were slightly more than 5,000. This past January, the figure has been halved; and one can expect that this downward trend will continue.

There are also commercial implications for the United States in the sale of its medical products abroad which shouldn't be ignored.

This bill, in section (3) (b) does exactly the right thing. It makes the residency period coterminus with the specialty which the foreign medical graduate has selected. It also, intelligently I think, adds a degree of flexibility into the procedure. People should be allowed, within reason, to change their minds; and if within the first 2 years of his stay he changes his mind and selects another specialty, in appropriate cases, the Director of the U.S. ICA can grant an extension of stay if needed.

Along the following lines, the bill should do something better: In subsection (b) (3)–(5), it extends this kind of coterminus and flexible

treatment to new arrivals after the effective date of the act. There is no reason this shouldn't be grandfathered so people, whenever they arrived, can take advantage of this unproved approach.

I would also like to comment on two general tendencies I have seen since coming to the Government: The first is a needless proliferation of detail. If you will take a look at section (B) (4) of the bill, you will see— think beginning on page 3, carrying over—an awful lot of text which is guidance to one of the review panels, the Substantial Disruption Waiver Appeal Board, on the type of findings they have to make.

It's my information that this Appeal Board is now following substantially all, if not all, of these guidelines; and to proliferate detail by putting this in legislation I don't think would be helpful.

My suggestion is that the oversight, your justifiable desire for oversight, be accomplished in the following way: Under section (C) (3) of the bill, in 2 years the committee gets a report. I think if that section were to add the provision that the committee also be told about how the Waiver Review Panel has been operating, how they've been applying these guidelines set out in the draft bill, and what kind of suggestions they make for loosening or tightening or otherwise changing these procedures, the Appeal Board will have some flexibility and a chance to operate on its own. The committee has oversight and can look at the whole area and decide whether it needs to place in legislation or not.

This provision is beginning to look like the esoteric parts of the Internal Revenue Code, which is not something desirable to be achieved.

My second general point has to do with the needless layering of authority. Under reorganization plan No. 2 of 1977—which created the U.S. International Communication Agency—all of the educational and cultural exchange programs, of which foreign medical graduates program is an important part, were transferred from the Bureau of Educational and Foreign Affairs in the Department of State to the new agency.

There is nothing left in the Department of State which focuses on educational and cultural exchange programs. By statute, my agency takes foreign policy guidance from the Secretary of State. If any issue in the context we are discussing rises to the level of a foreign policy consideration, we consult with the Department at the appropriate level.

The Secretary of State has many things to do these days, and I don't know that having him serve on the various commissions, various committees, and so forth—which are specified in section (b) (4) and (5) of the bill—really helps the process at all, nor does it lighten his workload.

That's all I have to say. I have just one concluding remark. When the chairwoman and I were at law school together, I—and many others of that generation—decided to go to law school rather than medical school because I couldn't stand the sight of other people's blood; therefore, we find it somewhat ironic and amusing that my first appearance before any part of the Judiciary Committee is an area having to do with medical science and doctors, except I can make the link,

however, that I am very happy to be here, because—as I said at the outset—it is our foreign policy which is being gored.

Ms. HOLTZMAN. Thank you very much, Mr. Glass.

Dr. Foley, would you be good enough to summarize your testimony briefly for the benefit of the subcommittee?

Dr. FOLEY. Thank you, Madam Chairwoman.

I would like to suggest that H.R. 7118 attempts to ameliorate several problems relating to the application of these new FMG requirements, the requirements coming out of the 1976 law. I would like to summarize those.

First, the bill would amend existing legislative restrictions on the entry of alien physicians to make it unnecessary for a physician who was fully and permanently licensed and practicing in a State before January 10, 1977 to have also held on that date a specialty certificate, in order to be exempt from the requirement of passing parts I and II of the National Board of Medical Examiners' examination or an equivalent examination.

We favor on equity grounds the provision for a "grandfather clause" for physicians who were in active practice in the United States when the new restrictions went into effect.

Second, the bill would relax the present limit on the number of years an FMG exchange visitor may stay in the United States to complete residency training. The bill would allow participants in graduate medical education programs to remain in the United States for "the time typically required to complete such program, as determined by the International Communications Agency * * *." We clearly favor that.

Third, the bill proposes to extend the "substantial disruption" waiver authority through December 31, 1982, with a possible 1-year extension to December 31, 1983, for programs which have substantially reduced their reliance on alien foreign medical graduates. In addition, there are requirements placed on the Department of Health and Human Services to coordinate, monitor, publish regulations, and submit reports to Congress on various aspects of the waiver provisions.

We support the extension of waivers and the administration has submitted legislation to provide a simple extension of the waiver authority, H.R. 6800, to December 31, 1983.

The waiver provision mechanism has been operational for 2 calendar years, 1978 and 1979. Applications have been submitted from all regions of the Nation, although the Northeast and Central Northeast have been most heavily represented in the applicant pool.

They have been reviewed by the Educational Commission and by the Federal-level Substantial Disruption Waiver Appeal Board, which I chair.

The criteria for implementation of the program were developed after extensive analysis of the expected national and regional impact of the amendments of 1976. During these 2 years it's been possible to make approval/disapproval decisions at the tier I level, that is the ECFMG-review level, which does not require departmental action, insufficient numbers to reduce the load at the Federal level to a manageable number. There are 50 program requests. This has al-

lowed the waiver provision to be implemented efficiently, equitably, and effectively.

The administration of the current waiver provision has included stringent requirements for detailed narratives on the service-related problems associated with a potential reduction in FMG's; and, second, the plans for reducing dependence on FMG's. However, these requirements have been placed only on tier II level applications.

We also believe the elements of the plan required in H.R. 7118 for hospitals to decrease their dependence on FMG's has merit. The plan would require us to explore other alternatives, a description of changes in the present program designed to attract domestic graduates, and the institution of active recruitment efforts to attract these graduates.

We support this because this is the way the current board actually functions in its requirements. A well-developed and executed plan of this nature will not only be easy but should be sufficient to enable hospitals to reduce the number of their alien FMG residents.

Fourth, H.R. 7118 would require that any public or private nonprofit hospital which has received a "substantial disruption" waiver for alien FMG's during the previous 12 months be automatically designated a health manpower shortage area. The bill would further provide that such areas automatically be considered among the areas with the greatest need for placement of National Health Service Corps personnel.

The designation of areas, population groups and facilities as health manpower shortages is based on objective criteria with the involvement of local health planning and other agencies knowledgeable of particular local circumstances. The purpose of the process is to determine areas, population groups, and facilities which have the greatest need for National Health Service Corps personnel in order that we may best deploy our limited resources.

The criteria now used to demonstrate "substantial disruption" are of two types. Those used for category A and C waivers depend only on the percentages of the training program slots which were occupied by foreign physicians on January 10, 1978. Those used for category B and D waivers also involve indicators that the facility involved is serving a shortage area or underserved population; specifically, that the facility is located in a primary medical care manpower shortage area designated under section 332 of the Public Service Act, or had more than 25 percent medicaid patients.

It should be emphasized that public and nonprofit hospitals themselves may be designated as shortage areas and, of course, may be serving shortage areas—although they do not necessarily do so, even when they are located near underserved populations. It should also be pointed out that alien FMG's who do not have a permanent resident visa and who are employed by hospitals are excluded from the physician count in the designation process. Thus, hospitals do not face an impediment in being designated by reason of having large numbers of alien FMG's. We think this existing provision is sufficient to enable hospitals with waivers to fully and fairly compete for the limited resources of the National Health Service Corps and that additional special considerations are unwarranted.

For that reason we oppose the approach in this regard proposed by H.R. 7118.

Within the limits of our resources, we support the placement of fully qualified National Health Service Corps personnel in hospitals which have qualified as health manpower shortage areas under the present law. Moreover, we believe that the primary purpose of the National Health Service Corps is the placement of primary care physicians in medically underserved areas and the highest priority areas are those with no primary care physicians.

The bill is not clear as to whether it is meant that a hospital which receives a "substantial disruption" waiver for, say, its anesthesiology program would be designated as a shortage area for anesthesiologists only, for primary care physicians as well, or for any and all specialties.

It would be damaging to the National Health Service Corps scholarship and placement programs if the intent or the effect was to consider such a hospital as a shortage area for all specialties because of a problem identified for one specialty.

Fifth, the bill would allow the assignment of corps physicians to residency positions in "waivered" hospitals, with each year of residency training to be credited as a year of obligated service for corps scholarship recipients. Madam Chairwoman, this provision raises problems in respect to quality of care provided under the corps program and to equity in the application of service obligation requirements.

Many hospitals that have developed a dependency on alien FMG residents use them in large part for providing ambulatory primary health care to the population of the area it serves. Before we assign a National Health Service Corps provider to an area we require that they complete at least 1 year of clinical training, and we are required by law to defer those who wish to seek advance training for up to 3 years and in certain cases even longer. We believe these provisions enable us to insure that, when the National Health Service Corps assigns physicians to an area or facility, the assignees will furnish high quality health care.

Currently, two-thirds of National Health Service Corps physicians have completed residency training and are board eligible or board certified. The practice of relying on residents, be they domestic graduates or alien FMG's, for primary care is not in the interest of optimal medical care.

The most disruptive aspect of the provisions in H.R. 7118 for assigning corps physicians to hospitals as residents, however, is that would establish a basic inequity in the National Health Service Corps. Some scholarship obligees—those serving in hospitals with waivers—would have the opportunity of fulfilling their residency training while at the same time serving their scholarship obligation. We would be expending approximately $60,000 to train a physician so that we could be repaid by that physician's entering and serving in a training program. It should be noted that under H.R. 7118 the residency training need not even involve direct patient care. Other obligees serving residencies and who may be providing primary care to needy patients would be denied this benefit.

Finally, the bill provides that if a National Health Service Corps assignment to a waivered hospital is due to termination of positions filled by alien physicians, the hospitals will only owe the Federal Government the amount they would have paid the alien FMG's.

All entities that have the benefit of National Health Service Corps personnel are subject to repay the Federal Government for the salary and proportionate share of scholarship costs for each assignee. Currently that is approximately $39,000 per physician assignee per year. We do not believe hospitals with waivers for alien FMG's should be given special consideration.

Again, we should stress that we have no difficulty in granting waivers of repayment to hospitals or other entities when conditions warrant. Indeed, as a consequence of our efforts to place National Health Service Corps personnel in the most needy areas, our collections for salary and scholarship costs have been low.

One exception is that of State and local entities. It is the administration's policy that the National Health Service Corps should not be used to subsidize functions such as prison health and the operation of mental health institutions which traditionally have been the function of State and local governments.

In closing, the National Health Service Corps is available and should be used to assist in ameliorating the many difficulties of hospitals still dependent on alien FMG's. The National Health Service Corps can be of significant assistance to these institutions. Other programs such as the community health center program and the hospital-affiliated primary care center program can also be of great help in addressing the problems of these hospitals. We stand ready to aid these hospitals, but firmly believe they must compete for Federal resources on the same footing as other entities.

Madam Chairwoman, this concludes my testimony. I would be happy to answer any questions.

Ms. HOLTZMAN. Thank you.

Mr. Glass, you state that the detailed language spelling out the review procedures in H.R. 7118 is not necessary because of the present practice. If present practice has been so successful, can you explain to me why the requests for waivers have been increasing and why we are in a situation where the dependency in a number of hospitals, particularly in New York City—but also in other urban areas—has not been diminished?

Mr. GLASS. I can't explain that with any degree of clarity. My point is mainly an institutional one. That is, you have a board that's been operating for 2 years in what before was an uncharted area.

As they go along, they are developing their own criteria. Because of various practical situations, it tends to be dynamic. Rather than tying its board down with as much detail as there is in the statute, if you give them 2 years more and then have a report, you can probably fine tune better in case there is any legislation needed for any specific detail.

Ms. HOLTZMAN. I appreciate your explanation, except it seems to me almost 4 years has elapsed already and you have yet to begin to deal with this serious problem. Very little progress has been made.

Mr. GLASS. It's been 2 years now; and, of course, 2 more are being asked for. That would be 4. They have only been operating 2 years.

Ms. HOLTZMAN. The legislation was enacted almost 4 years ago.

Mr. GLASS. Yes. That's true.

Ms. HOLTZMAN. The gentleman from Texas?

Mr. HALL. No questions.

Ms. HOLTZMAN. I don't have any further questions. Thank you very much for your testimony here today.

Our next witnesses will be from New York State and New York City. First, we will hear from the very distinquished president of the City Council of New York, Carol Bellamy, who will be accompanied by Richard Berman, director of the office of health systems management. Then we will hear from David Mannis, the director of intergovernmental relations of the Health and Hospitals Corp.

TESTIMONY OF CAROL BELLAMY, PRESIDENT, CITY COUNCIL OF NEW YORK, ACCOMPANIED BY BARRY ENSMINGER, COUNSEL; RICHARD BERMAN, DIRECTOR, OFFICE OF HEALTH SYSTEMS MANAGEMENT; AND DAVID MANNIS, DIRECTOR, INTERGOVERNMENTAL RELATIONS, HEALTH AND HOSPITALS CORP., ACCOMPANIED BY ROBERT DeCRESCE

Ms. BELLAMY. I think we have enough for a basketball team here.

Ms. HOLTZMAN. I want to welcome you before the subcommittee. We are very proud to have the president of the New York City Council, who is one of the most distinguished elected officials not just in New York City but in the country. You have done a great deal of work on this, I know, and we are very pleased to have the benefit of your testimony.

I might say that, without objection, the text of your entire testimony will be incorporated in the record. If you wish, you may summarize, or you can read it.

Ms. BELLAMY. I will attempt to summarize. I appreciate the opportunity to appear before this Subcommittee on Immigration. You have indicated some of the other people at the table: Richard Berman from the State; Dave Mannis from the city; my counsel, Barry Ensminger.

We are here to attempt to respond and offer comments at this point on H.R. 7118. I come before you today as an elected official with special interests in health care.

Over the past 9 months, my office has been examining the role of foreign medical graduates in New York City teaching hospitals. In February, I issued a report, "Is There a Doctor in the House?", which documented the critical physician shortage that New York City and other localities, particularly in the Northeast and Midwest, will face if the present immigration law is not amended.

I have set forth in my testimony—and won't go through it in detail—a bit of history in terms of the issue of foreign medical graduates, dealing first with the issue of the perceived shortage of doctors, the move for a waiver, the subsequent amendments, and the determination of self-sufficiency in terms of doctors in this country, and now the phasing-out period and the critical nature of the phasing-out period.

What I would like to turn to now, if I can provide that information to you for the record in my testimony, is to talk a bit about the New York City situation.

The loss of foreign medical graduates will be most severely felt in the industrialized sections of the Northeast and North Central States.

New Jersey, for example, reported that 58 percent of all interns and residents were FMG's in 1977. In Connecticut, the figure exceeded 70 percent. Over one-third of the teaching hospitals in Illinois, Michigan, Ohio, Maryland, Delaware, and New York had more than 50 percent of their house staff positions filled with alien doctors.

New York City is, and will continue to be, particularly hard hit. The New York State Health Planning Commission predicts the number of foreign graduates in New York City will drop from 3,056 in 1978 to between 1,050 and 1,100 by 1984 as foreign medical graduates move on to new positions or return home and are not replaced. New York City, with its large concentration of teaching hospitals, now trains one of every 12 physicians nationwide and relies upon these trainees to provide many essential services. Of the 8,103 doctors training in voluntary and municipal hospitals in New York City in 1978, 3,056—or 38 percent—were foreign medical graduates.

This high proportion of FMG's stems from the problem many New York City hospitals face when recruiting U.S. medical graduates. Elite teaching hospitals in Manhattan can easily attract interns and residents from top medical schools, but attempts to enroll these students for graduate training in aging and deficit-ridden hospitals in poor neighborhoods have been difficult in the past and certainly are not getting any easier.

Medical students are uncertain about the future of New York's troubled hospitals; 27 private institutions have filed for bankruptcy since 1975, several municipal facilities are scheduled to be closed, and there is an overall shortage of nurses, equipment, and medical supplies. Medical students also cite high crime rates and the deteriorated condition of inner-city neighborhoods where many municipal and small voluntary hospitals are located.

Thus, the reduction of foreign medical graduates in New York will have an uneven impact, barely affecting some hospitals, while crippling others. Although foreign medical graduates account for nearly 40 percent of the interns and residents citywide, the proportion in individual voluntary and municipal hospitals ranges from 7 percent to 100 percent. Foreign medical graduates amount to more than 50 percent of the housestaff—interns and residents—in 23 hospitals, and in 12 of these institutions, the proportion of foreign medical graduates is more than 75 percent. Eight hospitals with strong affiliations to medical schools have been able to reduce their use of foreign medical graduates since 1978, but again many municipal and small voluntary hospitals serving poor patients remain heavily dependent on the FMG's.

The reduced pool of FMG's will cause the greatest problems in hospitals run by the New York City Health and Hospitals Corp. which trains about 40 percent of the foreign graduates in the city.

David Mannis from that agency will speak about some of their plans. I would like to talk again just briefly as to the impact.

If the prediction of a two-thirds reduction of FMG's nationally holds true for New York City, our municipal hospitals alone will lose more than 800 physicians by 1984—one-half the housestaff in pediatrics, child psychiatry, general surgery, and OB/GYN. These losses will jeopardize the delivery of health services where the dependence

on foreign medical graduates is most acute. That is particularly true in two of our boroughs, the boroughs of Brooklyn and the Bronx.

Moreover, there is the strong possibility that New York City hospitals will lose more than two-thirds reduction projected for the entire country. As the nationwide pool of FMG's shrinks, the competitive position of hospitals to recruit housestaff becomes more important. Again, the problems that I spoke about—financial problems and outdated facilities—already put New York City's municipal hospitals at a disadvantage. Applications for internships and residences dropped 8 percent between late 1977 and late 1978, and individual institutions heavily dependent on foreign medical graduates reported falloffs from 25 percent to 75 percent. New York's difficulties in recruiting physicians will only be compounded by the immigration restrictions.

One other problem: While foreign medical graduates enter all medical specialties, they have tended to emphasize areas of less interest to American graduates.

More than 80 percent of our FMG's, for example, are in four primary care specialties—medicine, general surgery, pediatrics, and obstetrics/gynecology—and four nonprimary care fields—pathology, psychiatry, anesthesiology, and rehabilitative medicine. FMG's now make up 93 percent of the Health and Hospitals Corp.'s pediatricians in Brooklyn, and the borough could be left without any children's services in municipal hospitals.

In this context, I am giving you some idea of the shape of the problem in our town. I would like to speak briefly about H.R. 7118.

Too many hospitals in New York City and elsewhere have not used the phase-in period already allowed by the Federal Government. Instead, as the pool of available FMG's has diminished, we have seen more and more waiver requests. Obviously, this is not an acceptable solution. Hospitals must develop—and implement—a suitable plan for seeking competent medical personnel to fill vacancies left by the shrinking pool of foreign doctors.

At this late date, however, additional time and Federal assistance is needed to do this job properly. In my opinion, H.R. 7118 would provide that time and assistance; and with one reservation, I support this legislation and hope it will be enacted by the Congress.

This legislation would allow the Federal Government to continue granting waivers to "avoid a substantial disruption of health services" until December 31, 1982, with an additional 1-year waiver available for qualifying institutions. In return for this extension of the phase-in period, hospitals would be required to develop a detailed plan for replacing alien doctors.

I fully support the strict reporting requirements contained in the bill. Having failed to prepare for the impending FMG reduction, hospitals cannot complain about requirements to develop suitable replacement plans. Any additional waiver extensions must be conditioned on firm evidence that hospitals are finally preparing for the phaseout of FMG's.

In fact, I would strengthen these provisions even further. FMG-dependent hospitals should also be required to undertake a program-by-program analysis to identify housestaff positions that can be eliminated without adversely affecting service delivery. Some FMG's are

filling positions in specialties, such as pathology, that often exist more for teaching purposes than for patient needs. Likewise, other FMG's train in specialties that are considered oversubscribed by the Federal Government. In many cases, these services could be consolidated and regionalized, allowing a more efficient use of a reduced number of physicians.

Having made that statement about more restrictive provisions in terms of reporting, I must say that I am concerned, however, with the extension of the waiver authority to Decembr 31, 1982, with an additional 1 year for hospitals that demonstrate a substantial reduction in FMG dependence. I would recommend a 5-year waiver authority instead.

Some institutions—particularly financially troubled hospitals serving poor and medically indigent patients—will have great difficulty reducing their heavy reliance on foreign doctors. In many cases, this will not reflect the absence of a good faith effort but rather the larger problems of physician maldistribution and the relative unattractiveness of medical practice in poor areas. For these hospitals, the Department of Health and Human Services should be allowed the administrative discretion to continue granting waivers provided that a good faith and substantial effort is made at reducing this dependence on FMG's.

H.R. 7118 amends existing law to coordinate the length of a foreign doctor's stay in the United States with the actual length of the training program. The present 2-year deadline, with an optional third year, is arbitrary. Alien physicians who come to the United States for graduate medical education, and who otherwise qualify for entry, should be allowed to remain here for a period equal to the length of their program. This will enable FMG's to return home with appropriate skills. Here in the United States, medical care will not be compromised by shortages of upper-level resident physicians created by the forced departure of FMG's after 2 years.

