JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY
VOL. 69, NO. 25, 2017

ISSN 0735-1097/$36.00
PUBLISHED BY ELSEVIER
http://dx.doi.org/10.1016/j.jacc.2017.05.027

FELLOWS-IN-TRAINING & EARLY CAREER PAGE

Effect of Changes in Visa Policies and Procedures on Fellows-in-Training and Early Career Cardiologists

Zaher Fanari, MD

On January 27, 2017, President Donald J. Trump signed an executive order banning nationals of Iran, Iraq, Libya, Somalia, Sudan, Syria, and Yemen from entering the United States for limited period of time, with the possibility of including other countries and extending this ban for a longer time, if needed (1). This executive order was blocked in multiple courts. A second executive order was announced on March 6, 2017. The new executive order excluded Iraq from the list (2). It also clarified that Green Card holders as well as those on a current valid visa will not be denied entry. However, the new order maintained the ban on granting new visas to nationals of these countries, and was unclear on how it would will applied in cases of visa status adjustments. The new executive order also is being challenged in multiple courts. The U.S. Citizenship and Immigration Services (USCIS) subsequently announced that starting April 3, 2017, USCIS will temporarily suspend premium processing for all H-1B petitions. This suspension may last up to 6 months, and will affect all FY18 cap-subject H-1B petition applicants (3). The goal of this paper is to discuss these visa policies and their effect on fellows-in-training (FITs) and early career (EC) cardiologists.

The Trump administration has argued that this executive order is essential to give USCIS sufficient time to assess the security threat that may be imposed by citizens of these countries and devise a new approach for confirming background checks. Similarly, the USCIS goal of suspending H-1B premium processing is to allow the agency to reduce the overall process time for all H-1B applicants. Although these goals may be very important, the sudden implementation of these policies attracted a lot of criticism due to their potential effect on the health care and technology industries. Most international medical graduate (IMG) FITs are currently on either J-1 visa status or H-1 visas. These policies are expected to result in delays in the visa adjustment of status and visa waiver processes, which could affect the cardiac care of many patients in underserved areas. Furthermore, the expected delay in visa processing will make many IMG FITs less attractive options for employment.

Since the 1960s, IMGs have constituted 10% of the U.S. physician workforce. This increased to 18% by 1970, and has grown in the 1980s and 1990s (4). In early 2000s, IMGs filled around 40% of cardiology FIT positions and represented about 25% of practicing cardiologists in the United States (4). In 2016, this trend stayed stable with non-U.S. citizen IMGs filling 29.5% of cardiology FIT positions (5). Many of the IMGs have nonimmigrant visas, including J-1 Visitor Exchange visa, and therefore they provide an important resource for providing care to patients in rural and underserved urban (inner-city) areas through the Conrad 30 Waiver Program (3,4). Many IMG cardiologists who are providing cardiac care to underserved U.S. areas come from these 7 countries. In fact, Syria—a country on the ban—is 1 of the top 10 countries of origin that contribute to the Conrad 30 Waiver Program (3). During the process of the Conrad 30 Waiver Program, IMGs on J-1 obtain an H-1B visa and can use premium processing to join their new jobs on time. Therefore, the suspension of the premium process will affect all current IMG FITs who are planning to join the workforce this year. Future expected limitations on the H-1B program would have an even larger

Structural and Endovascular Fellow, Prairie Heart Institute, Springfield, Illinois.

effect on cardiology job supply in underserved areas. The delay may result in many seeking other candidates for the jobs. Even if this is not the case, these FITs transitioning to EC jobs will not be allowed to work and may be deprived of income during the visa processing time.

IMGs face many challenges before they can join the cardiology workforce. The major challenge is related to immigration policies, which can affect employment opportunities (4). Even before the recent changes, there are anecdotal cases of IMGs feeling "trapped" in the United States during their training out of fear of being not admitted back into the country if they return their country of origin. The effect of immigration and visa policies extends beyond IMG cardiologists and cardiology fellows themselves, and extends to immediate family members. Furthermore, many of these physicians, especially those coming from the countries involved in the travel ban, are experiencing survival guilt over leaving their parents, siblings, and relatives in war zone areas while living a safer life in the United States. Despite these difficulties, IMGs deliver a similar quality of care compared with their U.S.-born colleagues (6). In a recent study that compared patient outcomes between IMG physicians from 7 countries (including Syria) and U.S. graduate physicians showed that IMGs were more likely to work in medium-sized, nonteaching, for-profit hospitals, and hospitals without intensive care units (6). Furthermore, patients treated by IMGs were more likely to be nonwhite, have lower median household income, have Medicaid coverage, and have more comorbid conditions, including congestive heart failure, chronic obstructive pulmonary disease, and diabetes (6). After adjustment for patient and physician characteristics and hospital-fixed effects, patients treated by IMGs had lower mortality (adjusted mortality 11.2% vs. 11.6%; adjusted odds ratio 0.95; 95% confidence interval: 0.93 to 0.96; $p < 0.001$) and slightly higher costs of care per admission (adjusted costs $1,145 vs. $1,098; adjusted difference $47; 95% confidence interval: $39 to $55; $p < 0.001$) (6).