Finally, H.R. 7118 provides Federal manpower assistance to FMG-dependent hospitals during the phase-in period. Institutions demonstrating the need for a waiver would qualify for National Health Service Corps placement at no additional cost over and above house-staff salaries. Medical students would be encouraged to seek placement in these programs by allowing the training period to satisfy the corps service obligation.

This assistance would be targeted to communities where it is needed the most. Only hospitals that had successfully obtained a waiver—first, by demonstrating that a substantial disruption of essential health services would otherwise occur, and second, by developing a comprehensive plan for reducing FMG dependence—could qualify for corps personnel.

Furthermore, the Department of Health and Human Services would retain the administrative discretion to assign corps physicians to areas of greatest need. Qualifying hospitals would merely join other medically underserved areas in the competition for corps personnel. This would enable the Federal Government to be a partner in the hospital's comprehensive plan for reducing FMG dependence, when it was appropriate.

In enacting this legislation, Congress should not lose sight of the larger issue of maldistribution—by specialty and geography—of physicians trained here in the United States. Stopgap legislation regarding the FMG cutoff is not a long-term solution. We must redistribute medical personnel, so that all specialties and regions are sufficiently covered and access to health care is assured for the poor and working class. Ultimately, this depends on reordering the basic priorities of American medical education. It rests with health policymakers, both public and private, and physicians themselves to develop a coherent medical policy to accomplish these goals.

I thank you for the opportunity to appear before the committee.

[The complete statement follows:]

PREPARED STATEMENT OF HON. CAROL BELLAMY, CITY COUNCIL PRESIDENT, NEW YORK CITY

Chairwoman Holtzman, Honorable Members of the House Judiciary Subcommittee on Immigration. Thank you for the opportunity to testify on H.R. 7118, a bill to amend the Immigration and Nationality Act with respect to the admission of alien physicians for graduate medical education.

I am President of the New York City Council. I come before you today as an elected official with a special interest in health care. Over the past nine months, my office has been examining the role of foreign medical graduates in New York City teaching Hospitals. In February, I issued a report, "Is There a Doctor in the House?", which documented the critical physician shortage that New York City and other localities, particularly in the northeast and midwest, will face if the present immigration law is not amended.

Before I comment on the provisions of H.R. 7118, however, I would like to place the issue of foreign medical graduates in context.

Over the past two decades, foreign-born graduates of overseas medical schools have played an increasingly prominent role in the delivery of health services in the United States. They often serve in inner-city hospitals lacking doctors, and enter specialties such as pediatrics, gynecology and anesthesiology, which are frequently shunned by their American counterparts.

Concerned about the nationwide shortage of doctors in the 1960's, the federal government encouraged the influx of foreign medical graduates (or FMG's). The usual immigration requirements were waived for foreign doctors in 1965 amendments to the Immigration and Naturalization Act. These amendments exempted foreign physicians from the national origins quota system, thus providing easier access to the United States. Between 1965 and 1975, an average of 7,375 foreign medical graduates entered the country every year, receiving valuable training in U.S. hospitals and providing essential medical services in return.

Finding the lucrative earning power of American doctors hard to resist, many FMG's converted their temporary permits into permanent visas to stay in the United States. By 1976, FMG's accounted for 85,000—or 21 percent—of the nation's 409,000 physicians. Many of these doctors set up practice in low-income neighborhoods avoided by U.S. medical graduates.

As thousands of foreign doctors stayed in the United States, their native countries felt the impact of the "brain drain". Leaders of underdeveloped countries asked why their nations should provide expensive medical school training to young men and women, only to see them leave to practice in the United States.

At the same time, the need for foreign medical graduates in the United States declined as increasing numbers of doctors graduated from American medical schools. From 1966 to 1977, a 6 percent annual increase in the number of U.S. graduates helped alleviate the physician shortage of the early sixties, nearly doubling the number of U.S. medical graduates. Fears of physician surpluses in many sections of the country were voiced with increasing frequency.

Questions were also raised about the medical qualifications of the FMG's. Critics pointed out that foreign doctors were not scoring as well as American graduates in standardized tests and questioned their proficiency in the English language. Language and cultural barriers often created obstacles to proper treatment and diagnosis, it was argued.

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Congress responded to these growing concerns by passing the Health Professions Educational Assistance Act of 1976, declaring the United States self-sufficient in physician manpower and ending the national policy of preferential treatment for foreign medical graduates desiring entry visas. The new law tightened the educational standards and visa qualifications necessary for foreign medical graduates desiring to enter the United States for post-graduate training. It also imposed a two-year time limit on such training programs, with an optional third year if requested by the FMG's home country.

The potential adverse consequences of this change in policy did not go unnoticed. Congress provided a phase-in period which waives the more stringent educational requirements if a particular training program can demonstrate that a "substantial disruption in medical services" would otherwise occur. This phase-in period runs out in December 1980, at which time the more restrictive immigration requirements will have full force and effect.

Thus, the 1976 law greatly reduces the pool of foreign medical graduates eligible for entry into the United States each year; cutting the annual supply of FMG's by two-thirds—from 7,500 to 2,500—by 1980 or 1981, according to a recent forecast by the Department of Health, Education and Welfare. Foreign medical graduates, beginning four to five year long residency programs before December 31, 1980, will still be able to enter the country under the waiver provision. The full impact of the law will not be felt until 1985, when the 1980 group will have graduated, and virtually all foreign medical graduates in the country will have entered under the stricter regulations.

The loss of FMG's will be most severely felt in the industrialized sections of the northeast and northcentral states. New Jersey, for example, reported that 58 percent of all interns and residents were FMG's in 1977.

In Connecticut, the figure exceeded 70 percent. Over one-third of the teaching hospitals in Illinois, Michigan, Ohio, Maryland, Delaware, and New York had more than 50 percent of their housestaff positions filled with alien doctors.

New York City is, and will continue to be, particularly hard hit. The New York State Health Planning Commission predicts the number of foreign graduates in New York City will drop from 3,056 in 1978 to between 1,050 and 1,100 by 1984 as foreign medical graduates move on to new positions or return home and are not replaced. New York City, with its large concentration of teaching hospitals, now trains one of every 12 physicians nationwide and relies upon these trainees to provide many essential services. Of the 8,103 doctors training in voluntary and municipal hospitals in New York City in 1978, 3,056—or 38 percent—were foreign medical graduates.

This high proportion of FMG's stems from the problem many New York City hospitals face when recruiting U.S. medical graduates. Elite teaching hospitals in Manhattan can easily attract interns and residents from top medical schools, but attempts to enroll these students for graduate training in aging and deficit-ridden hospitals in poor neighborhoods have been difficult in the past and certainly are not getting any easier.

Medical students are uncertain about the future of New York's troubled hospitals; 27 private institutions have filed for bankruptcy since 1975, several municipal facilities are scheduled to be closed, and there is an overall shortage of nurses, equipment and medical supplies. Medical students also cite high crime rates and the deteriorated condition of inner-city neighborhoods where many municipal and small voluntary hospital are located.

Thus, the reduction of foreign medical graduates in New York will have an uneven impact, barely affecting some hospitals, while crippling others. Although foreign medical graduates account for nearly 40 percent of the interns and residents city-wide, the proportion in individual voluntary and municipal hospitals range from 7 percent to 100 percent. Foreign medical graduates amount to more than 50 percent of the housestaff—interns and residents—in 23 hospitals, and in 12 of these institutions, the proportion of foreign medical graduates is more than 75 percent. Eight hospitals with strong affiliations to medical schools have been able to reduce their use of foreign medical graduates since 1978, but again many municipal and small voluntary hospitals serving poor patients remain heavily dependent on the FMG's.

The reduced pool of FMG's will caues the greatest problems in hospitals run by the New York City Health and Hospitals Corporation which trains about 40 percent of the foreign graduates in the City.

If the prediction of a two-thirds reduction of FMG's nationally holds true for New York City, our municipal hospitals alone will lose more than 800 physicians

by 1984—one-half the housestaff in pediatrics, child psychiatry, general surgery and obstetrics gynecology. These losses will jeopardize the delivery of health services where the dependence on foreign medical graduates is most acute. That is particularly true in 2 of our boroughs, the Boroughs of Brooklyn and the Bronx.

Moreover, there is the strong possibility that New York City hospitals will lose more than the two-thirds reduction projected for the entire country. As the nationwide pool of FMGs shrinks, the competitive position of hospitals to recruit housestaff becomes more important. Again the problems that I spoke about—financial problems and outdated facilities already put New York City's municipal hospitals at a disadvantage. Applications for internships and residencies dropped 8 percent between late 1977 and late 1978, and individual institutions heavily dependent on foreign medical graduates reported falloffs from 25 percent to 75 percent. New York's difficulties in recruiting physicians will only be compounded by the immigration restrictions. While foreign medical graduates enter all medical specialities, they have tended to emphasize areas of less interest to American graduates.

More than 80 percent of our FMGs, for example, are in four primary care specialties—medicine, general surgery, pediatrics, and obstetrics/gynecology—and four non-primary care fields—pathology, psychiatry, anesthesiology, and rehabilitative medicine. FMGs now make up 93 percent of the Health and Hospitals Corporation's pediatricians in Brooklyn, and the borough could be left without any children's services in municipal hospitals.

In this context, let me turn to H.R. 7118. This is legislation that would not alter the basic federal decision to reduce our dependence on foreign medical graduates.

However, unfortunately, too many hospitals in New York City and elsewhere have not used the phase-in period already allowed by the Federal government. Instead, as the pool of available FMG's has diminished, we have seen more and more waiver requests. Obviously, this is not an acceptable solution. Hospitals must develop—and implement—a suitable plan for seeking competent medical personnel to fill vacancies left by the shrinking pool of foreign doctors.

At this late date, however, additional time and federal assistance is needed to do this job properly. In my opinion, H.R. 7118 would provide that time and assistance; and with one reservation, I support this legislation and hope it will be enacted by the Congress.

This legislation would allow the federal government to continue granting waivers to "avoid a substantial disruption of hen'th services" until December 31, 1982, with an additional one year waiver available for qualifying institutions. In return for this extension of the phase-in period, hospitals would be required to develop a detailed plan for replacing alien doctors.

I fully support the strict reporting requirements contained in the bill. Having failed to prepare for the impending FMG reduction, hospitals cannot complain about requirements to develop suitable replacement plans. Any additional waiver extensions must be conditioned on firm evidence that hospitals are finally preparing for the phase-out of FMGs.

In fact, I would strengthen these provisions even further. FMG-dependent hospitals should also be required to undertake a program-by-program analysis to identify housestaff positions that can be eliminated without adversely affecting service delivery. Some FMGs are filling positions in specialties, such as pathology, that often exist more for teaching purposes than for patient needs. Likewise, other FMG's train in specialties that are considered oversubscribed by the Federal government. In many cases, these services could be consolidated and regionalized, allowing a more efficient use of a reduced number of physicians.

I am very concerned, however, with the extension of the waiver authority merely to December 31, 1982 (with an additional one year for hospitals that demonstrate a substantial reduction in FMG dependence). I would recommend a five year waiver authority instead.

Some institutions—particularly, financially troubled hospitals serving poor and medically indigent patients—will have great difficulty reducing their heavy reliance on foreign doctors. In many cases, this will not reflect the absence of a good faith effort but rather the larger problems of physician maldistribution and the relative unattractiveness of medical practice in poor areas. For these hospitals, the Department of Health and Human Services should be allowed the administrative discretion to continue granting waivers provided that a good faith and substantial effort is made at reducing this dependence on FMGs.

H.R. 7118 amends existing law to coordinate the length of a foreign doctor's stay in the United States with the actual length of the training program. The present two year deadline, with an optional third year, is arbitrary. Alien physicians who come to the United States for graduate medical education, and who otherwise qualify for entry, should be allowed to remain here for a period to the length of their program. This will enable FMG's to return home with appropriate skills. Here in the United States, medical care will not be compromised by shortages of upper level resident physicians created by the forced departure of FMG's after two years.

Finally, H.R. 7118 provides federal manpower assistance to FMG-dependent hospitals during the phase-in period. Institutions demonstrating the need for a waiver would qualify for National Health Service Corps placement at no additional cost over and above housestaff salaries. Medical students would be encouraged to seek placement in these programs by allowing the training period to satisfy the Corps service obligation.

This assistance would be targeted to communities where it is needed the most. Only hospitals that had successfully obtained a waiver—first, by demonstrating that a substantial disruption of essential health services would otherwise occur, and second, by developing a comprehensive plan for reducing FMG dependence—could qualify for Corps personnel.

Furthermore, the Department of Health and Human Services would retain the administrative discretion to assign Corps physicians to areas of greatest need. Qualifying hospitals would merely join other medically underserved areas in the competition for Corps personnel. This would enable the federal government to be a partner in the hospital's comprehensive plan for reducing FMG dependence, when it was appropriate.

In enacting this legislation, Congress should not lose sight of the larger issue of maldistribution—by specialty and geography—of physicians trained here in the United States. Stopgap legislation regarding the FMG cut-off is not a long-term solution. We must redistribute medical personnel, so that all specialties and regions are sufficiently covered and access to health care is assured for the poor and working class. Ultimately, this depends on reordering the basic priorities of American medical education. It rests with health policy-makers, both public and private, and physicians themselves to develop a coherent medical policy to accomplish these goals.

Thank you for the opportunity to submit my views.

Ms. HOLTZMAN. Thank you very much for your excellent testimony. Will your time schedule allow you to stay while we have the other testimony?

Ms. BELLAMY. Absolutely.

Ms. HOLTZMAN. The next witness is Mr. Richard A. Berman, director of New York State's Office of Health Systems Management.

Mr. Berman, the text of your testimony will be incorporated in the record in full. I would appreciate your summarizing it briefly.

Mr. BERMAN. Thank you very much. We are particularly pleased to have been asked to be here, since you have been a champion of the availability of New York's health services.

In the interests of time—and taking your hint—I will just go to basically the back several pages, which deal specifically with the bill before you.

Again I would also like to thank the president of the city council and her staff. As you can tell from both of our statements, there has been a lot of exchange of information and data; and it gives you some hope that elected officials can still work together.

Specifically, just to run over quickly, I would amend our testimony on page 5 to support the addition of Ms. Bellamy's—what I call—fifth provision, which is a reevaluation of current housestaff physicians in the reporting requirements.

I think up until that point, with the exception of the 3- or 5-year, we are consistent and we would support completely her testimony and thrust.

The one area that we do have a difference in is that from our perspective, it is difficult for us to support the amendments to the Public Health Service Act for which the waiver to either public or private hospitals has been approved, to deem that as a high priority health manpower shortage area.

We would have to oppose that provision, because we believe that through a lot of other considerations, the National Health Service Corps has been a very effective program; but, as with all programs, has a very limited number of positions. Those positions have been allocated by region; and, within a region, those have been designated to provide ambulatory care in underserved areas.

To basically take physicians away from this activity and put them into a hospital, which may not be in a medically underserved area and for which they may not be spending the bulk of their time in the provision of primary care, is one which we cannot support, since we feel that it is a serious problem that we now are facing in a lot of our underserved areas and would not want to see that effort reduced.

The same applies to the use of National Health Service Corps positions and individuals and relieving them of their obligations to serve in primary capacities in underserved areas while they are taking their hospital-based training programs.

With the exception of those provisions, I'm proud to say that we support the testimony of Ms. Bellamy.

[The complete statement follows:]

PREPARED STATEMENT OF RICHARD A. BERMAN, DIRECTOR OF THE NEW YORK STATE OFFICE OF HEALTH SYSTEMS MANAGEMENT

Ms. Chairwoman, members of the subcommittee, I am Richard A. Berman, Director of the New York State Office of Health Systems Management. I appreciate being able to testify on behalf of the State of New York concerning foreign medical graduates.

The New York State Office of Health Systems Management was created by Governor Carey in 1977, to give a new organizational focus and an increased emphasis to the initiatives being taken by his Administration to ensure that health care services of the highest quality are available to all of New York's people at an affordable price. The power exercised by OHSM's thirteen hundred staff include review and approval of all proposals for development and operation of institutional health programs—certificate of need; monitoring and regulating the delivery of both institutional and noninstitutional health care services; and, setting reimbursement rates and reimbursement policies for a wide range of health care services under several major third-party programs. Moreover, if legislation proposed this year by the Governor is passed by the Legislature, the Office of Health Systems Management will also become New York's single state agency for management of the Medicaid program.

I am particularly pleased that Chairwoman Holtzman is conducting these hearings, because this is a problem which impacts severely on New York State and the City of New York.

Congresswoman Holtzman has championed improved access and availability of essential health care services. Her commitment to these ends is shared by New York State.

Because OHSM's functions encompass efforts to assure access to essential and high quality health services, we are deeply concerned about the problems concerning the loss of foreign medical graduates.

Foreign medical graduates have become an integral part of New York's health care network. In 1976, 40 percent of all non-federal physicians in New York

State were foreign medical graduates, that is, nearly double the national average.[1] Over 47 percent of residencies in New York in 1976, were filled by foreign medical graduates[2] and almost 70 percent of the medical staff in the State and county mental health hospitals are foreign medical graduates.[3]

Furthermore, Public Law 94–484, which H.R. 7118 addresses requires two-thirds reduction in immigration of foreign medical graduates in New York State from approximately 3,000 to 1,100.[4] This reduction, without Congressional intervention, will occur over a short period of time, and is likely to cause problems, especially in the 23 New York City hospitals which have FMG's staffing over 50 percent of their interns and residency positions.[5] (Attached is a listing of these programs.)

However, this is not a simple problem. In order to understand the problem fully, a review of its history is necessary. During the 1960's and early 1970's, New York State and federal health manpower policy was predicated on the widespread belief that there was a serious shortage of physicians. Consequently, both the state and federal governments began major financial assistance programs to support medical education and expand medical school enrollments.

At the same time, foreign physicians were encouraged to enter this country. Occupational preferences were provided for immigrating physicians, and immigration policy allowed entry to aliens obtaining further graduate medical education. This created a surge of FMGs entering the United States. Between 1963 and 1976, the FMG population increased from 31,000 or 11 percent of all United States physicians, to 85,620 or 20 percent of all United States physicians.[6] The impact of the influx of FMGs reached a peak in 1972, when 46 percent of new licenses to practice medicine in the United States were granted to FMGs. This ratio has since declined to under 35 percent.[7]

This influx similarly affected the internship and residency programs. Between 1950 and 1973, the national percentage of training programs filled by FMGs increased from 10 percent to 33 percent.[8] Much of this increase has taken place in the mid-Atlantic region and, specifically, in New York State. For example, although 26 percent of all residencies nationally were filled by FMGs, 45 percent of the positions in the mid-Atlantic region were filled by FMGs, and 47 percent of all positions in New York State were filled by FMGs.[9] These residencies were especially concentrated in a small number of large teaching hospitals, many of which are part of the New York City Health and Hospitals Corporation.

Throughout the country, the heavy influx of FMGs has led to a dependence of state and county mental health hospitals upon FMG staff. In 1975, over half of these positions nationwide were filled by FMGs. In New York State, over 70 percent of these positions were filled by FMGs in 1975, or over 1,000 FMGs were working in state or county mental hospitals.[10]

Foreign medical graduates have clearly had a significant impact on the nation's supply of physicians and have served as a safety valve over the past two decades whereby work forces could induce additions to the physician supply beyond those provided by graduates from the United States educational system.

As a result of the increasing percentage of FMGs in the United States health care system, many substantial concerns have been raised by various parties. For example, the Sun Valley Forum on National Health's Symposium on Foreign Medical Graduates, which in 1975 I had the opportunity to participate in, noted the following concerns:

A. In the view of some persons, United States immigration policy with regard to FMGs drains highly qualified, trained personnel from developing countries

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[1] "Toward a Balanced Health Manpower Policy," report of the Task Force on Health Manpower to the New York State Health Advisory Committee. Report of the Short Term Policy Issues, September, 1979, p. S–31.
[2] Ibid., p. 23.
[3] Ibid., p. 24.
[4] "Is There a Doctor in the House?" How the Loss of Foreign Medical Graduates Will Affect Health Care Delivery in New York City. Office of the City Council President, February, 1980, p. 2.
[5] New York State Health Planning Commission, "Foreign Medical Graduates in Graduate Medical Education Programs in New York City Hospitals," 1979.
[6] "Toward a Balanced Health Manpower Policy," p. 23.
[7] Ibid., p. 23.
[8] Ibid., p. 23.
[9] Ibid., p. 23.
[10] Ibid., p. 24.

where they are sorely needed—an unwise and unseemly policy for the United States to follow.

B. Many persons believe that the medical education received by FMGs is different from and often inferior to that offered by United States medical schools and that many FMGs do not provide a quality of medical service that is up to United States standards.

C. Some persons contend that it is unfair and improper for the United States to allow FMGs to come into the country, receive graduate medical training, and enter into the nation's medical system as physicians while at the same time capable young men and women who are United States citizens are denied entry to undergraduate medical school and are thus excluded from careers as physicians.

D. Some persons believe that, given present rates of increase in the number of physicians in the United States, in time there will not be a shortage of physicians but instead a surplus. They fear that such a surplus, if it were to develop, might increase the incidence of improper professional practice, such as the performance of unnecessary medical procedures.

E. Some persons believe that it is inequitable and objectionable that FMGs—some unlicensed—should be the main providers of health care for the poor and ethnic minorities in inner-city areas and for patients in state mental hospitals.[11]

In summary, encouraging FMG immigration to the United States has had major positive and negative impacts on the United States and foreign health systems. Some of the major positive impacts of increased physician immigration include:

A drastic increase in the supply of physicians in the United States;

The admission of talented foreigners seeking full training in medical specialities;

The provision of substantial amounts of medical services to poor and medically underserved areas;

The availability of another source of low cost medical manpower;

The provision of needed physician manpower for public institutions; and,

The training of foreign physicians who have returned to their native country with needed specialty training.

Unfortunately, some of these positive impacts have also been offset by negative impacts, including:

An increased cultural and language barrier to patients seeking physical and mental health care;

An uncertain control on the quality of the skills and training received by FMGs;

A potential oversupply of physicians generally and in certain specialties;

A vulnerable dependence of public and voluntary institutions on low-cost manpower, i.e., resident FMGs; and,

A potential drain of essential medical manpower from the native countries. For example, in 1977, over 39 percent of the residents and interns were from India and Pakistan, which both have an undersupply of physicians and could reattract such physicians.[12]

The climate for this growth clearly changed with the passage by the Congress of the Health Professions Educational Assistance Act of 1976 (Public Law 94–484). Recognizing that "there is no longer an insufficient number of physicians and surgeons in the United States . . .", the Congress concluded "that there is no further need for affording preference to alien physicians and surgeons in admission to the United States under the Immigration and Nationality Act." [13] This trend has continued to be supported by more recent research. It is projected that Public Law 94–484 has decreased the immigration of FMGs from approximately 7,500 per year to 2,500 per year.[14] In New York State, if Public Law 94–484 is not amended, it is expected to decrease the FMG immigration by two-thirds or from 3,056 in 1978, to less than 1,100 by 1984.[15] Although New York

[11] "Sun Valley Forum on National Health, Inc., The Foreign Medical Graduate in the United States Health Care System." Report of the Symposium, Jan. 14–17, 1978, p. 6.
[12] Annual Report on Medical Education in the United States, 1977–78. Journal of American Medical Association, 240: 2837–2846 (1978).
[13] Public Law 94–484.
[14] "Toward a Balanced Health Manpower Policy," p. 24.
[15] "Is There a Doctor in the House?," p. 2.

State supports the intent of Public Law 94–484, the sudden reduction of foreign physicians will cripple some hospitals and public institutions. Specifically, in 1976, in 23 New York City hospitals over 50 percent of the house staff were FMGs.[18] The impact of FMG reduction on services at these facilities and public institutions such as mental health hospitals may be devastating to the quality and accessibility of care for New York State citizens.

In an effort to assess the potential impact of inevitable FMG reduction, a Task Force of the New York State Governor's Health Advisory Council conducted a study of FMGs. Based on preliminary findings of a survey sample of 18 highly FMG dependent hospitals conducted in 1978, only one hospital reported some negative impact on services for 1978–79. Five hospitals anticipated a negative impact for 1979–80, and four had already taken measures to reduce the impact. Unfortunately, this study and others indicate that many facilities have not adequately planned for what they should have realized to be an immediate and eminent manpower reduction. Although there was no sense of real crisis, the chief executive officers of 13 of the 18 hospitals foresaw problems beginning in July of 1979. Because the New York State Governor's Health Advisory Council Task Force is greatly concerned, they have directed the New York State Health Planning Commission to resurvey these hospitals to determine the impact of the results of the 1980–81 residency matching of New York hospitals. This resurvey is now in progres. The results of this study and subsequent recommendations will direct the needed changes in New York State's response to this problem.

For these reasons, New York State generally supports the efforts of H.R. 7118 to postpone the impact on Public Law 94–484, Specifically, New York State's position on the provisions of this legislation is as follows:

Section (b)(3)(B) states that: ". . . the duration of aliens' participation is limited to the time typically required to complete such programs . . . The alien may, once and not later than two years . . . change the alien's designated program. . . . of training."

New York supports this provision because, if the purpose of these visas are to provide training for FMGs, then the FMGs need to be able to stay long enough to complete the approved programs.

Section (b)(3(c) extends the date for which waivers are available in cases where there would be substantial disruption in health care services. The provision extends the date from December 31, 1980 to December 31, 1982. (An additional one year extension may be granted by the Secretary of Health and Human Services for programs which have substantially reduced their reliance on FMGs.)

New York State supports this provision which is essential because it gives those hospitals with the greatest dependence on FMGs, time to adapt to the drastic decrease in FMG population.

Section (b)(4)(A) amends the PHS Act, to reflect approval by the Secretary of Health and Human Services of all waivers on a case by case basis.

New York State supports this provision which gives the Secretary greater control over the implementation of these provisions and provides a greater potential for assuring the plans specified below are developed.

Section (b)(4)(C) requires that all facilities requesting waivers prepare a comprehensive plan to reduce reliance on alien physicians. The plan must:

1. Discuss problems that the program anticipates without a waiver and methods that will be applied to reduce disruption of services;
2. Discuss program changes to make the program more attractive to graduates of medical schools who are United States citizens;
3. Discussion of recruitment efforts to attract United States citizens; and,
4. Description of how the program has and will phase down its dependence on FMGs completely by December 31, 1982.

New York State strongly supports this provision. Numerous studies conducted in New York generally show that facilities have inadequately planned for the impacts of Public Law 94–484. Without these additional provisions the facilities will face the same problems in 1983 that they face today.

[18] New York State Health Planning Commission, 1979.

A provision is added that requires the Secretary of Health and Human Services, the Attorney General and the Secretary of State to monitor the issuance of waivers, the needs of the communities, the assurance of quality medical care, and the review of programs receiving waivers to assure appropriate supervision of FMGs.

We support this provision because it is essential that the activities carried out relating to this legislation be closely monitored.

Provisions are added to require a report to Congress in Fiscal Year 1981 and 1982 on waivers granted and to require the Secretary of Health and Human Services to evaluate and report to Congress on the effectiveness and value of exchange programs to graduate training for FMGs within two years of enactment of this legislation.

New York State suports these provisions and believes that it is essential that the Secretary of Health and Human Services report to the Congress yearly on the implementation of this legislation.

The Public Health Service Act is amended to consider that any public or private hospital with an approved residency program for which a waiver has been granted (within the last twelve months) shall be deemed a high priority health manpower shortage area.

New York State opposes this provision. The National Health Service Corps has been a very effective program that has provided essential ambulatory care services in truly medically underserved areas. However, federal appropriations for the NHSC program have not substantially increased, and each region effectively has a cap on the number of NHSC physicians available. As it stands, this provision would drain essential resources away from ambulatory care in medically underserved areas to inpatient care in areas of dubious medical need. This provision is inconsistent with the intent of the NHSC and is not the appropriate route for a long term solution to the FMG problem.

The Public Health Service is amended to allow residency training in programs for which waivers have been granted under Section 212 of the Immigration and Nationality Act, to meet obligations for service for NHSC commitments.

New York State strongly opposes this provision for the same reasons it opposes the previous provision. In addition, the NHSC program would be further undermined by allowing residency training programs to meet the service obligations to the NHSC.

Clearly, H.R. 7118 as a whole, must be viewed in the context of comprehensive manpower policy and legislation. Substantial changes are taking place in health manpower. Most important to remember is that although HEW's estimates that there will be an excess of physicians by a much as nine percent in the country by 1990,[17] there will continue to be geographic and specialty maldistribution. For example, the problem of over two million New Yorkers currently living in medically underserved areas will not disappear.

H.R. 7118 and all health manpower legislation must be analyzed considering the impacts on: the FMGs; the FMGs' native country; the recognized oversupply of physicians; the specialty and geographic distribution of physicians; the quality of medical care; and the training and service institutions.

Furthermore, the Congress' support of proposals in H.R. 7118 and a reconstruction of the health manpower resources should not be mistakenly considered as the panacea for all health manpower problems. H.R. 7118 does not respond to the additional serious issues of the fates of foreign medical graduates who are United States citizens.[18] It also does not encourage redistribution of physicians geographically and among specialities.

In conclusion, the intent of H.R. 7118 is an essential component of a comprehensive federal health manpower policy. But, the amendments to Section 212 of the Immigration and Nationality Act, especially the provisions noted by facilities thereby correcting deficiencies in previous legislation.

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[17] Cited from Barhydt, Nancy R., Strategies for Reduced Number of Foreign Medical Graduates in New York City Hospitals Dissertation Columbia University School of Public Health. May, 1979, p. 246.

[18] Fleisher, Philip F., M.D., Dr. Anthony Tartaglia, Dr. Steven Tomas, and Dr. John Siegel. Report on Problems of United States Citizen Foreign Medical Graduates. Printed by Association of American Medical Colleges, Jan. 11, 1980.

TABLE I.—DEPENDENCE ON FOREIGN MEDICAL GRADUATES IN NEW YORK CITY BY HOSPITAL AND INCOME OF CATCHMENT AREA FAMILIES

Hospital	Location	Catchment area families with income less than $5,000 a year
More than 75-percent foreign medical graduates:		
Bronx—Lebanon [1]	Bronx	30 to 40 percent.
Cumberland	Brooklyn	20 to 30 percent.
Goldwater	Manhattan	Less than 20 percent.
Greenpoint	Brooklyn	More than 40 percent.
Brooklyn—Jewish [1]	do	Do.
Jewish Memorial [1]	do	30 to 40 percent.
Kingsbrook [1]	do	More than 40 percent.
Methodist [1]	do	20 to 30 percent.
St. Johns Episcopal [1]	do	More than 40 percent.
Sydenham	Manhattan	20 to 30 percent.
Catholic Medical Center [1]	Brooklyn	Not available.
Flushing [1]	Queens	Do.
51- to 75-percent foreign medical graduates:		
Beekman [1]	Manhattan	More than 40 percent.
Cabrini [1]	do	Less than 30 percent.
Coler	do	Do.
Coney Island	Brooklyn	20 to 30 percent.
Elmhurst	Queens	Not available.
Jamaica [1]	do	More than 40 percent.
Veterans' Administration	Bronx	Not available.
Long Island College [1]	Brooklyn	20 to 30 percent.
St. Vincent's [1]	Staten Island	Do.
Lutheran [1]	Manhattan	30 to 40 percent.
New York Infirmary	do	Less than 20 percent.
26- to 50-percent foreign medical graduates:		
St. Luke's [1]	do	30 to 40 percent.
Beth Israel [1]	do	Less than 20 percent.
Booth [1]	Queens	Not available.
Brookdale [1]	Brooklyn	30 to 40 percent.
Kings County/Downstate	do	Do.
Harlem	Manhattan	20 to 30 percent.
Staten Island [1]	Staten Island	Do.
Metropolitan	Manhattan	More than 40 percent.
Einstein [1]	Bronx	Less than 20 percent.
Long Island Jewish [1]	Queens	Do.
Maimonides [1]	Brooklyn	Do.
Less than 26-percent foreign medical graduates:		
Bellevue	Manhattan	Do.
Bronx Municipal	Bronx	Do.
Lenox Hill [1]	Manhattan	Do.
Mount Sinai [1]	do	More than 40 percent.
Montefiore [1]	do	Less than 20 percent.
New York University [1]	do	Do.
St. Vincent's [1]	do	30 to 40 percent.
New York Hospital [1]	do	Less than 20 percent.
Misericordia [1]	Bronx	Do.
New York Eye and Ear [1]	Manhattan	Do.
Presbyterian [1]	do	30 to 40 percent.
Roosevelt [1]	do	Less than 20 percent.

[1] Voluntary hospitals.

Source: "Foreign Medical Graduates in Graduate Medical Education Programs in New York City Hospitals," New Yokr State Health Planning Commission, 1979.

Ms. HOLTZMAN. Thank you.

We have as our next witness David Mannis, who is the director of intergovernmental relations of the Health and Hospitals Corp.

Mr. Mannis, the text of your testimony, without objection, will be incorporated fully in the record at this point.

[The statement follows:]

PREPARED STATEMENT OF DAVID MANNIS

Madam Chairman and subcommittee members: I am David Mannis, Director of Intergovernmental Relations for the New York City Health and Hospitals Corporation. I have asked Dr. Bob DeCresce of the Downstate Medical College to join me today to assist in answering any questions you may have.

First, I would like to say, on behalf of Joseph Hoffman, President of the Health and Hospitals Corporation, how pleased he is that this subcommittee has focused its attention on the troublesome question of foreign medical graduates and to express his appreciation for the opportunity to comment on H.R. 7118.

The Health and Hospitals Corporation operates the seventeen municipal hospitals of the City of New York. These hospitals have a combined complement of eleven thousand beds and provide over three million inpatient days of care and some six million emergency room and clinic visits each year. The hospitals serve neighborhoods where few if any private physicians practice, and treat populations too poor to pay hospital bills or private insurance premiums. (As you know, Madam Chairman, the Corporation counts among its patients many of the large population of illegal aliens which presently drain the resources of the City in so many ways.)

To serve the City's poor and near poor, Corporation hospitals are generally located in the City's least desirable neighborhoods. Since they operate with all the constraints of a municipal agency and provide health care for so many non-paying patients, substantial deficits and restrictions on quality of service cannot be avoided. Accordingly, our hospitals simply cannot compete with many of the voluntary hospitals in New York City for the services of graduates of American medical schools.

As a result, the Corporation now employs over 1,500 foreign medical graduates as interns, residents and staff physicians. Our dependence on FMG's is not a matter of choice; but for FMG's, programs in many Corporation hospitals would have no applicants for house officer positions.

At the end of this year existing provisions of the Immigration and Nationality Act prohibit entry of all but a few foreign medical graduates. The Health and Hospitals Corporation has viewed this deadline with great concern. It has been clear to us, however, that it would not be appropriate to request any extension of the deadline without preparing a plan for complying with Congress' avowed policy of reducing hospitals' dependence on foreign medical graduates.

I have submitted to this subcommittee copies of a working paper devised by the Corporation which sets forth in some detail all the strategies which we are preparing to reduce the number of FMG's in our hospitals. I would like to summarize those strategies today, and comment on some of the problems facing us in carrying them out.

First, the Corporation is willing to aggressively recruit U.S. medical graduates, but it is unrealistic to count on improved recruitment to overcome the innate disadvantages of our hospitals which deflect medical graduates to voluntary facilities.

A more productive approach would be to recruit American graduates of foreign medical schools. These schools appear anxious to place students in our hospitals, but at the present time the State of New York has called into question the suitability of some of these schools, and until the State determines which schools if any are acceptable, it will be difficult to initiate training programs for USFMG's.

We would like to see students who receive State assistance while attending medical school to exchange forgiveness of student loans for assignments in hospitals in urban medically underdeserved areas. This requires action by the State Legislature, which we are seeking at this time.

If appropriate interns and residents are unavailable, the Corporation is prepared to hire staff physicians and physician extenders to provide services now performed by FMG's The cost of such personnel would be immense, since they command higher salaries—and work far shorter hours—than interns on residents. We estimate that it would cost one million dollars a year to replace thirty FMG's with salaried staff, and the Corporation employs over fifteen hundred FMG's at this time.

Another approach would be to seek the services of National Health Service Corps doctors in our outpatient programs. The provisions of H.R. 7118 regarding the Corps would be an ideal way to bring some of the resources of that program to bear on the FMG program. In its recent consideration of the Health Manpower Act, the House Committee on Interstate and Foreign Commerce has further enhanced this concept by accepting an amendment which would allow public gen-

eral hospitals to obtain the services of Corps doctors on the same financial basis as proviate non-profit facilities. We urge inclusion of that provision in this subcommittee's bill.

Finally, the Corporation intends to find out which training position in its hospitals can be eliminated without ending medical services. Resistance to such reductions has been intense.

In short, while there are many approaches we can take to reduce FMG dependence, none of them are sure to produce substantial results. The Corporation believes that our best bet is to pursue all strategies at first, and rely on those which prove fruitful.

But this will take time and effort. We are committed to provide the latter, but we must look to Congress for the former. H.R. 7118 provides a grace period which the Corporation and similarly situated hospitals need to explore alternatives to FMG's. However, we feel that two years is an insufficient time in which to show a "substantial" reduction of FMG's. We agree that a strictly defined schedule for reduction is appropriate, but we suggest that a longer period of time be allowed.

Likewise, we believe that H.R. 7118 properly calls for a working plan in which each hospital must show how it hopes to reduce FMG dependence—indeed, the Health and Hospitals Corporation outlined such a plan prior to the advent of H.R. 7118—but we urge strongly that such plans, and the authorities monitoring them, acknowledge the obstacles now blocking the substantial changes necessary to eliminate FMG dependence; it would be unfortunate if hospitals felt compelled to draw up unrealistic plans so ambitious that they could not be executed in the time allowed.

Finally, while we agree that while upgrading training programs is probably the surest way to attract United States medical graduates, upgrading often implies expanding affiliations with teaching institutions. That approach can have negative effects on a hospital with strained finances and often counteracts any plans to reduce the overall number of training positions now filled by FMG's. We suggest that any Congressional action regarding FMG's make clear that a hospital may choose to improve its existing training programs without necessarily deepening its relationships with medical schools or teaching hospitals.

Aside from the points already raised, the Health and Hospitals Corporation supports H.R. 7118. Passage of such legislation will afford our hospitals time and means to reduce our present reliance on foreign medical graduates.

Thank you.

[See appendix at p. 113 for "Proposal for Reducing Reliance on Foreign Medical Graduates."]

Ms. HOLTZMAN. I would appreciate you summarizing your testimony briefly.

Mr. MANNIS. Thank you, Madam Chairwoman. I am here representing Joseph Hoffman, the president of the Health and Hospitals Corp., who asked me to express his pleasure that the subcommittee has taken the time to focus its attention on the problem of foreign medical graduates, which—I venture to say—affects the corporation as greatly as any other part of the hospital community.

The Health and Hospitals Corp. administers the 17 municipal hospitals in the city of New York. This system contains approximately 11,000 beds and provides 6 million emergency room and clinical visits each year and 3 million patient-days of care in the city of New York.

The vast bulk of the patients served come from neighborhoods where there are very few practicing physicians, very few providers of primary and health care.

Also, the vast bulk of the patients we serve are indigent and certainly are not in a position to pay in-full hospital bills or even to pay the private health insurance. Among that patient population—as you know—are a substantial number of illegal aliens for who we provide substantial amounts of health care; and the city provides many other services for that group.

An important aspect of H.R. 7118 is the requirement of hospitals to provide a working plan for gradually reducing their dependence on foreign medical graduates. Since Ms. Bellamy has summarized so well the general situation that we face in the city, I would like to speak to the possible strategies that we could use to reduce our dependence.

Somewhat before the advent of the legislation that you are considering, the corporation prepared a set of alternative strategies, knowing that it would not be appropriate to seek an extension of the time that we could obtain waivers at our hospitals if we were not prepared to discuss what steps we were willing to take, what we thought we would be able to do.

I would like to summarize those very quickly. First, it would seem that recruitment of U.S. graduates would be the best way of replacing foreign medical graduates; but I must say that given the characteristics of our hospitals, the budget constraints on us, the amenities that we offer, it's unlikely that without other changes, we would simply be able to attract U.S. graduates merely by inviting them more emphatically than we do now.

We are very interested in the possibility of placing U.S. FMG's in our hospitals, and we are looking into that, both with specific schools and relevant agencies; but it is our understanding now that doubt exists as to which, if any, of these schools are appropriate sources of personnel, particularly in preinternship programs.

So we are trying to resolve that and to be informed about that before we proceed with serious recruitment in that area.

We are very interested in the possibility of asking the State of New York to provide some kind of forgiveness program for medical students who attend school in the State, so that loans which they now obtain might be forgiven in whole or in part in exchange for service in urban, underserved areas. We are again pursuing that with the State legislature at this time.

Failing these techniques or procedures, we face the real possibility that at the end of 1980, absent any legislative change, we will be out of a great number of physicians in our hospitals and physicians who cluster in some very important areas, particularly pediatrics, in many of our institutions.

Failing anything else, we are prepared to think about hiring physicians and physician extenders to replace our FMG's and have staff medical personnel instead of trainees to provide the services.

Again, I would like to point out that the fiscal implications are substantial. We estimate that roughly due to the lesser number of hours that staff physicians serve in a week, compared to an intern, and the greater salary required to pay them, that—for example—to replace 35 FMG's with a salaried staff would cost us approximately $1 million a year. Multiplying that times our FMG component in our hospitals, which is around 1,500, that comes to somewhere around $42 or $43 million of budget that we would have to find somewhere.

That is an imposing problem. If we must do that, we will; we are looking in other di tions wherever possible.