IMG cardiologists provide an important source of cardiac care in the United States. Many of these IMG cardiologists are originally from the countries that are included in the first and second executive orders. Furthermore, a larger percentage of IMG cardiology FITs are currently on J-1 status and will need to apply for an H-1B visa to be able to work in the interim. The expected delay in processing H-1B visas for all J-1 waiver applicants may severely affect the current shortage of cardiac clinicians in many underserved areas in the United States, which may impose a greater risk on public safety and health. Future suggested changes in the H-1B visa would exacerbate the expected shortage even more. Even if these policies were limited in duration, the resulting delay in expected start day for many of the graduating IMG FITs in the next few months will affect the potential of employers to hire IMGs in the future. The effect on income in the financially vulnerable FITs due to this delay is a large concern as well.

As an IMG fellow-in-training who is invested in promoting the quality of cardiac care in the United States, I ask for support from our cardiac community to address the effect of these policies not only on current FIT and cardiology members of the American College Cardiology, but also on the current state of cardiac care in the United States.

ADDRESS FOR CORRESPONDENCE: Dr. Zaher Fanari, Prairie Heart Institute, 619 East Mason Street, Springfield, Illinois 62769. E-mail: zfanari@gmail.com.

REFERENCES

1. The White House. Executive Order: Protecting the Nation From Foreign Terrorist Entry Into the United States. Available at: http://www.Whitehouse.Gov/The-Press-Office/2017/01/27/Executive-Order-Protecting-Nation-Foreign-Terrorist-Entry-United-States. Accessed May 11, 2017.

2. The White House. Executive Order Protecting the Nation From Foreign Terrorist Entry Into the United States. Available at: http://www.Whitehouse.Gov/The-Press-Office/2017/03/06/Executive-Order-Protecting-Nation-Foreign-Terrorist-Entry-United-States. Accessed May 11, 2017.

3. U.S. Citizenship and Immigration Services. Conrad 30 Waiver Program. Available at: http://www.Uscis.Gov/Working-United-States/Students-And-Exchange-Visitors/Conrad-30-Waiver-Program. Accessed May 11, 2017.

4. Zoghbi WA, Alegria JR, Beller GA, et al. Working group 4: international medical graduates and the cardiology workforce. J Am Coll Cardiol 2004;44:245–51.

5. NRMP Results and Data Specialties Matching Service, 2016 Appointment Year. Available at: http://www.Nrmp.Org/Wp-Content/Uploads/2016/03/Results-And-Data-Sms-2016_Final.Pdf. Accessed May 11, 2017.

6. Tsugawa Y, Jena AB, Orav EJ, Jha AK. Quality of care delivered by general internists in US hospitals who graduated from foreign versus US medical schools: observational study. BMJ 2017;356.

RESPONSE: Immigration Travel Ban

Long-Term, Pejorative Impact on U.S. Care Delivery

William A. Zoghbi, MD
Houston Methodist DeBakey Heart & Vascular Center, Houston Methodist Hospital, Houston, Texas
E-mail: wzoghbi@houstonmethodist.org

In his Fellows-in-Training & Early Career Page contribution, Dr. Fanari emphasizes the downstream effects of the new immigration policies on cardiology: by protracting the visa processing, many of the international medical graduates (IMGs) upon whom our health care system depends—they form nearly one-third of the health care workforce—will disappear from our ranks. Patients in already underserved areas will be affected more, as openings for cardiologists will go unfilled. Worse, some IMGs may be required to leave, and there are not enough qualified physicians to replace them.

All of this seems indisputable to me. As the chair of a leading cardiology department, I am concerned about training slots going unfilled because many applicants are required to have visas. The travel ban would thus not only affect health care this year, but for years to come as we experience a shrinking talent pool. One element of the ban not mentioned by Dr. Fanari is its indefinite suspension of the entry of Syrian refugees, who currently constitute the world's largest refugee population. We have not seen such a mass exodus from a war-torn region since the 1994 Rwandan genocide.

I happen to be a refugee myself. I left Lebanon in the late 1970s in the middle of medical school at the American University of Beirut, because it had become too dangerous to attend classes amid the bombings. My then-girlfriend, now wife, had left the American University of Beirut the summer after her first year of medical school to visit relatives in the United States, and she could not return to Beirut when the borders closed. Both of us, then, were unwilling refugees (is there any other kind?), but we were deeply thankful to be accepted as transfers to medical school here in the United States. We stayed on for residency and further training, and were proud to become American citizens, even though our families remain in Lebanon. We have been even more proud to give back to this country, which opened its arms to us when we were in need. My wife, Huda, has devoted herself to basic research; I have devoted myself to clinical research and, as past president of the American College of Cardiology (ACC), to strengthening international cooperation among cardiologists. The international reach of the ACC has strengthened the organization and is improving cardiology training and care around the world (1).

All evidence suggests that the existing systems for vetting immigrants for safety and IMGs for medical competence work very well: IMGs have significantly contributed to the advancement of medical science, and may in fact have better patient outcomes than nonimmigrant physicians (1), and no refugee has been implicated in a fatal terrorist attack on U.S. soil since the establishment of the U.S. Refugee Act of 1980. Given these clear successes, it would seem more prudent to focus our attention on the systems that are not working very well, such as our health care system.

As physicians and academics, we must be advocates for our patients first and foremost. The requirements for good health are clear and beyond dispute: we need clean air and water, wholesome food, exercise, community, and when we get sick, physicians who can spend time with their patients to arrive at an accurate diagnosis, provide care when it is needed, and explain when it is not. None of these things will be achieved by making immigration more difficult.

REFERENCE

1. Kalra A, Shah PK, Zoghbi WA. Travel bans and threats to US health care—our hearts are at stake. JAMA Cardiol 2017;2:351–2.