One of those is the possible use of National Health Service Corps doctors, an issue which you have addressed in your legislation. We are very excited about that possibility, and we are interested in

coming up with an approach or using an approach which is suitable to the people who administer that program.

If that means restricting our eligibility for doctors by specific areas of medicine, particularly the primary care areas, we think that's a good idea.

Certainly we would want to demonstrate that our hospitals are either in medically underserved areas or serving medically underserved populations before we would consider ourselves eligible for those doctors.

I think the issue that I most want to address is the timing in H.R. 7118. We feel, frankly, that 2 years is a very short time to turn around what are very substantial problems in our hospitals, particularly the provision that calls for substantial reduction after 2 years. We agree and support the idea of a disciplining device for hospitals. I think clearly it was shown that we need it, because the last 3 years we have been relatively inactive in taking serious steps to correct this problem.

However, I would urge that the total period of adjustment be extended beyond 3 years and certainly if there is a phased reduction, that that be as much as possible moved toward the end of the period, because I think in honesty that, particularly in the area of recruitment, it will take some time to develop some real programs in that area.

So other than those conditions that I have raised, the bill that you have drafted certainly addresses all the issues that we are concerned about, both regarding FMG's and the National Health Service Corps. It's very pleasing to be able to support it with the few conditions that we mentioned.

Thank you.

Ms. HOLTZMAN. I would like to ask this question, to which any of you may respond. The Association of American Medical Colleges says that the problem of recruitment is not really a factor of a bad neighborhood or of a hospital physical plant but rather it is attributable to the quality of a particular training program. In fact, the Association of American Medical Colleges points to the fact that in some hospitals, the use of foreign medical graduates exists in high degree only in certain specialties, only in certain programs, and not in others and suggests that the difference has to do with the quality of different training programs in a particular hospital.

What is your answer to that?

Dr. DECRESCE. I think I would like to address that. I am Robert DeCresce from the Downstate Medical School.

I think one of the problems has been, first of all, the large number of positions that are available to house officers. I know the Association of American Medical Colleges feels that a strong program should have no difficulty in recruiting people. On the face of that, it does make sense. That would be true.

Graduates of American medical schools have a tremendous number of options. You take a place like New York City, in an individual hospital. Some programs will have a large number of foreign graduates. That doesn't necessarily mean that the program is not of a high quality. It may suffer competitively compared to other programs.

For example, the closeness of its medical school affiliation; a close, medical-school-affiliated program is more desirable to medical students because they like to be around the medical school environment. A program which may offer a quality education but it is not as closely affiliated with the medical school will have more difficulty in attracting graduates.

I think also location does play some role since house officers like to live in neighborhoods where they work. Unfortunately, many of the hospitals—not just municipal hospitals—are in areas that are not as desirable to graduates of American medical schools. I think the quality issue is not one of programs that are offering poor training. I think it's a matter of other competitive factors which may be perceived by applicants as quality, closeness of affiliation, the numbers and types of physicians on the staff.

Ms. HOLTZMAN. How would you rate the quality of the training programs for most of these foreign medical graduates in New York City?

Dr. DECRESCE. I think that's a fairly general question. There are hundreds to evaluate. The programs are accredited by the accrediting organizations. They meet the standards that are set up.

Ms. HOLTZMAN. How would you evaluate them?

Dr. DECRESCE. I don't think I am in a position to evaluate the ones other than the ones I know. I evaluate some of the ones at Downstate.

I don't think the quality is of a type that is inferior. I can't judge ones I don't have direct knowledge of.

Ms. HOLTZMAN. Let me just turn to the period of time for extension of the waiver, a point about which there is some disagreement. Councilperson Bellamy, you feel 3 years would be inadequate and that a 5-year period is important. Mr. Berman, you feel a 3-year period would be appropriate. Councilperson Bellamy, perhaps we can have some further elaboration as to why you think 3 years would not be adequate?

Ms. BELLAMY. Well, I think the key really is the plan that's put in place and then some attempt to determine, through these reporting requirements, that there is some compliance with the plan; but the 2 years, with the additional time for good behavior, it seems to me inadequate. What our concern ought to be again is with the plan. The plans as they are developed, the implementation of those plans and some determination that the hospital is successfully going through a transition period.

So my emphasis, then, is allowing for adequate time and monitoring through strict reporting requirements to assure that something is being done, rather than cutting back on time and, in a sense, saying, "You better move in that time or you are going to be in trouble." I don't think it is the time period that's going to force the compliance. I think, rather, it's going to be the reporting that has the greater chance of forcing the compliance.

That's why I am urging the strict reporting requirements together with extension of the time.

Ms. HOLTZMAN. How do you feel about that, Mr. Berman?

Mr. BERMAN. I really feel if you put a signal out now that this bill is for 5 years you really do take away, I think, the type of incentive

and the type of pressure that we have seen institutions need, unfortunately. I would feel much more comfortable 3 years from now coming before you and having a list of the handful of institutions which, you know, need 1 or 2 more years, therefore, to go ahead and ask for some special extension for several institutions. But as a group, to take all institutions out for 5 years seems to be not necessary and probably not helpful to move it in the direction that the legislation some time ago was aiming for.

Ms. BELLAMY. Barry Ensminger, my counsel, would like to speak to that.

Mr. ENSMINGER. I would like to respond again. In order to obtain a waiver at all, a hospital has to demonstrate two things: One, that there is going to be a disruption of essential health services. And two, that it has not only developed a suitable plan but is complying with a suitable plan.

It seems to me you are talking about a yearly process whereby the Secretary of HHS is going to have to judge compliance before another waiver is given. So it seems to me the problem Mr. Berman alludes to can be avoided entirely by strict administrative monitoring. I think the councilwoman's testmony underscored that.

Ms. HOLTZMAN. Isn't that a question whether a plan calls for compliance within a 3-year period of time or a 5-year period of time? Surely you can monitor, but the question is do we want to reduce the dependence on foreign graduates.

Mr. MANNIS. May I repeat a suggestion I made to some of your staff a couple of weeks ago, which was that just as a schematic approach, that since one of the things that troubles us most is that we could write a plan but many of the elements are conditioned on actions of people other than ourselves, that pieces may blow up. Then, you may say, we don't have a working plan. My suggestion was that the submission of a plan occur very early, as soon as possible, and that those agencies which are going to have regulatory oversight be involved in that, work closely with us, more than just say yes or no; let us know whether it's a good plan, so that the pieces of the plan are credible to them as well as to us.

But that early on, the parameters should be laid out and the monitoring that we are talking about, and even this phased reduction of FMG's, should follow from there perhaps over a longer period of time.

Ms. HOLTZMAN. I want to ask a final question to try to put this in context. Are we talking about second-class health care? Is that what the issue is really about?

Ms. BELLAMY. Is the question are we giving second-class health care in our hospitals located in poor areas, because we are really talking about municipals and voluntaries in this case? Or are we talking about FMG's providing second-class care?

Ms. HOLTZMAN. Does the use of foreign medical graduates to the degree that we see—especially in some New York City voluntary hospitals and many of the municipal hospitals—indicate second-class health care? Isn't that the problem that we are trying to address?

Mr. ENSMINGER. I was——

Ms. BELLAMY. Let the doctor comment first.

Dr. DeCresce. I think the issue of second-class medicine in terms of being delivered by foreign medical graduates is one that has been addressed by a number of studies in the literature. It's never been demonstrated that in terms of on-hands taking care of patients foreign medical graduates do qualitatively something different than American graduates.

One can look at test results, and even that's in some way ambiguous, although foreign medical graduates have not been perhaps as successful on tests; in terms of studies done in actual observance of foreign medical graduates versus American medical graduates, there really hasn't been any study that definitively shows that foreign medical graduates or American medical graduates provide a superior degree of care.

Ms. Bellamy. The study points to perhaps the ability to articulate in the English language being a greater problem than the hands-on delivery of health care. It is my view we have different levels of health care in this country. I am not sure I put the FMG problem at the top of the list as the reason for the differing level. Even in my own city there is a differing level of health care.

Your example of American doctors choosing to go into specialties rather than into primary care, rather than into family care highlights the major problem with quality INS unavailability. There are a number of other factors as well: The age of the facility, the ability to finance operations, the problems that financially troubled hospitals are having today in terms of paying for the nonpaying patients and the failure to take that into account in terms of a rational financing system. All of these, it seems to me, contribute potentially to a dual system of health care.

The FMG's may be an element of that, but I don't see it as the primary element.

Mr. Berman. I would like to agree that I don't believe the mere numbers of foreign medical grads occupying any training program indicates the quality of the care of the training program; but I would say that where institutions are having trouble matching, whether with foreign or with American students, it is an indication that the training program is less desirable; and to the extent that the high level of attractiveness of a training program then relates to the quality of care would get you to your issue probably a little more directly.

Ms. Holtzman. But the question here is whether or not the foreign medical graduates are going to have to take a certain test. The reason that is an issue is that they can't pass the test.

There are a lot of people who say testing is irrelevant, but the fact of the matter is that is what is at stake here. I am concerned. I don't know whether it is a symptom or a cause of lack of quality in health care, but I do think we have problems with regard to testing and with regard to training in certain basic medical courses.

I do think it's a reflection of a very serious problem. While we are talking about time periods for extending the waiver, I would just like to get some sort of sense of the underlying problem in the quality of health care delivery that we really are talking about here.

Ms. Bellamy. If I may again, I support—as I indicated in my testimony—the move toward the use of the American-trained physicians,

and perhaps what we are talking about—I merely am articulating it myself—is that we are talking about assuring the inavailability of at least some health care. I use a striking example, but it is striking considering the number of people affected. Over 90 percent of pediatric care in the borough of Brooklyn in the municipal hospitals is provided by FMG's. Where they are no longer available, but then we are talking about recruiting, and the costs of the additional personnel, what that would mean in terms of the already strained economic condition of these hospitals?

As an elected official I can say what we are talking about in some ways is no care or very little care versus some care.

Ms. HOLTZMAN. Thank you very much. My time has expired.

Before you leave, the other members may have questions. Mr. Lungren?

Mr. LUNGREN. I would just like to mention something that I didn't hear brought up. That is, the alternative plans you have when you don't have these FMG's available to you, hospitals had to go out and hire staff physicians. It has always been my impression in conversations I have had with physicians over the years—that they tended to look upon teaching hospitals that had experience and residents or the staff as hospitals that were a cut above those that were not teaching. Somehow where there's a teaching function of the hospital, along with giving care, there's a greater tendency, I think, to be concerned about the cutoff of the care, to make some judgmental values as to how you are doing against some standard, other than just going ahead.

Do you see that as a problem if you had to shift from a teaching hospital focus to a staff focus?

Mr. MANNIS. Definitely. Let me try to respond in this way: I think the alternatives that we have to reduce FMG's are sort of bracketed by two ideas that we get a lot of pressure on which are totally contradictory. One is that we should move all of our hospitals into whatever situation we can so that they resemble teaching hospitals by whatever means. The most elaborate forms of affiliation and all the responsibilities and budgetary implications that that kind of a move has for our hopsitals.

That would then attract perhaps U.S. graduates to come and train. On the opposite end of the spectrum, we are under a lot of criticism for perhaps having too many trainees in our hospitals; that perhaps in certain areas they are totally unnecessary; perhaps we have too many in certain areas; and that drains our resources from providing primary care to our particular clientele which has this very heavy need for basic medical services since they have no physicians. To reduce our training program, the number of slots incures the wrath of those people who believe in medical training as an art form.

If we try to reduce programs you can understand that it's totally contradictory to the idea of moving toward a teaching hospital model. I think if we have the resources, we would clearly want to go that way and have 17 Bellevue hospitals. Really it would be wonderful.

I think that it implies kinds of services, a certain amount of amenity that I don't believe we are in a position to do.

Mr. LUNGREN. I understand. It seems to me when you were focusing on going from teaching facilities to nonteaching facilities, you didn't talk about the implications of that beyond the costs.

Mr. MANNIS. I would defer to Dr. DeCresce, but I would say it's my understanding a lot of people feel strongly that the business of treating the poor involves primary care, providing the kind of service that the patients need and not trying to fit them into the mold of a traditional hospital patient.

So, as I say, it's definitely in conflict.

Dr. DECRESCE. I would say the perception is that teaching hospitals tend to be more prestigious. Physicians like to be on the staffs of teaching hospitals. There is an appeal; and probably the teaching hospitals—and I think our experience in New York City is the major teaching hospitals and medical schools do a better job in recruiting house officers.

I think to reduce the number of training positions by replacing house officers with attending physicians doesn't necessarily dilute the quality. If the overall goal was to keep the program but cut down the size of it, I don't think that cuts down the quality.

Every hospital wants to be a medical center. That may be part of the whole problem. I don't think quality, by reducing the number of residents, is necessarily lower.

Mr. LUNGREN. In California we have a tendency to no longer call them hospitals. We call them all medical centers. It just seemed to me to coincide with the television show "Medical Center."

Thank you very much.

Ms. BELLAMY. If I may, as a comment, after 5 years of trying to reestablish financial security in our town, we are so happy to hear the health people talking about costs that I thought I would pass that along to you.

Ms. HOLTZMAN. Congressman Hall?

Mr. HALL. Ms. Bellamy, you stated that there's a surplus of physicians in the United States, I thought you said. Did you not? Here it is, page 8. It says, "Study after study has documented a nationwide surplus of physicians."

Is there a surplus of doctors in New York?

Ms. BELLAMY. Well, I always find these numbers rather distrustful. If one wants to take a look at the Bronx as one borough, one of the five counties in New York, I think they have determined there is 1 doctor per 10,000 population. I don't know where that falls in the determination of a surplus. Clearly those figures would be much smaller if one took a look at the island of Manhattan in terms of one doctor per population ratios.

I don't know that I can make an evaluation. Perhaps the people that read health studies could make a better evaluation. I don't want to mislead in my answer to you.

Mr. HALL. I was just quoting from your testimony that study after study has documented a nationwide surplus of psysicians. It simply makes no sense for the United States to train more doctors than we need and simultaneously import large numbers of alien physicians.

Ms. BELLAMY. Again, I speak to that because of the history of FMG's. The amendments in 1976 were based on a belief in Congress

that we were seeing in this country a greater number of graduates of medical schools, and—therefore—it would no longer be necessary to encourage the immigration of FMG's.

Therefore, the immigration restrictions were imposed with the phased-in period allowed. That's what I am referring to in talking about the determination of a nationwide surplus.

Mr. HALL. How many medical schools do you have in New York State? How many graduates do you usually have each year in New York State?

Third, where do they go to when they graduate?

Ms. BELLAMY. May I ask Mr. Berman to try to respond? I am sorry to shift that over. I don't have the information.

Mr. BERMAN. I don't have the numbers.

Dr. DECRESCE. I can comment on New York City. There are 1,200 graduates, 8 medical schools in New York City. These 1,200 people graduate from those schools per year, about 8 percent of the Nation's doctors. About 50 percent stay in New York for their training and 50 percent leave New York.

About half stay in New York City of the doctors who graduate from medical school.

Mr. HALL. Do they stay in the State or go out in the other areas of the country?

Dr. DECRESCE. I assume they go out to other areas of the country.

Mr. BERMAN. It is both.

Mr. HALL. What you are concerned about primarily is that, as is indicated in the testimony of Mr. Mannis, at the end of this year, existing provisions of the act prohibit entry of all but a few foreign medical students. What you attempt to do is to impress upon that an extension of maybe 3 to 5 years before that termination date occurs?

Ms. BELLAMY. Yes; that is what we are supporting. We have some differences on the time.

Mr. HALL. I understand.

Ms. BELLAMY. You managed to do what others haven't in the city and the State, actually agree on something here.

Mr. HALL. Do you have any studies as to how the rest of the country, other than New York City, might react to this bill? You know, there is another portion of it extending all out to the west coast and down to the Rio Grande.

Do you have any facts and figures on how the rest of the world might react to this bill?

Mr. MANNIS. Well, Congressman, we had some numbers that were gathered. This is a couple of years ago, 3 years ago. Is Michigan on the Rio Grande? We definitely——

Mr. HALL. You say is Michigan on the Rio Grande? If that's all you know about this country——

[Laughter.]

Mr. HALL. I am jesting, of course.

Mr. MANNIS. Because in part we are from the city, we always assume our problems are the biggest and so forth. When we came to look at what numbers were available regarding distribution of FMG's in the country, we found that while there was not—clearly not a

nationwide distribution, there was substantial distribution of FMG's in the Northeast, including—well, the States that I—let me just, if I may, read these, the States and the total dependence on FMG's. This would be percentage of all house officers in 1977. The State of Connecticut, 73 percent; New Jersey, 58 percent; New York, 41; Illinois, 41; Delaware, 40; down Maryland, Michigan, the State of Ohio, 28 percent.

So clearly it is a regional problem, but it seemed also clear to us that it was not one focused in the city of New York.

Mr. HALL. It was mentioned here today about the quality of care. The experience I have had with foreign medical graduates has been very, very good. Of course, I come from an area in the Southwest where there's a shortage of physicians. There's not a day goes by or week goes by that I don't have some communication from a hospital in areas requesting help in getting foreign graduates, foreign physicians into that area.

When they come, they are excellent doctors. I gage that by what you hear from medical personnel, staff privileges, and all those things, that they acquire after being here a certain period of time.

So I am not in favor of prohibiting all foreign medical students or foreign medical graduates, but I don't know how the provisions of this 7118 will be received nationwide. I can see the problem that you have in New York City an in the State of New York.

Ms. BELLAMY. Again I would point out, so you have it on the record, my testimony on pages 4 and 5 speaks to the various percentages that Mr. Mannis just read you from Illinois to Michigan to Ohio, Maryland, New York, Connecticut, and New Jersey.

We obviously can speak best to our own areas of knowledge; but point out that this is not a problem inherently confronting just those of us who are in New York.

Mr. HALL. Thank you.

Ms. HOLTZMAN. I will recognize myself briefly to respond to the remarks of the gentleman from Texas. Not only has similar legislation been passed by another subcommittee of the Congress, but the administration has testified in favor of it. This is a problem that has an impact beyond one city. I should say the chairman of the full committee has a serious problem in his district in Newark in New Jersey.

The second bells have rung. We will adjourn, but I would like to thank again the panel for the extremely valuable testimony, particularly Mr. Berman and the very distinguished and able city councilperson.

Ms. BELLAMY. Thank you.

Mr. BERMAN. Thank you.

Ms. HOLTZMAN. The subcommittee will adjourn for 10 minutes.

[Recess.]

Ms. HOLTZMAN. The subcommittee will resume the hearing.

We will hear from the final panel of witnesses consisting of, first, the Association of American Medical Colleges, represented by Jack T. Myers; second, the Educational Commission for Foreign Medical Graduates, represented by Ray L. Casterline; and the American Medical Association, represented by Leonard Fenninger.

TESTIMONY OF JACK D. MYERS, PROFESSOR (MEDICINE), UNIVERSITY OF PITTSBURGH, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES; RAY L. CASTERLINE, EXECUTIVE DIRECTOR, ON BEHALF OF THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES; AND LEONARD FENNINGER, GROUP VICE PRESIDENT FOR MEDICAL EDUCATION, ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION

Ms. HOLTZMAN. Thank you very much for coming before the subcommittee. The Chair has to be in a meeting at the White House very soon. I would ask the indulgence of the witnesses, please, to summarize the testimony within about 3 minutes apiece, and then we will have time for some questions.

Without objection, the text of each of your statements will be included in the record.

We will begin with Dr. Myers.

Dr. MYERS. Madam Chairwoman, I appreciate this opportunity. I will try to be very brief. The first comment I want to make has to do with the extension of the training period. This has been discussed by other witnesses. The AAMC is strongly in favor of this and feels this should be extended to the full amount of specialty plus in some instances subspecialty training that the foreign medical graduate should receive in this country.

We recommend actually that your bill spell this out in regard to the full extent of specialty and in some instances subspecialty training.

The second point has to do with the elimination of the specialty board certification as a requirement for waiver of the VQE. We don't feel strongly about this one way or the other. It's a "one-shot" deal and would perhaps help that one class of foreign medical graduate.

We would hope it wouldn't be a precedent, however, for future exemptions to be made.

The point on which we feel, I think, most strongly has to do with the VQE waiver for the J visa for incoming medical graduates. There we are against the provision in the bill. The AAMC has always been in strong support of the VQE examination and we feel that it is a good check on the quality of the incoming foreign medical graduate to profit and reasonably participate in our U.S. educational system.

We emphasized that 95 percent or more of U.S. medical graduates can pass the equivalent of this examination, and we can see no reason why the foreign medical graduate shouldn't be equivalent in preparation, coming into the same type of residency training program.

We are looking at residency programs primarily as educational experiences and secondarily as programs which provide, of course, health care in the progress of the educational experience.

We have further concern in regard to problems like that of New York City; that unless high quality residents do get into a program, since they teach one another a great deal, and where medical schools are involved, they also are involved in the teaching of medical students; but you can't build a quality program that in due time is going

to attract U.S. medical graduates unless those foreign medical graduates who are in the program are really capable individuals.

If they are second rate, then the program is not going to be attractive to U.S. graduates who by and large do choose their programs in graduate medical education on the basis of quality. I would emphasize that particular point.

We have been disappointed in the last 4 years since the legislation was passed that many institutions have made no progress in improving the attractiveness of their graduate medical educational programs to U.S. medical graduates.

This gets into the subject of how much additional time, if any, should these programs have as has been discussed by many witnesses here today, to allow a transfer from emphasis on foreign medical graduates to U.S. medical graduates.

From the poor past record and from the fact that in talking to some of these persons we have not been impressed that any good plans exist for this transition, we have reservations about the prognosis on this issue and would oppose any extension of not having the VQE as a requirement for a J visa.

The last issue I want to comment on has to do with the substantial disruption waiver and declaring such areas health manpower shortage areas.

We have no objection to this at all. Then there are two ways the bill provides that this be implemented: That the physicians in the—I lost my terminology here—in the National Health Service Corps—the physicians in the National Health Service Corps—that either serve in these institutions which are declared shortage areas as residents or as what I call staff physicians.

We favor them serving or being able to serve as staff physicians, but would oppose their serving in these areas as residents.

In the first place, the National Health Service Corps wasn't set up for this purpose. It could be changed for that purpose; but residency is a very important part of overall medical education and to a great degree I can say, as a medical educator, that the career of the young man or woman in medicine is determined by the experiences of the residency period.

I would hate to see any coercion or other pressure—and there would be fiscal pressures in this plan, because they do get time off, so to speak, for the years spent as a resident—influencing the career and perhaps damaging or altering the career of an otherwise very good person.

So we would be most willing to have the National Health Service Corps physicians serve as staff physicians, to replace FMG's in these instances——

Ms. HOLTZMAN. Dr. Meyers, I must interrupt you at this point.

Dr. MYERS. I was just finishing.

[The complete statement follows:]

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, PRESENTED BY JACK D. MYERS, M.D.

Madam Chairwoman and members of the subcommittee: The Association of American Medical Colleges is pleased to have this opportunity to comment upon H.R. 7118, a bill to amend the Immigration and Nationality Act with respect to the admission of certain aliens to graduate medical education training programs.

The Association is the national voice for all of the 126 operational U.S. medical schools and their students, more than 400 teaching hospitals and over 60 academic and professional societies whose members are engaged in teaching, research, and patient care. The Association, through its constituents, has a fundamental interest in the system of graduate medical education in the United States; thus its keen concern about H.R. 7118 and its impact upon the quality of graduate medical training.

The provisions proposed in this legislation relate to foreign medical graduates (FMG's) in, or coming into, the United States for graduate medical education under the student exchange (J–Visa) provisions of the Immigration and Nationality Act (INA), and include, as you well know, the following:

The premissible duration of the training program would be extended to the time necessary to permit an alien to complete a training program in a given specialty or subspecialty.

One of the exceptional conditions under which the Visa Qualifying Exam (VQE) requirements can now be waived for either an exchange visitor or permanent immigrant is modified. The present law exempts those FMG's who, as of January 9, 1977, were: Fully and permanently licensed by a state, and certified by an ABMS specialty discipline, and engaged in medical practice in a state.

This proposal eliminates the second of these requirements—that for board certification.

The requirement to pass the VQE as a condition for receiving a J–Visa would be waivable until December 31, 1982, if the Secretary of Health and Human Services (the "Secretary") were to determine on a case-by-case basis that its imposition would substantially disrupt the health and medical services provided by the hospitals in which the graduate medical education of these physicians is taking, or was to take, place. An additional one-year extension, until December 31, 1983, could be granted if the Secretary were to find that a program had substantially reduced its reliance on alien graduates of foreign medical schools. In order for a program to be eligible for a waiver of the VQE requirement, it would have to submit a detailed discussion of the problems anticipated without such a waiver and the alternatives that had been considered to reduce such disruption. The Secretary would also have to receive a description of the efforts that had been or would be made: to use alternative resources (including physician extenders), to improve the graduate medical education offered and to recruit resident physicians who are U.S. citizens. Finally, a comprehensive plan, on a year-by-year basis, would have to be submitted, detailing the way in which the program intended to reduce its dependency upon alien FMG's.

The definition of a health manpower shortage area would be amended to include hospitals which have received a substantial disruption waiver within the last 12 months. This statutory redefinition would have the effect of making such hospitals appropriate sites for the assignment of physicians who had held National Health Service Corps (NHSC) scholarships while in medical school. Whenever possible, Corps personnel would be assigned to these shortage areas to reduce the number of FMG's in residency training programs. An institution would be required to reimburse the Federal government not for the entire amount of an assigned Corps member's salary, but only an amount equivalent to the stipend it would have paid an alien resident.

Physicians who had held NHSC scholarships would be permitted to credit the time spent in these hospitals in the status of graduate medical education students (interns and residents) toward the service payback obligation in their scholarship agreements.

EXTENSION OF TRAINING PERIOD PERMITTED UNDER THE J-VISA

Of the provisions concerning FMG's in H.R. 7118, the one to permit an extension of the period of training has been the most widely discussed and is the least controversial. A similar provision is contained in S. 2378, a bill introduced by Senator Jacob Javits, and in H.R. 7204, a bill introduced by Representative Henry Waxman and recently marked-up by the House Committee on Interstate and Foreign Commerce. Currently, FMG's who have passed the VQE may come to the United States for graduate medical education for a period of two years, with extension for a third year contingent upon approval from the visitor's home government. This arrangement does not give resident physicians adequate time to meet eligibility requirements of many of the medical specialty certifying boards

of the American Board of Medical Specialists (ABMS), requirements that may be assumed to reflect the necessary period of training for a designated specialty. Under the current law, the VQE and language requirements assure the competence of the alien graduate medical education students. Thus, there would seem to be little reason to limit the participation of such qualified aliens in U.S. education programs, provided of course that they could be accommodated locally. This country has had a long tradition of welcoming exchange students, and U.S. educational institutions point with pride to the achievements of alumni who attain distinction in their country of origin.

If graduate medical education programs accept alien physicians, there is little reason to truncate tenure prematurely, i.e., before the training program has been completed. The only real objection is that the longer training period gives the exchange visitor a longer exposure to the "hazard" of acquiring an American spouse, and, therefore, American citizenship. By and large, however, extension is in the best interest of the individual, the program, the individual's country of origin, and the U.S.; on that basis the Association supports the proposal to amend Section 212(j)(1)(D) as drafted in H.R. 7118. However, the Association urges the Subcommittee to consider amending this provision to provide, as do S. 2378 and H.R. 7204, that the duration of an alien graduate medical education student's stay be limited to the lesser of seven years or the time typically required to complete such a program. It would also be reassuring if the bill indicated that the criteria to be used by the Director of the International Communication Agency were required to be consonant with the specialty board requirements established by the member organizations of the ABMS. Such changes to the provision in H.R. 7118 would serve to limit any possible abuse of it.

VQE WAIVER UNDER EXCEPTIONAL CIRCUMSTANCES

The significance of the proposal in H.R. 7118 to further relax the circumstances under which the VQE requirement can be waived for exchange visitors or permanent immigrants who were licensed by and practicing in a state prior to January 7, 1977 is not clear to the AAMC. In principle, the Association strongly supports the VQE screen to protect the American public from encounters with alien physicians whose education is not up to U.S. standards. The proposal would appear to have a limited impact, to involve a relatively small number of individuals and to be non-recurrent. Without clarification of the intent, meaning and significance of this amendment, the AAMC is unable to determine whether it represents a reasonable and just accommodation in behalf of individuals caught in a period of transition or a serious violation of an important principle.

EXTENSION OF VQE WAIVER UNTIL DECEMBER 31, 1982

One of the most significant changes to the INA wrought by Public Law 94–484 was the institution of a requirement that J-Visa holders pass the VQE. The purpose of this modification by the Congress in 1976 was to raise the educational achievement standards for FMG entry into the U.S. for graduate medical education, and thereby to protect the American public from contact with inadequately educated physicians serving as hospital residents. The current statute requires that, as of January 1, 1981, all FMG's coming to the U.S. for training will have passed theVQE; until then, institutions can file for a waiver of this VQE requirement, on the ground that there would be "substantial disruption" of medical service if FMG's on the staff of an institution were required to have passed this examination.

The AAMC recognizes that a few hospitals in this country, particularly in areas such as New York City, are faced with severe problems in recruiting U.S. medical graduates for their residency programs. Nonetheless, the issue is no different today than it was when Public Law 94–484 was passed in October, 1976. I "substantial disruption" waivers are continually granted, these hospitals which have had four years to correct their deficiencies will postpone confronting the real problem—the quality of the graduate medical education offered and the consequent inability of the program to attract graduates of U.S. medical schools. The AAMC does not take pleasure in appearing to be unsympathetic to the needs of these distressed hospitals. But it is equally distressed by the fact that a substantial segment of the least advantaged American citizens, who live in the affected areas and who depend on these hospitals almost exclusively for their medical care, must rely on physicians who cannot pass

an examination so designed that 95 percent of U.S. medical graduates would be expected to pass. Current practices—apparently little different than those prevailing before the enactment of Public Law 94-484—are not a socially acceptable, let alone an ideal, solution to even the medical care aspect of this problem.

The proposal to extend the substantial disruption waiver process implies that the purpose of a residency program is to provide service, ignoring the fact that the fundamental raison d'etre of a residency program is educational. Residents are important participants in the American system of medical education. They both receive education from more senior residents and from fully trained attending faculty physicians while, at the same time, they assist in the training of more junior house staff and, depending on the nature of the hospital's affiliation with a medical school, medical students. The solution offered by the use of waivers would undermine the quality of education offered and ultimately worsen the very problem it is designed to address. Medical school graduates applying for residency positions are primarily concerned about the quality of education and training offered by a given program. The presence of poorly trained upper-level residents can only serve to lower the quality of a program and thus its attractiveness to the graduates of U.S. medical schools.

In the course of their education, residents, by participating in patient care under supervision, do contribute to an institution's provision of care to those whom it serves. However, because education is primary the Association must regard this as an education, not a health care, issue. In this context, it is persuaded that, if the directors of those graduate medical education programs and the medical schools with which they are affiliated were forced to focus attention on the quality of the training programs, the dependence of these programs on FMG's would rapidly diminish.

The Association does not recognize that the provision in H.R. 7118 to extend the waiver process is a modest improvement over like provisions in other legislation recently introduced in Congress (i.e., H.R. 7204 and H.R. 6800 which would permit waivers through the end of 1983, and S. 2378 which would do so through 1985) in that it limits the general availability of the waiver to an additional two year period and requires that before a substantial disruption waiver may be issued, the institution must have a fairly detailed plan for reducing its dependency on alien FMG's. However, in implementing the current law, institutions have already been required to formulate such a plan and this requirement has apparently not been successful in resolving the problem; therefore, the Association does not believe that the change incorporated in H.R. 7118 is of sufficient substance to permit support of the provision.

DESIGNATION OF SELECTED HOSPITALS AS HEALTH MANPOWER SHORTAGE AREAS

The root causes of the difficulties encountered by public urban hospitals in attracting sufficient numbers of residents lie in the serious social problems of poverty and the economic decline of many of our cities. The long-term solutions to these problems are not within the capacity of the hospitals to solve. They must, however, try to deal, in the short term, as competently and humanely as possible with the enormous problems of disease and disability facing them each day. Steps to improve the financial health of these institutions would contribute importantly to solving the problem of attracting qualified physcians to participate in residency training programs. There are, however, actions which can be taken to address directly the problems facing public hospitals because of recently stiffened immigration laws. A short-term solution is offered by the provision in H.R. 7118 for the use of National Health Service Corps physicians to fulfill their service obligations by serving as faculty or staff in such hospitals. As in the case of extending the substantial disruption waiver mechanism, no additional expenditure of Federal money would be required, but unlike that alternate solution, medical services would be provided by individuals whose competency in language and medicine is not in doubt. H.R. 7118 would permit any hospital which receives a substantial disruption waiver to be considered a shortage area (as defined in Section 332 of the Public Health Service Act).

While the association is opposed to the continuation of the substantial disruption waiver provision, it views as an appropriate means of defining a shortage area for this purpose a provision of the sort contained in S. 2378, the Bill introduced by Senator Jacob Javits, which proposes that certain hospitals be

designated as health manpower shortage areas if more than a given percentage of their resident staff is composed of FMG's. The exact magnitude of dependence on FMG's necessary to permit such a designation might be left to the Secretary to difine through appropriate regulations.

While providing that these institutions may be eligible for assignment of NHSC scholarship recipients has attractive features, it also may cause some new fiscal problems in a situation where the basic problem is overwhelmingly fiscal. The Association has no quarrel with the requirement that the assignment of Corps members in a hospital should, whenever possible, reduce the number of alien FMG's in residency training programs in that institution. However, it must be borne in mind that the status of Corps members is *not* the same as that of alien resident physicians. Members of the Corps are fully trained physicians who have already completed residency training; members of the Corps would probably be reluctant to once again invest the long hours typically spent by resident physicians in their first years of graduate medical training to extract the maximum benefit from the educational opportunities derivable from participation in residency training programs. Thus, even though a fully-trained NHSC member may be more productive than a resident physician, the round-the-clock medical staff coverage that must be available in hospitals could not be met by a one-for-one substitution.

In order to hire additional staff to make up for the fact that one Corps member would not be sufficient to deliver the health services regularly provided by a single house staff physician, the hospital will have to find additional sources of funds—a very difficult to unlikely prospect in light of the dire financial condition of many of these hospitals, and made even more difficult by the requirement that the institution would have to reimburse the Federal government for each Corps member assigned to it an amount which is equivalent to the stipend it would have paid an alien resident. It is hard to imagine how a hospital could solve the problem of upgrading or rebuilding its residency programs when it would have to spend down its resources for that activity in order to subsidize the problem's short term solution—the use of Corps physicians. The Association, therefore, recommends that the hospitals be released of any obligation to repay for services provided by NHSC physicians and that placement of NHSC physicians in such institutions be made on a case-by-case basis by inquiry into the actual needs of the hospitals rather than by use of an arbitrary formula of one-NHSC M.D. added for one-alien FMG position removed. Otherwise many may never be able to engage in quality graduate education and may become permanently dependent upon the NHSC.

FULFILLMENT OF NHSC OBLIGATION THROUGH PARTICIPATION IN DESIGNATED RESIDENCY TRAINING PROGRAMS

While the AAMC supports defining hospitals with a significant dependence on FMG's as health manpower shortage areas for the purpose of having NHSC volunteers assigned to them, it must oppose the award of service pay-back credit to residents for the period of graduate medical education received in these hospitals. A review of the legislative history of the National Health Service Corps indicates that this program was designed to provide fully trained and qualified physicians to deliver medical care to the undeserved populations of this country. Residents are not fully trained; in fact, they are trainees. To allow them to accrue pay-back credit while still in student status contravenes the original, and still valid, intent of the Congress. Section 752b5(A) of the PHS Act very clearly states: "No such period of internship, residency or other advanced clinical training shall be counted toward satisfying a period of obligated service" for NHSC. Again, it must be reiterated that the fundamental purpose of residency programs is to provide further education to medical school graduates and not to provide medical service—the NHSC program is one whose reason for existence is the provision of health care services and not medical training.

CONCLUSION

Over the long-term the real solution to the health service delivery problems resulting from the changes in immigration laws is the improvement of the quality of graduate medical education offered by these public general hospitals. In a study sponsored by the Human Resources Administration of the Department of Health, Education, and Welfare,[1] improvement of the quality of medical training

[1] *Identification of Special Efforts of Title VI Restrictions on Selected Hospitals and Implications for Health Manpower.* Urban Systems Research Engineering, Inc.

programs was one of the few proposed solutions that was considered to address adequately the potential manpower problems due to restrictions on entrance of FMG's into the United States contained in the 1976 law. Comparisons of recruitment results in different specialty residency programs in the same hospital show the correctness of this assertion: some residency programs in some specialties have been able to recruit U.S. medical graduates while others in that identical institution continue to attract few. The fact that differences in recruitment results are observed in the same hospital suggests that they are not attributable to hospital physical plant, to socioeconomic characteristics of patient population, to neighborhood area or to type of hospital ownership, but reflect the commitments of individual clinical departments to innovative leadership, improved staffing and a heightened educational emphasis. These factors appear to be the critical variables which effect the program's attractiveness.

The Association is willing to work with the schools to assist them in anyway it can in an effort to improve their graduate medical education programs. However solutions of this character may well require substantial financial assistance to defray the additional costs of hiring new faculty at all levels, of providing better support services such as laboratory services and of expending in-house educational programs.

Ms. HOLTZMAN. Thank you very much.

The next witness is Ray Casterline who represents the Educational Commission for Foreign Medical Graduates. Without objection, your testimony will be incorporated in the record. You may proceed very briefly, please.

Dr. CASTERLINE. I appreciate this opportunity to appear before you to discuss these various provisions of H.R. 7118 with respect to the admission of certain aliens for graduate medical education.

The points I would like to emphasize briefly relate to comments made earlier today, in particular the reason, as I see it, why the number of requests for waiver is increasing, whereas, as the years go on, you thought there would be a reduced number.

During this period since 1970, 29 programs requested 35 waived positions; 19 were approved. In 1979, 34 programs requested 140 waived positions; 108 were approved. During the first 4 months of 1980, 35 programs requested a total of 206 positions; 187 have been approved.

In my opinion this increase is a matter of efficiency in the provision of medical care. Senior residents, most of whom were here at the time the Public Law 94–484 became effective, are much more effective in the provision of health care, medical care services. A fourth-year resident can provide considerable care. A first-year resident provides a much smaller amount of care per hour, much less service for training.

Thus, as I see it—and as I predicted at the beginning of the waiver program—this would happen because of the need for increased numbers to make up for the senior residents who were leaving programs because they had completed them.

Therefore, the increased duration of the waiver provisions would seem to be required to allow a catchup in this if the increased duration of stay of the individual is to be allowed.

Second, I think that you should—the committee should be aware of the numbers of individuals who are available in the pool upon which this country can draw, as it were, for individuals who are qualified under the provisions of the Public Law 94–484 examination and other areas; particularly the VQE.

Of the 12,618 who took the examination, and the 3,545 who passed the VQE in the 3 years 1977–79, only 3,245 actually are eligible for admission to a training program in the United States as well as obtaining a visa to enter.

That is a substantially lower number than were admitted in earlier years. I think it's something that the committee should consider seriously in their deliberations.

From our perspective, extension of the waiver through December 1983 would not increase the exchange visitor numbers to the point of running contrary to the point of the law nor would it result in exceeding the January 1980 cap imposed by the Congress.

It would give areas such as New York a more realistic time to phase down reliance on alien positions.

Ms. HOLTZMAN. I am going to have to warn you. I will let you testify 1 more minute.

Dr. CASTERLINE. It would allow for a large number of people to be available to fill in the gap.

Ms. HOLTZMAN. Thank you. Please accept my apologies for this. I couldn't foresee this this morning.

[The complete statement follows:]

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104, U.S.A. ☐ PHONE 215 386-5900 ☐ CABLE: ECFMGCOUNCIL, PHILADELPHIA

May 9, 1980

The Honorable Elizabeth Holtzman
Chairwoman, Subcommittee on Immigration, Refugees, and International Law
Committee on the Judiciary
United States House of Representatives
Rayburn Office Building
Washington, D.C., 20515

Dear Chairwoman Holtzman:

The Educational Commission for Foreign Medical Graduates (ECFMG) has been asked to comment on certain provisions of a bill to amend the Immigration and Nationality Act with respect to the admission of certain aliens for graduate education or training programs (H.R. 7118).

I am submitting a statement that addresses the following provisions of H.R. 7118:

1. Deletion of "specialty certification" from the provisions of the August 1, 1977 (Public Law 95-83) amendment to the Immigration and Nationality Act. This would allow an alien physician to be considered to have passed the Part I and Part II examinations of the National Board of Medical Examiners if he was:

   a. on January 9, 1977, a doctor of medicine fully and permanently licensed in a State; and was

   b. on that date practicing medicine in a State.

2. Increase in the duration of stay of Exchange Visitor Foreign Medical Graduates (EVFMGs) in accredited graduate medical education training programs in this country to allow them to complete their training objectives;

3. Permission for EVFMGs to make one change in their training objectives not later than 2 years after they begin authorized training;

4. Extension through December 31, 1983 of the "substantial disruption waiver" provisions of the Health Professions Educational Assistance Act of 1976 (PL 94-84); and

5. Evaluation of the effectiveness and value to foreign nations and to the United States of exchange programs for the graduate medical education or training of aliens who are graduates of foreign medical schools.

I appreciate this opportunity to appear before the subcommittee and to discuss the provisions cited above from the vantage point of the Educational Commission for Foreign Medical Graduates.

Respectfully submitted,

Ray L. Casterline, M.D.
Executive Director

RLC:vdb

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104, U.S.A. ☐ PHONE: 215 386-5900 ☐ CABLE: EDCOUNCIL, PHILADELPHIA

May 14, 1980

Statement on H.R. 7118 by Ray L. Casterline, M.D., Executive Director,
Educational Commission for Foreign Medical Graduates

Madam Chairwoman and members of the subcommittee, I appreciate this opportunity to appear before you to discuss certain provisions of a bill to amend the Immigration and Nationality Act with respect to the admission of certain aliens for graduate medical education or training programs (H.R. 7118). This statement will address the proposed deletion of "specialty certification" as one of the requirements for alien physicians to meet, if they were in the United States, licensed to practice medicine, and in practice in a State on January 9, 1977, and wished to be considered to have passed the National Board of Medical Examiners Part I and Part II examinations; the proposed increase in the duration of stay of Exchange Visitor Foreign Medical Graduates (EVFMGs) in accredited programs of graduate medical education or training; the proposal to permit EVFMGs to make one change in their training objective; the substantial disruption waiver provisions of the Health Professions Educational Assistance Act of 1976 (Public Law 94-484) and the extension of those provisions proposed in H.R. 7118; and the proposal to evaluate the effectiveness and value to foreign nations and to the United States of exchange programs for the graduate medical education or training of aliens who are graduates of foreign medical schools.

The Educational Commission for Foreign Medical Graduates (ECFMG) is a separate nonprofit organization that is sponsored by seven of the leading organizations in the field of medical education and health care in the United States.

In recognition and fulfillment of their public responsibilities for health care and education, the sponsoring organizations established ECFMG to concern itself with foreign medical graduates.

To meet its responsibilities, ECFMG identifies the following as its aims and missions:

(1) To provide information to foreign medical graduates regarding entry into graduate medical education and health care systems in the United States:

(2) To evaluate their qualifications for such entry;

(3) To identify foreign medical graduates' cultural and professional needs;

(4) To assist in the establishment of educational policies and programs to meet the above-identified cultural and professional needs of foreign medical graduates.

(5) To gather, maintain, and disseminate data concerning foreign medical graduates; and

(6) To assist, through cooperation and recommendation, other agencies concerned with foreign medical graduates.

During the past two decades, ECFMG has become most widely known for its examination and certification program. ECFMG certification is a requirement to enter accredited graduate medical education training programs in the United States and facilitates obtaining a license to practice medicine in most of the states in the United States. In addition, ECFMG administers the Visa Qualifying Examination (VQE). Passing the ECFMG English test is not only a prerequisite for ECFMG certification but also to take the VQE.

Pertinent to this discussion, however, is ECFMG's role as a sponsor of an Exchange Visitor Program for alien physicians who enter the United States to participate in accredited programs of graduate medical education or training. The International Communication Agency provides ECFMG authority to serve as a sponsor and to issue the documentation (Form IAP-66) required as one of the prerequisites for an alien physician to obtain a J-1 (Exchange Visitor) visa to enter the United States.

At least four provisions of H.R.7118 relate to the graduate medical education of alien physicians who have entered, or will enter the United States as Exchange Visitors under the sponsorship of ECFMG. Each of those provisions will be discussed separately.

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SPECIALTY CERTIFICATION

The Educational Commission for Foreign Medical Graduates is not directly involved in the process of licensure to practice medicine in the United States. Nonetheless, I believe that it is important to delete "specialty certification" from the provisions of the Public Law 95-83 amendments to the Immigration and Nationality Act. Specialty certification has little to do with licensure to practice medicine in the United States.

INCREASED DURATION OF STAY

ECFMG is aware of concern regarding the three-year maximum limitation of stay for Exchange Visitor alien physicians. The concern has been expressed by government officials as well as by leaders in the medical profession of various foreign countries. This restrictive provision of the law has disrupted many traditional programs of international exchange in graduate medical education between medical schools in Latin America and institutions in the southeastern United States. Physicans from Venezuela, in particular, have expressed concern regarding the hazards that will result if young Latin American physicians are forced to receive training in the Soviet Union and other countries where Marxist attitudes prevail The restrictive provision has also caused comparable interference with similar programs between institutions in the United States and those in the United Kingdom, Italy, Egypt, Saudi Arabia, Australia and New Zealand. Of interest is that schools in countries which provide medical education comparable to that offered in the United States are also most concerned about the restricted

length of stay. From meetings with various officials and medical leaders, I believe there is a consensus that the current permissable length of stay poses problems and that the problems are primarily educational relating to the inability of trainees interested in high quality graduate medical education to remain for a sufficient period of time to obtain the education they require.

From the ECFMG perspective, the ECFMG Board of Trustees supports increasing the duration of stay to allow completion of a training objective and maintains that such an increase would not jeopardize the intent of the law nor would it result in exacerbation of the classic brain-drain syndrome.

As you are aware, one of the recent amendments to PL 94-484 requires that exchange visitor alien physicians must make a commitment to return to their home country upon completion of training in the United States. This requirement, in addition to the controls ECFMG has over the issuance of the form (IAP-66), which allows exchange visitors to obtain a J-1 visa, would preclude the exchange visitor from remaining in this country indefinitely.

Consequently, increasing the duration of stay would 1) do much to enhance our international relations with many countries who value the training that the United States has to offer and 2) would benefit hospitals which are currently depending upon the substantial disruption waiver provision of the law to carry them through the transition period.

PERMISSION TO CHANGE TRAINING OBJECTIVE

Most alien physicians who enter the United States as Exchange Visitor Foreign Medical Graduates adhere to their initial training objective (chosen specialty), complete it and return home. Some trainees (and some countries) learn that the initial objective is not appropriate. This can occur for a wide variety of reasons, i.e. inadequate prior knowledge regarding the scope of medical specialties in the United States, reevaluation or self-assessment of the alien physicians particular talents, etc. At present, the three-year maximum stay for Exchange Visitors, discourages alien physicians from making what could be appropriate changes in their training objectives. Presently, if the exchange visitor were to make a change, the three year limit would not provide enough time for a valid educational experience.

If the duration of stay for Exchange Visitors is increased, the ECFMG Board of Trustees supports limiting alien physician EVFMGs to only one change of objective and that change should take place no later than the end of the second year of participation in the Exchange Visitor program.

As you are aware amendments to PL 94-484 require that an alien physician who enters the United States as an Exchange Visitor must provide a letter from his home country government stipulating that there is a need in that country for physicians with the type of training that the alien is seeking. Furthermore, the home country government must also certify that the alien has filed a written assurance with the government of his country that he will return upon completion

of training in the United States and intends to enter the practice of medicine in the specialty for which the training is being sought. In addition, under the Memorandum of Understanding between the International Communication Agency and ECFMG, the alien trainee is permitted to make one change in his training objective, but only with the agreement of his home country government.

With such caveats, alien physicians' changes in their training objectives should not contribute to abuse of the Exchange Visior Program. More positively, it will allow those alien physicians and countries depending upon the United States for graduate medical education an opportunity to select the most appropriate training.

WAIVER PROVISION EXTENSION

Amendments to the Immigration and Nationality Act, contained in Public Laws 94-484 and 95-83, require the application of stringent requirements for issuing Exchange Visitor (J-1) Visas to alien physicians who seek to enter the United States to participate in accredited programs of graduate medical education or training.

In brief, these requirements are

(A) an accredited school of medicine, or any one or more of its affiliated hospitals, must agree in writing to provide or assume responsibility for the graduate medical education or training;

(B) the alien physician must pass the Visa Qualifying Examination (VQE), must demonstrate competency in oral and written English, must be able to adapt to the educational and cultural environment in which he will be receiving his training, and must have adequate prior education for successful participation in the program;

(C) the alien must make a commitment to return to his home country upon completion of training in the United States, and his country must provide written assurance that there is need for the alien's services in his country; and

(D) the alien will be allowed to stay in this country no more than 2 years, unless additional time is specifically requested by his country for a maximum of one additional year. The extension is for the purpose of continuing the alien's education or training under the specific program for which he or she came to the United States.

The stated intent of these amendments was to decrease reliance on alien physicians and to assure quality medical care for individuals served by these physicians during their participation in graduate medical education training programs in the United States.

The intent has come to fuition insofar as there has been a decrease in numbers of exchange visitor foreign medical graduates. On January 10, 1977 ECFMG sponsored 5,090 exchange visitors. To date ECFMG is currently sponsoring 2,000 exchange visitors. As you can see this represents a substantial reduction on numbers of exchange visitors.

Since the Congress anticipated this severe reduction they provided for waiver of two of the requirements on a case-by-case basis, if a graduate medical education program could demonstrate that application of these requirements would result in a "substantial disruption" of health services.

Under the substantial disruption waiver, an Exchange Visitor Foreign Medical Graduate (EVFMG) is not required to:

1. have an accredited school of medicine, or any one or more of its affiliated hospitals provide the graduate medical education; and

2. pass the Visa Qualifying Examination.

The substantial disruption waiver was designed to permit programs and institutions traditionally placing significant reliance on alien physicians a transition period during which placement of such physicians may continue, but in decreasing numbers. During this transition period, extending through December 31, 1980, programs and institutions are expected to develop alternative provider resources and attract primarily graduates of American medical schools.

To put the waiver mechanism into effect, the Department of Health, Education, and Welfare (HEW) developed: 1) eligibility criteria to identify programs and institutions affected by these provisions and 2) decreasing numerical limits to permit programs and institutions a gradual rate of phase out for dependency on alien physicians while developing alternative provider resources.

The design of the waiver mechanism provides for two tiers of waiver application. Tier I is for programs and institutions which meet the eligibility criteria and are requesting waivers within the numerical limitations. Tier II is for programs and institutions which:

1) meet the eligibility criteria but are requesting waivers in excess of the numerical limitations or

2) do not meet the eligibility criteria

ECFMG is the receipt point for Tier I applications, and reviews and processes the applications under the established numerical limits.

Tier II appeal applications are also mailed to ECFMG for initial processing. ECFMG forwards appeal applications to the Health Resources Administration of the Department of Health, Education, and Welfare for consideration. A Federal Substantial Disruption Waiver Appeal Board consisting of seven Federal members has been established to review these applications. The appeal board determines whether programs qualify for additional waivers.

Length of Validity for Waived J-1 Visa Holders

An individual who obtains a J-1 visa under a waiver may remain in this country without further waiver review for two years, and for one additional year, if the third year is requested by the home country government. However, an individual must apply to ECFMG each year for continuation of Exchange Visitor Sponsorship (IAP-66). Also, waived J-1 visa holders must be counted in determining the program's eligibility for future waivers.

Since waivers are assigned to programs and/or institutions, individual EVFMGs cannot transfer from waived positions to non-waived positions without meeting the new requirements of the law and do so at the risk of loss of their J-1 visa (Exchange Visitor) status.

Also, an alien physician entering under a substantial disruption waiver must hold ECFMG certification.

Statistics

During a seven month period in 1978, 20 programs requested a total of 35 waived positions. Nineteen (19) of the waived positions were approved. The programs represented 19 specialties and 14 states.

During 1979, 34 programs requested a total of 140 waived positions. One hundred and eight (108) were approved. The programs represented twelve specialties and twelve states.

During the first four months of 1980, 35 programs requested a total of 206 waived positions; 187 have been approved. Although the programs represent eleven specialties and twelve states, 168 of the positions were requested by New York hospitals.

Controls

Congress provided that in no case will substantial disruption waivers result in a number to exceed the total number of alien physicians participating in programs of graduate medical education or training in the United States on January 10, 1978.

ECFMG monitors the exchange visitor program via a computerized record system. This system permits verification of program start dates and duration of stay for each exchange visitor being sponsored. The system also provides yearly reports which in addition to providing specific information on exchange visitors also provides total counts.

Despite a substantial increase in waiver requests in 1980, the exchange visitor count is 43% less than the January 10, 1978 index of 3,531.

In conclusion, from ECFMG's perspective, extension of the waiver provision through December 1983 would not increase the Exchange Visitor numbers to the point of running contrary to the intent of the law, nor would it result in exceeding the January 10, 1978 "cap" imposed by the Congress. Extending the waiver provision would, however, give areas such as New York a more realistic period of time to develop and carry out plans to phase down reliance on alien physicians. The procedures currently being implemented to carry out the waiver provision permit the appeal board to monitor the requesting institution's respective situation. Programs and institutions currently provide information regarding alternative provider resources, recruitment efforts geared toward the U.S. medical student population and future plans to phase down reliance on alien physicians.

EFFECTIVENESS AND VALUE OF INTERNATIONAL EXCHANGE

As stated earlier, there is increasing concern among foreign nations that graduate medical education in the United States is becoming less accessible, thus forcing these countries to send their medical graduates to countries where graduate medical education is less well-developed. A case in point as relayed to me while in Egypt is the frustration experienced by Egyptian physicians who during the 1960's and early 70's obtained their graduate training in the Soviet Union. It is the knowledge of this experience that has caused Egyptian officials and medical educators to express concern over the United States closing its doors. Officials and leaders in the medical profession from several countries I visited during 1977 and 1978 also expressed the same concern. Consequently, from the ECFMG perspective, foreign countries do rely on the availability of the top quality medical education this country has to offer.

This concludes my prepared statement. I will be pleased to answer questions of the Chairwoman and Members of the Subcommittee.

Respectfully submitted,

Ray L. Casterline, M.D.

SUBSTANTIAL DISRUPTION WAIVERS - 1980

STATE	PROGRAM	NUMBER REQUESTED	NUMBER APPROVED
Illinois	Pediatrics	1 T2 **	0
Kansas	Psychiatry	1 T1 *	1 T1
Maryland	Pathology	1 T1	1 T1
Missouri	Urology	1 T2	0
New Jersey	Pediatrics	2 T1	2 T1
		20 T2	20 T2
New York	Anesthesiology	20 T2	20 T2
	Child Psychiatry	3 T2	3 T2
	Family Practice	1 T1	1 T1
	General Surgery	12 T2	12 T2
	Internal Medicine	1 T1	1 T1
		28 T2	19 T2
	Pathology	2 T1	2 T1
		3 T2	3 T2
	Pediatrics	5 T1	5 T1
		70 T2	69 T2
	Physical Medicine	7 T2	7 T2
	Psychiatry	16 T2	13 T2
Ohio	Pathology	1 T2	0
	Pediatrics	2 T2	0
	Therapeutic Radiology	1 T1	1 T1

*T1 = Tier 1

**T2 = Tier 2 Appeal Level

Pennsylvania	Child Psychiatry	1 T1	1 T1
	Pediatrics	1 T2	0
Tennessee	Psychiatry	1 T1	1 T1
Texas	Pediatrics	1 T1	1 T1
	Psychiatry	1 T1	1 T1
Washington, D.C.	Therapeutic Radiology	2 T1	2 T1
Wisconsin	Pathology	1 T1	1 T1
	TOTAL	206	187

Revised May 9, 1980

SUBSTANTIAL DISRUPTION WAIVERS - 1979

STATE	PROGRAM	NUMBER REQUESTED	NUMBER APPROVED
Connecticut	Pediatrics	1 T1 *	1 T1
	Psychiatry	1 T1	0
		4 T2 **	4 T2
Georgia	Pathology	1 T1	1 T1
Illinois	Anesthesiology	1 T2	1 T2
	General Practice	1 T1	0
	Psychiatry	1 T1	1 T1
Massachussetts	Anesthesiology	2 T2	0
	General Surgery	1 T1	1 T1
	Neurosurgery	1 T2	1 T2
Michigan	General Practice	1 T1	0
	General Surgery	1 T2	0
	Pediatrics	5 T1	2 T1
New Jersey	Internal Medicine	1 T1	0
		3 T2	0
	Pediatrics	1 T2	0
New York	Anesthesiology	6 T1	6 T1
		8 T2	6 T2
	General Surgery	6 T1	6 T1
	Internal Medicine	9 T1	0
	Neurology	6 T2	6 T2
	Pathology	2 T1	2 T1
		2 T2	2 T2
	Pediatrics	20 T1	20 T1
		30 T2	30 T2
	Psychiatry	2 T1	2 T1
		7 T2	4 T2
	Therapeutic Radiology	1 T2	1 T2

Substantial Disruption Waivers - 1979

Ohio	Anesthesiology	1 T1	1 T1
	Family Practice	1 T1	1 T1
	General Surgery	1 T1	1 T1
	Internal Medicine	3 T1	3 T1
	Neurology	1 T2	1 T2
	Psychiatry	1 T1	1 T1
	Therapeutic Radiology	1 T2	1 T2
Pennsylvania	Opthalmology	1 T2	1 T2
	Psychiatry	1 T2	0
Tennessee	Internal Medicine	2 T2	0
Texas	Pediatrics	1 T1	0
Washington, D.C.	Pathology	1 T1	1 T1
	TOTAL	140	108

* T1 = Tier 1

** T2 = Tier 2 Appeal Level

Rev. March 18, 1980

SUBSTANTIAL DISRUPTION WAIVERS - 1978

STATE	PROGRAM	NUMBER REQUESTED	NUMBER APPROVED
Arizona	General Surgery	2 T1 *	0
Colorado	Pediatrics	2 T1	2 T1
Connecticut	General Surgery	4 T1	0
Illinois	Pediatrics	1 T1	0
Louisiana	Internal Medicine	1 T1	0
Maryland	Pediatrics	1 T1	1 T1
Michigan	Pediatrics	1 T1	0
	Psychiatry	1 T1	1 T1
Missouri	Psychiatry	1 T1	1 T1
New Mexico	Neurology	1 T1	1 T1
New York	General Surgery	3 T1	3 T1
	Pathology	1 T1	1 T1
	Pediatrics	5 T1	1 T1
	Psychiatry	4 T1	4 T1
	Therapeutic Radiology	2 T1	2 T1
North Carolina	General Surgery	1 T1	0
	Neurosurgery	1 T1	0
Ohio	Ob/Gyn	1 T1	1 T1
Pennsylvania	General Surgery	1 T1	1 T1
Puerto Rico	Internal Medicine	1 T1	0
	TOTAL	35	19

*T1 = Tier 1

Rev. March 18, 1980

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104, U.S.A. ☐ PHONE: 215 386-5900 ☐ CABLE: EDCOUNCIL, PHILADELPHIA

February 19, 1980

MEMORANDUM

TO: United States Medical School Deans
Hospital Administrators
Institutional Directors of Medical Education
Graduate Medical Education Training Program Directors
and Training Program Liaison Personnel

FROM: Executive Director, ECFMG

SUBJECT: Background Information and Application Procedures for Substantial Disruption Waivers

Last April, I mailed a memorandum describing amendments to the Immigration and Nationality Act in which the Congress applied stringent requirements for the issuance of J-1 (Exchange Visitor) Visas to alien physicians. Congress then provided for the waiver of certain portions of those requirements, if rigorous implementation of all of the provisions of that section of the law would cause a "substantial disruption in health services."

I am enclosing recently-revised background material, instructions and application forms graduate medical education training programs or institutions may use to apply for substantial disruption waivers. The extensive revisions resulted from the joint efforts of the Educational Commission for Foreign Medical Graduates and officials of the Division of Medicine, Bureau of Health Manpower, Health Resources Administration, Department of Health, Education, and Welfare. We believe that the revisions will enable you to gain a better understanding of the waiver mechanism and application procedures.

If you have questions about any aspect of the substantial disruption waiver process, ECFMG will be pleased to respond to your queries and to provide any assistance you may need.

Ray L. Casterline, M.D.

RLC:eg
Enclosures

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SUBSTANTIAL DISRUPTION WAIVER APPLICATION

Calendar Year 1980

Background Information

and

Application Procedure

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EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES
3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104, U.S.A. ☐ PHONE: 215 386-5900 ☐ CABLE: EDCOUNCIL, PHILADELPHIA

SUBSTANTIAL DISRUPTION WAIVER APPLICATION

PART I - BACKGROUND

Requirements for Issuance of Exchange Visitor (J-1) Visas

Recent amendments to the Immigration and Nationality Act, contained in Public Laws 94-484 and 95-83, require the application of stringent requirements for issuing Exchange Visitor (J-1) Visas to alien physicians who seek to enter the United States to participate in accredited programs of graduate medical education or training.

In brief, these requirements are

(A) an accredited school of medicine, or any one or more of its affiliated hospitals, must agree in writing to provide or assume responsibility for the graduate medical education or training;

(B) the alien physician must pass the Visa Qualifying Examination (VQE), must demonstrate competency in oral and written English, must be able to adapt to the educational and cultural environment in which he will be receiving his training, and must have adequate prior education for successful participation in the program;

(C) the alien must make a commitment to return to his home country upon completion of training in the United States, and his country must provide written assurance that there is need for the alien's services in his country (Attachment 3); and

(D) the alien will be allowed to stay in this country no more than 2 years, unless additional time is specifically requested by his country for a maximum of one additional year. The extension is for the purpose of continuing the alien's education or training under the specific program for which he or she came to the United States.

Requirement (B) above does not pertain to a graduate of a school accredited by the Liaison Committee on Medical Education. Hence, alien graduates of accredited U.S. or Canadian medical schools are not affected by this requirement. Moreover, an alien physician who was fully licensed to practice medicine in a State on January 9, 1977, held a valid specialty certificate issued by a component board of the American Board of Medical Specialties, and was actually practicing medicine in a State on that date will be considered to have met the examination requirements in (B) above.

The stated intent of these amendments is to decrease reliance on alien physicians and to assure quality medical care for individuals served by these physicians during their participation in graduate medical education training programs.

Substantial Disruption

Because of the expected severe reduction in the number of alien physicians entering the United States annually as a result of these amendments to the law, the Congress provided for waiver of two of these requirements on a case-by-case basis, if a graduate medical education program can demonstrate that application of these requirements would result in a "substantial disruption" of health services.

Under a substantial disruption waiver, an Exchange Visitor Foreign Medical Graduate (EVFMG) is not required to:

1. have an accredited school of medicine, or any one or more of its affiliated hospitals provide the graduate medical education; and

2. pass the Visa Qualifying Examination.

However, an alien physician entering under a substantial disruption waiver must hold ECFMG certification and meet all of the other requirements for issuance of Form IAP-66 (formerly DSP-66) to qualify for an Exchange Visitor (J-1) Visa.

Congress also provided that in no case will these waivers result in a number to exceed the total number of alien physicians participating in programs of graduate medical education or training in the United States on January 10, 1978.

Substantial Disruption Waiver Mechanism

The substantial disruption waiver was developed to permit programs and institutions traditionally placing significant reliance on alien physicians a transition period during which placement of such physicians may continue, but in decreasing numbers. During this transition period, extending through December 31, 1980, programs and institutions are expected to develop alternative provider resources and attract primarily graduates of American medical schools.

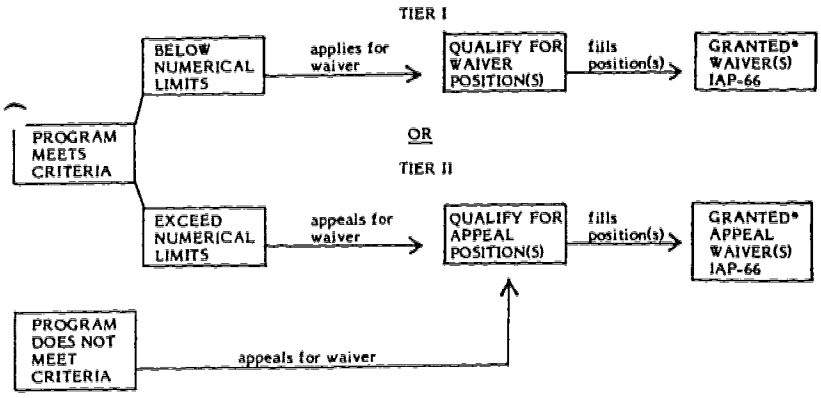
To put the waiver mechanism into effect, the Department of Health, Education, and Welfare (HEW) developed: 1) eligibility criteria to identify programs and institutions affected by these provisions and 2) decreasing numerical limits to permit programs and institutions a gradual rate of phase out for dependency on alien physicians while developing alternative provider resources.

To assist programs or institutions which have a substantial disruption of health services but do not meet the routine specifications developed by HEW, the waiver mechanism provides for an appeal process. A Federal Substantial Disruption Waiver Appeal Board has been established to consider appeals from these programs and institutions.

In essence the waiver mechanism provides for two tiers of waiver application. Tier I is for programs and institutions which meet the eligibility criteria and are requesting waivers within the numerical limitations. Tier II is for programs and institutions which 1) meet the eligibility criteria but are requesting waivers in excess of the numerical limitations or 2) do not meet the eligibility criteria and can demonstrate a need for waivers based on a substantial disruption of health services.

ECFMG has been designated by federal authorities to process waiver requests and to submit appeal applications to the Federal Board. ECFMG is available for consultation and will provide assistance to programs and institutions at their request.

WAIVER MECHANISM FLOW CHART



Substantial Disruption Waiver Guidelines

When determining eligibility status and the numerical limits, programs must count all alien physicians in the program on January 10, 1978 regardless of visa status, or date of entry into the program.

Programs may submit waiver applications either before or after interviewing alien physicians to fill positions.

Programs may fill waived positions any time during the calendar year, but any unused waived positions may not be carried over into a subsequent calendar year.

Programs or institutions granted* waivers may not subsequently recruit, in excess of the numerical limits, alien physicians who have met the new requirements of the law. However, programs or institutions do have the option to utilize such alien physicians in lieu of filling waived positions.

Waivers may be granted for alien physicians entering training programs, so that on December 31 of the respective calendar year, the limits established for that year will not be exceeded.

If no waivers are granted, there is no numerical restriction on the recruiting of alien physicians who have met the new requirements of the law.

Please note: Only those programs utilizing waived positions are restricted by the numerical limits and only for that year in which waiver(s) were first granted.

*Granted - A waiver will be considered to have been granted only upon issuance of a Certificate of Eligibility (Form IAP-66 formerly DSP-66) for the alien physician selected to fill the position.

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Length of Validity for Waived J-1 Visa Holders

An individual who obtains a J-1 visa under a waiver may remain in this country without further waiver review for two years, and for one additional year, if the third year is requested by the home country government. However, an individual must apply to ECFMG each year for continuation of Exchange Visitor Sponsorship (IAP-66). Also, waived J-1 visa holders must be counted in determining the program's eligibility for future waivers.

Since waivers are assigned to programs and/or institutions, individual EVFMGs cannot transfer from waived positions to non-waived positions without meeting the new requirements of the law and do so at the risk of loss of their J-1 visa (Exchange Visitor) status.

Criteria for Eligibility and Numerical Limits

The four eligibility categories and their corresponding numerical limits are described below. The rate of phase-out of dependence on alien physicians varies with the category and is consistent with the anticipated impact such phase-out will have on the provision of services as well as the ability of the programs to find alternative resources.

Category A

Eligibility Criteria

For accredited graduate medical education training programs in anesthesiology, child psychiatry, general practice, nuclear medicine, pathology, pediatrics, physical medicine, psychiatry, or therapeutic radiology, which had more than 25 percent of all their positions occupied by alien physicians on January 10, 1978.

Numerical Limits

In 1980, the total number of J-1 visa holders in each program may not exceed 80 percent of the number of J-1 visa holders on January 10, 1978, and the total number of alien physicians in the program may not exceed 70 percent of the number of alien physicians on January 10, 1978.

Category B

Eligibility Criteria

For accredited graduate medical education training programs in specialties other than those described in Category A above which had more than 25 percent of all their positions occupied by alien physicians on January 10, 1978, AND which provide 50 percent or more of their full time equivalent training in a facility located in a primary medical care manpower shortage area, designated under Section 332 of the Public Health Service Act, or had more than 25 percent Medicaid Patients in calendar year 1977.

Numerical Limits

In 1980, the total number of J-1 visa holders in each program may not exceed 80 percent of the number of J-1 visa holders on January 10, 1978, and the total number of alien physicians in the program may not exceed 70 percent of the number of alien physicians on January 10, 1978.

Category C

Eligibility Criteria

For accredited graduate medical education training programs which are in specialties or locations other than those described in Categories A or B and had more than 50 percent of all of their positions occupied by alien physicians on January 10, 1978.

Numerical Limits

In 1980, the total number of J-1 visa holders in each program may not exceed 60 percent of the number of J-1 visa holders on January 10, 1978, and the total number of alien physicians in the program may not exceed 40 percent of the number of alien physicians on January 10, 1978.

Special Note: Training programs under Categories A, B, and C which are conducted in more than one facility as integrated programs and which obtain a waiver for one or more positions must maintain the same percentage of training positions among the participating facilities as was the case on January 10, 1978.

Category D

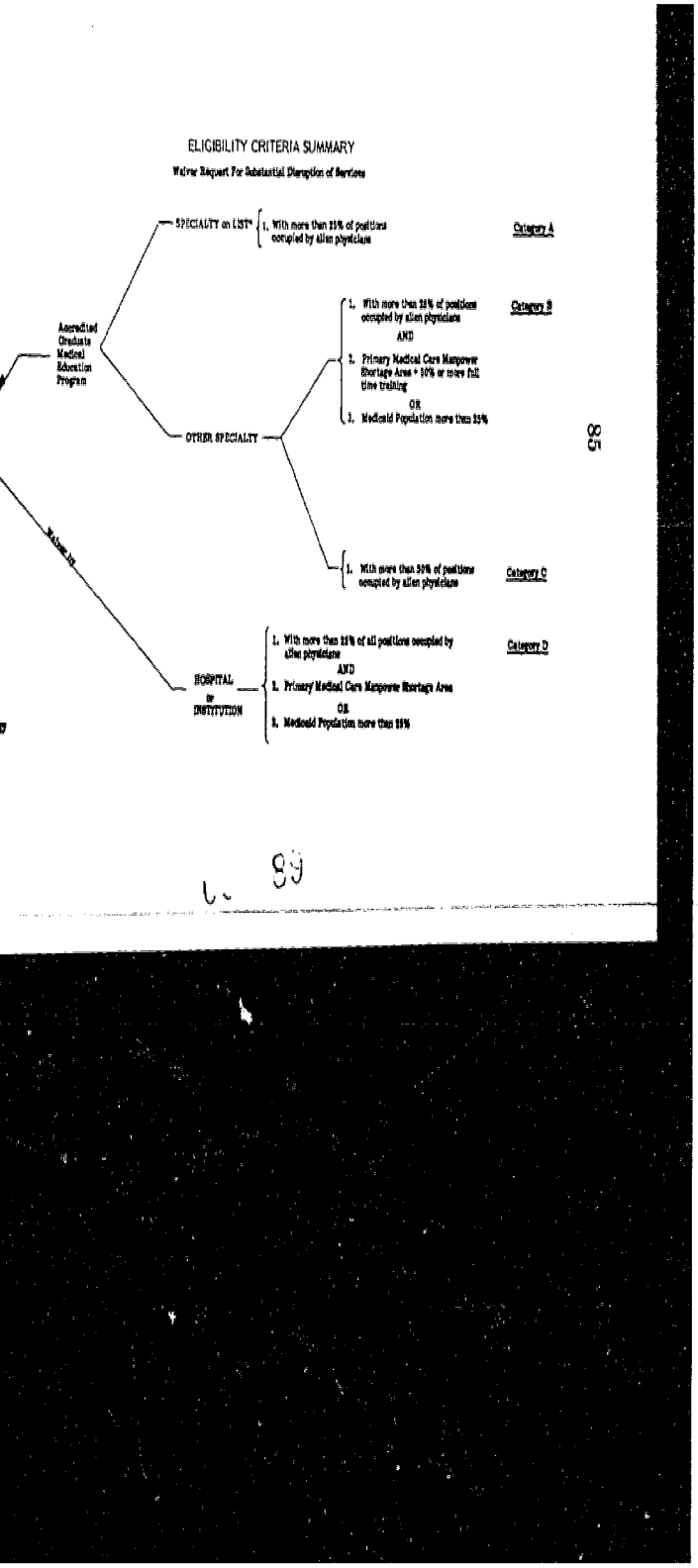
Eligibility Criteria

A hospital (a) which had more than 25 percent alien physicians, in total, in its training programs conducted solely within its facilities, on January 10, 1978, AND (b) which is located in a primary medical care manpower shortage area designated under Section 332 of the Public Health Service Act, or had more than 25 percent Medicaid patients in calendar year 1977, may apply for and obtain waivers for those training programs conducted solely within the institution, distributed among such programs at its discretion.

Numerical Limits

In 1980, the total number of J-1 visa holders in such programs may not exceed 80 percent of the total number of J-1 visa holders on January 10, 1978, and the total number of alien physicians in such programs may not exceed 70 percent of the number of alien physicians on January 10, 1978.

A diagram summarizing the eligibility criteria in each category follows.



Waiver Appeals

Present policy provides for an appeal process for programs or institutions most severely affected by the new requirements for entry of alien physicians as Exchange Visitors. These programs or institutions may have met the eligibility criteria but require waivers in excess of the numerical limits or they may not have met the eligibility criteria and were therefore automatically excluded from obtaining waivers under the Tier I process.

Favorable Action by the Waiver Appeal Board on applications will be based on clear and convincing evidence that, without such waivers, a severe "substantial disruption" of health services would result. These applications must include a full and detailed discussion of the specific problems that programs or institutions anticipate without such waivers, what alternative provider resources and methods have been sought to meet the deficit in health services, and what specific plan will be followed for phasing down, year-by-year, the reliance on alien physicians.

Waiver Application Review Process

There are two tiers of applications and review for waivers:

Tier I - Programs and institutions which meet the eligibility criteria (page 6) and are within the numerical limits may submit applications for waivers such that the number of waivers requested will not result in exceeding the maximum number of alien physicians and J-1 visa holders permissible for that category. ECFMG will be the receipt point for these applications, and will review and process the applications under the numerical limits established for each category.

Tier II - Appeal applications are to be mailed to ECFMG for initial processing. ECFMG will forward appeal applications to the Health Resources Administration of the Department of Health, Education, and Welfare for consideration. A Federal Substantial Disruption Waiver Appeal Board consisting of seven Federal members has been established to review these applications. The appeal board will determine whether programs qualify for additional waivers.

* * * * *

ECFMG will notify programs or institutions when it has been determined that they have qualified for waived positions. A waiver will be considered to have been granted only upon issuance of a Certificate of Eligibility (Form IAP-66) by ECFMG.

ECFMG will issue Certificates of Eligibility only to alien physicians who hold ECFMG Certification and meet other requirements to qualify for Exchange Visitor Visas, including Foreign Government Letters of Assurance of Need (See Attachment 3).

ECFMG will notify the Liaison Committee on Graduate Medical Education (LCGME) of all programs granted waivers. The concern of LCGME and ECFMG is that graduate medical education training programs provide high quality educational programs, which will permit Exchange Visitors to accomplish their training objectives within the limitations of time allowed under the law.

If you have questions or need further clarification, you may contact ECFMG for assistance.

ECFMG
3624 Market Street
Philadelphia, Pa. 19104
Telephone: Area Code 215: 386-5900

PART II - WAIVER APPLICATION PROCEDURE

Applying for a waiver, under any category, will consist of retrieving and compiling information and performing basic percentage calculations. Once you have reviewed all of the information, and are ready to request a waiver, follow these procedures.

Tier I - Waiver Application

1. Select the category (or categories) that best serve your situation based on the diagram summarizing the eligibility criteria (see page 6).

2. Obtain the information that you will need from any one or more of the following sources:

ECFMG	a)	number of J-1 visa holders under ECFMG sponsorship in training programs on January 10, 1978
Hospital Administration	a)	Medicaid population figures for inpatient admissions for calendar year 1977
	b)	total number of inpatient admissions for calendar year 1977
	c)	primary medical care manpower shortage area designation information
Health Systems Agency or State Health Planning and Development Agency	a)	primary medical care manpower shortage area designation information
Hospital Director of Medical Education or Program Director	a)	number of alien physicians in training programs
	b)	percentage of training time provided in physician shortage area

3. Select the appropriate Waiver Application(s). For example, if applying for a Waiver under Category B, please use the application labeled Category B. Copies of Waiver Applications are appended.

4. Be sure to complete each of the four sections of the waiver application. An application will not be processed if it is incomplete or filled out incorrectly.

5. When calculating percentages in Section II Determination of Eligibility, a fraction will be considered to have exceeded the previous whole number.

   e.g. 25.1% will be considered to be greater than 25%

When calculating numerical limits in Section III Calculation of Numerical Limits, if a fraction occurs, do not raise it to the next highest whole number.

e.g. 50% of 75 = 37.5
37 is the acceptable figure, not
37.5 or 38

6. In all categories, when calculating the number of alien physicians, include all non-United States citizen medical school graduates regardless of visa status (immigrant/non-immigrant) or location of medical school of graduation (includes alien graduates of United States and Canadian medical schools).

7. Forward the completed Waiver Application to ECFMG.

Tier II - Waiver Appeal Applications

A. For programs or institutions which meet the eligibility criteria described in Categories A, B, C, or D and require waived positions beyond the established numerical limits (see Waiver Application, Section III, line C and D):

1. Complete a Tier I Waiver Application in accordance with the instructions above.

2. Complete a Tier II Waiver Appeal Application providing the information requested in detail. Supporting documentation is essential.

3. Complete the Population and Distribution of Trainees Data Display through calendar year 1981.

4. Forward the Application(s), the Population and Distribution of Trainees Data Display(s) and the Narrative(s) to ECFMG.

B. For programs or institutions which are not eligible for Categories A, B, C, or D:

1. Complete a Category E Waiver Application Form.

2. Complete a Tier II Waiver Appeal Application providing the information requested in detail. Supporting documentation is essential.

3. Complete the Population and Distribution of Trainees Data Display through calendar year 1981.

4. Forward the Application(s), the Population and Distribution of Trainees Data Display(s) and the Narrative(s) to ECFMG.

ECFMG will be responsible for transmitting applications for appeals to the Federal Substantial Disruption Waiver Appeal Board chaired by the Administrator, Health Resources Administration, Department of Health, Education, and Welfare.

Please note, an incomplete appeal application will not be transmitted to the Waiver Appeal Board for consideration.

Part III - Attachments

1. Waiver Applications (Categories A, B, C, D, and E)
2. Waiver Appeal Application and Population and Distribution of Trainees Data Display
3. Foreign Government Letter of Assurance of Need

NOTE: The attached blank application forms are to be used as masters.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES

TIER I - WAIVER APPLICATION FOR CALENDAR YEAR 1980

CATEGORY A

Training Programs in Anesthesiology, Child Psychiatry, General Practice, Nuclear Medicine, Pathology, Pediatrics, Physical Medicine, Psychiatry, and Therapeutic Radiology.

Complete one form for each applicable program.

I. Identification

Institution:_____JCAH Number_____

Address:_____

Training Program
Responsible Official:_____Phone:_____

Program:_____

Is this an integrated program at more than one facility: YES_____NO_____

If Yes, list all facilities utilized on a continuation sheet and describe the program in terms of number of residents and time spent at each site.

II. Determination of Eligibility

If more than 25 percent of the positions in an approved training program in a specialty listed below were occupied by alien physicians* on January 10, 1978, the training program may apply for a Category A waiver for that specialty: Anesthesiology, Child Psychiatry, General Practice, Nuclear Medicine, Pathology, Pediatrics, Physical Medicine, Psychiatry, and Therapeutic Radiology.

A. Total Number of Positions Occupied on January 10, 1978 at all levels of the Training Program (PGY I, II, etc.) _____

B. Total Number of Positions Occupied By Alien Physicians on January 10, 1978 (This number includes permanent, H and J-1 visa holders) _____

C. Line B/line A x 100% (must exceed 25%) _____

If you meet the eligibility criteria, proceed to Section III.

*Alien Physicians: All non-United States citizen medical school graduates.

III. Calculation of Numerical Limits

For each training program meeting eligibility criteria to apply for a waiver under Section II above:

A. Total Number of J-1 Visa Holders In This Program on January 10, 1978. _____

B. Total Number of Alien Physicians In This Program on January 10, 1978. (This number includes permanent, H, and J-1 visa holders) _____

Limits for 1980:

C. J-1 Visa Holders Line A x 80%=____

D. Alien Physicians Line B x 70%=____

IV. Waiver Request

Waivers are requested for this program in the following numbers for 1980. These must be within the limits determined under Section III above.

A. Number of J-1 Visa Waivers Requested for 1980 _____

B. Number of J-1 Visa Holders With Waivers From Prior Years Projected on December 31, 1980 _____

C. Number of J-1 Visa Holders Not Holding Waivers Projected On December 31, 1980 _____

D. Number of other Alien Physicians Not Holding Waivers Projected On December 31, 1980. (This number includes permanent and H visa holders) _____

E. Line A + Line B + Line C (Cannot exceed Section III, Line C, 1980) _____

F. Line A + Line B + Line C + Line D (Cannot exceed Section III, Line D, 1980) _____

If the figures in lines E or F exceed the numerical limits established in Section III, lines C or D, submit an appeal application with this form for the number of J-1 visa positions desired in excess of the established limits.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES

TIER 1 - WAIVER APPLICATION FOR CALENDAR YEAR 1980

CATEGORY B

Training Programs Other Than Anesthesiology, Child Psychiatry, General Practice, Nuclear Medicine, Pathology, Pediatrics, Physical Medicine, Psychiatry, and Therapeutic Radiology.

Complete one form for each applicable program.

I. Identification

Institution:_____JCAH Number:_____

Address:_____

Training Program
Responsible Official:_____Phone:_____

Program:_____

Is this an integrated program at more than one facility: YES_____NO_____

If Yes, list all facilities utilized on a continuation sheet and describe the program in terms of number of residents and time spent at each site.

II. Determination of Eligibility

If more than 25 percent of the positions in an approved training program in a specialty other than those listed in Category A were occupied by alien physicians* on January 10, 1978, AND provide 50 percent or more of their full-time equivalent training in a facility located in a primary medical care manpower shortage area or had more than 25 percent Medicaid patients in calendar year 1977, the training program may apply for a Category B waiver for that specialty.

A program must qualify under (1) AND either (2) or (3).

1. Percent Training Positions.

   A. Total Number of Positions Occupied on January 10, 1978 at all levels of the Training Program _____

   B. Total Number of Positions Occupied By Alien Physicians on January 10, 1978 (This number includes permanent, H and J-1 visa holders) _____

   C. Line B/Line A x 100% (must exceed 25%) _____

*Alien Physicians: All non-United States citizen medical school graduates.

CHAPTER V

CONCLUSION

The role of visuals as a learning aid is undeniable; studies over the past few years have conclusively established that. What is still interesting researchers is the way visual material is absorbed, the ways in which visuals should be used, and how they should be designed, developed and presented, and research already shows that their usefulness notwithstanding, they should be used intelligently with a realistic appraisal of their uses. Clearly they are not endlessly applicable, nor is one type of visual useful in all circumstances.

The variables are many. The subject matter influences the kinds of visuals used: geography, for example, is likely to use a large number of maps and graphs. Similarly the behavioural objective will have an effect: whether it is factual or visual information which needs to be understood, explained or rehearsed, and what needs to be recalled from the experience - concepts or facts.

The students themselves influence not only what is likely to be recalled but what form the visuals should take. Children, for example, learn differently from adults

who, because of their greater experience and knowledge, learn concepts with the pictures. Mental ability has been examined in its bearings on learning from visuals, and it appears that high IQs learn readily from either the visual or verbal approach. Lower IQs achieve better from visual aids than they do from verbally emphasized work as long as those aids are keyed to the level of the students. Indeed, visuals, in these circumstances, can act as excellent motivational devices.

Motivation is another variable in the effectiveness of visual education, as it is in most educational circles. Students learn any content matter much better when they are interested in what is before them. For this, visuals can be both a cause and an effect. Visual materials play an important role in raising motivation and interest, and the information they contain is better transmitted when motivation and interest are high. This situation is achieved, too, when the visuals are part of a programme which is seen by the students to be valid and attuned to their needs, a factor especially true of adults, and when the visuals are well incorporated with the material being taught.

Cultural factors may affect what students interpret as important and what they see as worthwhile learning techniques. In addition, such factors will influence what they absorb from a visual. Objects and concepts which are not in their own culture or which that culture underemphasizes may be

misinterpreted, or, indeed, not noticed at all in visual materials. Visuals can be very effective in this context in realigning cultural acceptance patterns.

The way in which the illustrations are presented is yet another variable. Are they to be in a programme paced by the teacher or one where the students work at a more leisurely or self-controlled pace? Whichever is chosen, the matter of exposure time becomes increasingly important, as numerous studies have shown. A system such as charts allows the students to refer to the visual at any time they need. So, too, do textbook and workbook illustrations. Slides and transparencies may have much the same advantage if the students are given enough viewing time. Films, television and the like are excellent for the presentation of concepts involving movement, but frame time is externally dictated, and the speed at which viualized information passes before students may become a cause of interference.

Interference must be kept in mind when considering what form the visuals will take, and here one should give attention to the ideas of design and realism. All visuals should be clear to all students which means that their size, clarity, spacing and color are all important. It sounds unnecessary to say that a picture in education should not be too small and should not be too large. If it is too small, many details will be indecipherable and hence confusing; if it is too big, a sense of unity will be sacrificed as students,

in trying to scan the whole picture, will tend to have their attention taken by a small section. Spacing is part of this concern as well. When parts of the visual are spaced well, the scanning eye moves smoothly and logically from one to another.

The matter of complexity or simplicity is a feature which is in the context of interference. As was noted in Chapter II the realism continuum does not reflect the "learning continuum" and increasing detail tends, instead, to decrease the teaching potential of the visual. However, this remains an inconstant feature. Dwyer found in his study that realistic, colored photographs were useful in certain proscribed areas of a lesson on the part of the heart. All the same, on the whole, studies suggest that less complex illustrations are more readily understood and better for the transfer of information.

In the context of realism should be considered the matter of color. Again it is hard to be definite in any conclusions for sometimes it is true that black and white illustrations can be extremely effective - the contrast is strong. On the other hand, color can be important for clarification, for attention-getting, for visibility considerations, for the interpretation of relationships and for the subtle transmission of attitudes. Children tend to react to color, especially strong color, more definitely than adults who are accustomed to the symbolism of black

and white and the ideas it transmits, but all people can absorb a great deal from color. Wise use of color can add to the learning experience; undisciplined use adds nothing and can become an overload, resulting in a decrease of understanding.

Using the visuals requires cueing methodology. Adults in particular need to feel in touch with the work being presented and prefer to be told of the learning objectives in front of them. This has the advantage of focusing their attention and receptive concentration. Questions have a similar effect, written or oral, and are also vital for follow-up recall. Printed material, such as arrows, may continue this role. This rehearsal is important to the retention of learned material. All of these gambits, including patches of color in an otherwise black and white illustration, are further variables.

What this points to is that there is no single approach to visuals, and that there are no hard and fast rules for their use. The variables are vitally concerned in what is right for one situation and what is right for another; in order to adapt a visual for another use it may be necessary to change only one or two of these aspects. Educational effectiveness is dependent upon small things and cannot be made constant.

The variables do not change the fact that visuals are useful but they do mean that commercially made products can

seldom fit this fluctuating mould. They cannot take into account the varying needs of students in different learning environments. The whole idea of visuals is that they should respond to just those environments and the needs assessed on an individual basis, that they should deal with learning problems and learning situations which may be unique to an age group, a subject, a cultural attitude or a teaching form. Here lies the great strength of the teacher-made visual aid. No matter what the artistic skills of the teacher, it is he or she alone who recognizes and understands the variables. Only the teacher can produce visual materials which are that immediate response to the situation, and only those are effective teaching aids.

The teacher, then, should not be daunted by the artistic requirements. Experience teaches a lot of ways to deal with these needs, and furthermore brings more ideas. There is no need to turn to another person to translate ideas, for this introduces the potential interference of a third party and his/her interpretations. Necessity is the mother of invention, and it is that which makes teacher-made visual aids a continually vital part of the ESL classroom.

APPENDIX I

Sample Passage for Listening
Comprehension with Visual

I SIMPLE

(a) This woman is tired. She has been shopping most of the day. She is wearing a brown coat and on her head she has an orange hat. She is carrying two bags.

(b) This girl has been at school but now she is going home with her mother. She is wearing blue jeans, a blue hat and a red sweater.

II SLIGHTLY HARDER

(a) Mark Booth's waiting for the bus and he's been waiting quite a while. He's cold so he's put his hands in his pockets to keep them warm. He's wearing dark jeans and a yellow jacket, as well as a blue hat.

(b) Jane Stevens is talking to a friend of hers. She's going home from school. She's got on a blue coat and red boots and she's a blonde.

III CONVERSATION

/A/ Goodness, aren't these buses slow. If it doesn't come soon, I think I'll drop. I'm so tired.

/B/ I thought you looked rather weary. What've you been doing? Shopping?

/A/ Yes, I thought I'd get a few things I needed. But a few things always turns into a lot more. What have you been doing?

/B/ Oh, I had to take my daughter to the dentist so I picked her up from school. When I left the house this morning it was really quite cold so I put on this quilted coat and my fur hat. Now I'm so hot! I'll be glad to get home and shed everything.

/A/ Ah, I'm just looking forward to getting rid of parcels, hat, coat and shoes and putting my feet up.

APPENDIX II

POSSIBLE SCRIPT FOR ORDER! ORDER!

It was spring. The tree was in bud and flowers were beginning to appear. Within a few weeks, the tree was a mass of blossom in pink and red. As the weeks passed, spring faded into summer. The blooms on the tree gave way to leaves. The days grew warmer and the tree provided shade for people walking in the park and for the children who played under it with their toys in the long days.

Gradually these long days began to shorten. The green leaves began their change to red and gold. Before many more weeks had passed the snow had arrived once more. Winter had returned.

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CHAPTER V

CONCLUSION

The role of visuals as a learning aid is undeniable; studies over the past few years have conclusively established that. What is still interesting researchers is the way visual material is absorbed, the ways in which visuals should be used, and how they should be designed, developed and presented, and research already shows that their usefulness notwithstanding, they should be used intelligently with a realistic appraisal of their uses. Clearly they are not endlessly applicable, nor is one type of visual useful in all circumstances.

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who, because of their greater experience and knowledge, learn concepts with the pictures. Mental ability has been examined in its bearings on learning from visuals, and it appears that high IQs learn readily from either the visual or verbal approach. Lower IQs achieve better from visual aids than they do from verbally emphasized work as long as those aids are keyed to the level of the students. Indeed, visuals, in these circumstances, can act as excellent motivational devices.

Motivation is another variable in the effectiveness of visual education, as it is in most educational circles. Students learn any content matter much better when they are interested in what is before them. For this, visuals can be both a cause and an effect. Visual materials play an important role in raising motivation and interest, and the information they contain is better transmitted when motivation and interest are high. This situation is achieved, too, when the visuals are part of a programme which is seen by the students to be valid and attuned to their needs, a factor especially true of adults, and when the visuals are well incorporated with the material being taught.

Cultural factors may affect what students interpret as important and what they see as worthwhile learning techniques. In addition, such factors will influence what they absorb from a visual. Objects and concepts which are not in their own culture or which that culture underemphasizes may be

misinterpreted, or, indeed, not noticed at all in visual materials. Visuals can be very effective in this context in realigning cultural acceptance patterns.

The way in which the illustrations are presented is yet another variable. Are they to be in a programme paced by the teacher or one where the students work at a more leisurely or self-controlled pace? Whichever is chosen, the matter of exposure time becomes increasingly important, as numerous studies have shown. A system such as charts allows the students to refer to the visual at any time they need. So, too, do textbook and workbook illustrations. Slides and transparencies may have much the same advantage if the students are given enough viewing time. Films, television and the like are excellent for the presentation of concepts involving movement, but frame time is externally dictated, and the speed at which viualized information passes before students may become a cause of interference.

Interference must be kept in mind when considering what form the visuals will take, and here one should give attention to the ideas of design and realism. All visuals should be clear to all students which means that their size, clarity, spacing and color are all important. It sounds unnecessary to say that a picture in education should not be too small and should not be too large. If it is too small, many details will be indecipherable and hence confusing; if it is too big, a sense of unity will be sacrificed as students,

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In the context of realism should be considered the matter of color. Again it is hard to be definite in any conclusions for sometimes it is true that black and white illustrations can be extremely effective - the contrast is strong. On the other hand, color can be important for clarification, for attention-getting, for visibility considerations, for the interpretation of relationships and for the subtle transmission of attitudes. Children tend to react to color, especially strong color, more definitely than adults who are accustomed to the symbolism of black

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Using the visuals requires cueing methodology. Adults in particular need to feel in touch with the work being presented and prefer to be told of the learning objectives in front of them. This has the advantage of focusing their attention and receptive concentration. Questions have a similar effect, written or oral, and are also vital for follow-up recall. Printed material, such as arrows, may continue this role. This rehearsal is important to the retention of learned material. All of these gambits, including patches of color in an otherwise black and white illustration, are further variables.

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The teacher, then, should not be daunted by the artistic requirements. Experience teaches a lot of ways to deal with these needs, and furthermore brings more ideas. There is no need to turn to another person to translate ideas, for this introduces the potential interference of a third party and his/her interpretations. Necessity is the mother of invention, and it is that which makes teacher-made visual aids a continually vital part of the ESL classroom.

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I SIMPLE

(a) This woman is tired. She has been shopping most of the day. She is wearing a brown coat and on her head she has an orange hat. She is carrying two bags.

(b) This girl has been at school but now she is going home with her mother. She is wearing blue jeans, a blue hat and a red sweater.

II SLIGHTLY HARDER

(a) Mark Booth's waiting for the bus and he's been waiting quite a while. He's cold so he's put his hands in his pockets to keep them warm. He's wearing dark jeans and a yellow jacket, as well as a blue hat.

(b) Jane Stevens is talking to a friend of hers. She's going home from school. She's got on a blue coat and red boots and she's a blonde.

III CONVERSATION

/A/ Goodness, aren't these buses slow. If it doesn't come soon, I think I'll drop. I'm so tired.

/B/ I thought you looked rather weary. What've you been doing? Shopping?

/A/ Yes, I thought I'd get a few things I needed. But a few things always turns into a lot more. What have you been doing?

/B/ Oh, I had to take my daughter to the dentist so I picked her up from school. When I left the house this morning it was really quite cold so I put on this quilted coat and my fur hat. Now I'm so hot! I'll be glad to get home and shed everything.

/A/ Ah, I'm just looking forward to getting rid of parcels, hat, coat and shoes and putting my feet up.

APPENDIX II

POSSIBLE SCRIPT FOR ORDER! ORDER!

It was spring. The tree was in bud and flowers were beginning to appear. Within a few weeks, the tree was a mass of blossom in pink and red. As the weeks passed, spring faded into summer. The blooms on the tree gave way to leaves. The days grew warmer and the tree provided shade for people walking in the park and for the children who played under it with their toys in the long days.

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CHAPTER V

CONCLUSION

The role of visuals as a learning aid is undeniable; studies over the past few years have conclusively established that. What is still interesting researchers is the way visual material is absorbed, the ways in which visuals should be used, and how they should be designed, developed and presented, and research already shows that their usefulness notwithstanding, they should be used intelligently with a realistic appraisal of their uses. Clearly they are not endlessly applicable, nor is one type of visual useful in all circumstances.

The variables are many. The subject matter influences the kinds of visuals used: geography, for example, is likely to use a large number of maps and graphs. Similarly the behavioural objective will have an effect: whether it is factual or visual information which needs to be understood, explained or rehearsed, and what needs to be recalled from the experience - concepts or facts.

The students themselves influence not only what is likely to be recalled but what form the visuals should take. Children, for example, learn differently from adults

who, because of their greater experience and knowledge, learn concepts with the pictures. Mental ability has been examined in its bearings on learning from visuals, and it appears that high IQs learn readily from either the visual or verbal approach. Lower IQs achieve better from visual aids than they do from verbally emphasized work as long as those aids are keyed to the level of the students. Indeed, visuals, in these circumstances, can act as excellent motivational devices.

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CHAPTER V

CONCLUSION

The role of visuals as a learning aid is undeniable; studies over the past few years have conclusively established that. What is still interesting researchers is the way visual material is absorbed, the ways in which visuals should be used, and how they should be designed, developed and presented, and research already shows that their usefulness notwithstanding, they should be used intelligently with a realistic appraisal of their uses. Clearly they are not endlessly applicable, nor is one type of visual useful in all circumstances.

The variables are many. The subject matter influences the kinds of visuals used: geography, for example, is likely to use a large number of maps and graphs. Similarly the behavioural objective will have an effect: whether it is factual or visual information which needs to be understood, explained or rehearsed, and what needs to be recalled from the experience - concepts or facts.

The students themselves influence not only what is likely to be recalled but what form the visuals should take. Children, for example, learn differently from adults

who, because of their greater experience and knowledge, learn concepts with the pictures. Mental ability has been examined in its bearings on learning from visuals, and it appears that high IQs learn readily from either the visual or verbal approach. Lower IQs achieve better from visual aids than they do from verbally emphasized work as long as those aids are keyed to the level of the students. Indeed, visuals, in these circumstances, can act as excellent motivational devices.

Motivation is another variable in the effectiveness of visual education, as it is in most educational circles. Students learn any content matter much better when they are interested in what is before them. For this, visuals can be both a cause and an effect. Visual materials play an important role in raising motivation and interest, and the information they contain is better transmitted when motivation and interest are high. This situation is achieved, too, when the visuals are part of a programme which is seen by the students to be valid and attuned to their needs, a factor especially true of adults, and when the visuals are well incorporated with the material being taught.

Cultural factors may affect what students interpret as important and what they see as worthwhile learning techniques. In addition, such factors will influence what they absorb from a visual. Objects and concepts which are not in their own culture or which that culture underemphasizes may be

misinterpreted, or, indeed, not noticed at all in visual materials. Visuals can be very effective in this context in realigning cultural acceptance patterns.

The way in which the illustrations are presented is yet another variable. Are they to be in a programme paced by the teacher or one where the students work at a more leisurely or self-controlled pace? Whichever is chosen, the matter of exposure time becomes increasingly important, as numerous studies have shown. A system such as charts allows the students to refer to the visual at any time they need. So, too, do textbook and workbook illustrations. Slides and transparencies may have much the same advantage if the students are given enough viewing time. Films, television and the like are excellent for the presentation of concepts involving movement, but frame time is externally dictated, and the speed at which viualized information passes before students may become a cause of interference.

Interference must be kept in mind when considering what form the visuals will take, and here one should give attention to the ideas of design and realism. All visuals should be clear to all students which means that their size, clarity, spacing and color are all important. It sounds unnecessary to say that a picture in education should not be too small and should not be too large. If it is too small, many details will be indecipherable and hence confusing; if it is too big, a sense of unity will be sacrificed as students,

in trying to scan the whole picture, will tend to have their attention taken by a small section. Spacing is part of this concern as well. When parts of the visual are spaced well, the scanning eye moves smoothly and logically from one to another.

The matter of complexity or simplicity is a feature which is in the context of interference. As was noted in Chapter II the realism continuum does not reflect the "learning continuum" and increasing detail tends, instead, to decrease the teaching potential of the visual. However, this remains an inconstant feature. Dwyer found in his study that realistic, colored photographs were useful in certain proscribed areas of a lesson on the part of the heart. All the same, on the whole, studies suggest that less complex illustrations are more readily understood and better for the transfer of information.

In the context of realism should be considered the matter of color. Again it is hard to be definite in any conclusions for sometimes it is true that black and white illustrations can be extremely effective - the contrast is strong. On the other hand, color can be important for clarification, for attention-getting, for visibility considerations, for the interpretation of relationships and for the subtle transmission of attitudes. Children tend to react to color, especially strong color, more definitely than adults who are accustomed to the symbolism of black

and white and the ideas it transmits, but all people can absorb a great deal from color. Wise use of color can add to the learning experience; undisciplined use adds nothing and can become an overload, resulting in a decrease of understanding.

Using the visuals requires cueing methodology. Adults in particular need to feel in touch with the work being presented and prefer to be told of the learning objectives in front of them. This has the advantage of focusing their attention and receptive concentration. Questions have a similar effect, written or oral, and are also vital for follow-up recall. Printed material, such as arrows, may continue this role. This rehearsal is important to the retention of learned material. All of these gambits, including patches of color in an otherwise black and white illustration, are further variables.

What this points to is that there is no single approach to visuals, and that there are no hard and fast rules for their use. The variables are vitally concerned in what is right for one situation and what is right for another; in order to adapt a visual for another use it may be necessary to change only one or two of these aspects. Educational effectiveness is dependent upon small things and cannot be made constant.

The variables do not change the fact that visuals are useful but they do mean that commercially made products can

seldom fit this fluctuating mould. They cannot take into account the varying needs of students in different learning environments. The whole idea of visuals is that they should respond to just those environments and the needs assessed on an individual basis, that they should deal with learning problems and learning situations which may be unique to an age group, a subject, a cultural attitude or a teaching form. Here lies the great strength of the teacher-made visual aid. No matter what the artistic skills of the teacher, it is he or she alone who recognizes and understands the variables. Only the teacher can produce visual materials which are that immediate response to the situation, and only those are effective teaching aids.

The teacher, then, should not be daunted by the artistic requirements. Experience teaches a lot of ways to deal with these needs, and furthermore brings more ideas. There is no need to turn to another person to translate ideas, for this introduces the potential interference of a third party and his/her interpretations. Necessity is the mother of invention, and it is that which makes teacher-made visual aids a continually vital part of the ESL classroom.

APPENDIX I

Sample Passage for Listening

Comprehension with Visual

I SIMPLE

(a) This woman is tired. She has been shopping most of the day. She is wearing a brown coat and on her head she has an orange hat. She is carrying two bags.

(b) This girl has been at school but now she is going home with her mother. She is wearing blue jeans, a blue hat and a red sweater.

II SLIGHTLY HARDER

(a) Mark Booth's waiting for the bus and he's been waiting quite a while. He's cold so he's put his hands in his pockets to keep them warm. He's wearing dark jeans and a yellow jacket, as well as a blue hat.

(b) Jane Stevens is talking to a friend of hers. She's going home from school. She's got on a blue coat and red boots and she's a blonde.

III CONVERSATION

/A/ Goodness, aren't these buses slow. If it doesn't come soon, I think I'll drop. I'm so tired.

/B/ I thought you looked rather weary. What've you been doing? Shopping?

/A/ Yes, I thought I'd get a few things I needed. But a few things always turns into a lot more. What have you been doing?

/B/ Oh, I had to take my daughter to the dentist so I picked her up from school. When I left the house this morning it was really quite cold so I put on this quilted coat and my fur hat. Now I'm so hot! I'll be glad to get home and shed everything.

/A/ Ah, I'm just looking forward to getting rid of parcels, hat, coat and shoes and putting my feet up.

APPENDIX II

POSSIBLE SCRIPT FOR ORDER! ORDER!

It was spring. The tree was in bud and flowers were beginning to appear. Within a few weeks, the tree was a mass of blossom in pink and red. As the weeks passed, spring faded into summer. The blooms on the tree gave way to leaves. The days grew warmer and the tree provided shade for people walking in the park and for the children who played under it with their toys in the long days.

Gradually these long days began to shorten. The green leaves began their change to red and gold. Before many more weeks had passed the snow had arrived once more. Winter had returned.

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