The International Medical Graduate Pipeline

Whether to depend on IMGs to remedy the U.S. physician shortfall involves global ethical considerations.

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ABSTRACT: This paper presents information from the Educational Commission for Foreign Medical Graduates (ECFMG) on the certification and practice of international medical graduates (IMGs). IMGs constitute 25 percent of the U.S. physician workforce, and there is a vigorous pipeline of highly qualified candidates seeking graduate training in the United States. When considering how to address the potential physician shortfall described by Richard Cooper, policymakers will need to consider U.S. health care needs in the context of the intense international debate regarding global physician migration and its implications for the developing world.

Richard Cooper predicts a significant shortfall in U.S. physician supply over the next twenty to twenty-five years. He backs this up with an excellent analysis of the current status of medical schools, their applicants, and the factors that affect the supply of future applicants. As one potential solution to the anticipated workforce crisis, Cooper suggests increasing the numbers of international medical graduates (IMGs) entering the United States.

- IMG certification. The Educational Commission for Foreign Medical Graduates (ECFMG), the body that certifies IMGs for entry into U.S. postgraduate clinical training, cannot advocate for or against IMGs in the workforce debate but has a mission to provide policymakers with the most up-to-date information and data regarding IMGs. IMGs represent a sizable portion of U.S. physicians. In 2001 they accounted for 24.5 percent of the total physician population, 23.6 percent of all physicians in residency/fellowship training, and 32.9 percent of all hospital-based, full-time physician staff.1

The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited postgraduate training programs accept IMGs only if they are certified by the ECFMG, unless they possess a full and unrestricted license to practice medicine from a licensing jurisdiction in the United States. ECFMG certification is also one of the eligibility requirements for Step 3 of the three-step U.S. Medical Licensing Examination (USMLE). All states require ECFMG certification for an IMG to obtain an unrestricted license to practice medicine.

- ECFMG history. The need to assess the competency of IMGs was the catalyst for the formation of the ECFMG in 1956. At that time there were 544 medical schools operating outside of the United States and Canada. There are now more than 1,600 such international
medical schools. There is, and has been since 1956, wide variation in these schools, particularly regarding quality, curriculum content, and duration. Throughout its nearly fifty-year history, the ECFMG has been committed to evaluating the graduates of these diverse medical schools to ensure that they have the necessary knowledge, skills, and attitudes to begin training in the United States.2

■ Volume of applicants. Cooper raises the question of whether there will be sufficient numbers of qualified applicants to U.S. medical schools to generate the needed additional graduates. In that context, a word on current ECFMG volume is appropriate. In the aftermath of 11 September 2001, the conventional expectation was that the number of IMGs seeking ECFMG certification would drop precipitously. However, this has not happened. In 2002 the ECFMG saw increases of 12–25 percent in the number of candidates taking the ECFMG certification examinations.

The National Resident Matching Program (NRMP) results are also instructive.1 For the 2003 match year (1 February 2002–31 January 2003) the ECFMG issued 6,890 certificates, an increase of 14 percent over the 2002 match year. Relative to 2002, the number of IMGs who participated in the match increased 7 percent, and the number who matched to first-year positions increased 13 percent. Of particular note, the number of participating IMGs who were not U.S. citizens (5,029) increased 10 percent over the 2002 match, reversing a recent decline.

■ Global physician migration. The appropriateness of increased reliance on IMGs in the United States is for others to decide. However, Cooper correctly indicates that there are concerns related to this approach. They are not based on the supply of IMGs, as evidenced by the vibrant pipeline of qualified candidates seeking to enter U.S. graduate training. Rather, they relate to the intense international debate regarding global physician migration with all of its attendant ramifications, including “brain drain,” “brain push,” and the dilemma of physician recruitment by developed countries.4

The perspective of a global pipeline has been described nicely by Lynn Eckhert.5 She reports that there are approximately 350,000 graduates annually from medical schools outside the United States and Canada. She concludes that “the physician pipeline is at its narrowest in the regions with the highest expected rates of population growth. Conversely, capacity appears to exceed demand in regions of declining or minimal population growth.”6 Thus, the adequacy of the global supply remains a question to be answered by further research.

Within this context, the migration of physicians is not new, but recent patterns emphasize movement from less developed to more developed countries (for example, Sub-Saharan Africa to South Africa; South Africa to Canada; India to the United Kingdom, the United States, or Canada; and Pakistan to the United Kingdom or the United States). As migration occurs, the distribution of physicians must be addressed. In all countries there are underserved areas related to maldistribution of providers. As the move occurs from underdeveloped countries, the shortages in these areas may become more severe.

The reasons physicians move include improved salaries, improved lifestyle, safety for themselves and their families, and professional satisfaction with their practices. Although these are valid considerations for individuals, physicians’ movement results in problems for the countries from which they migrate.

When a less developed country loses physicians, it is “drained” of a vital resource for which it has often incurred the costs of training. This loss increases the load on the health care delivery system and increases need and maldistribution as noted above. The situation, characterized as “brain drain,” is further com-
plicated by active recruitment of physicians by developed countries that seek to remedy their health workforce needs without incurring the costs of training.

**Ethical considerations.** Physician recruitment by developed nations raises serious issues of fairness and equity. As one possible remedy, it has been suggested in the literature that less developed countries be reimbursed for the costs of medical education, either by the recruiters or by the migrating physician.7

These ethical questions were discussed at a preconference symposium, “Issues in Quality Improvement of Medical Education—Implications for Global Standards,” convened by the World Federation for Medical Education (WFME) 15 March 2003 in Lund, Sweden. While no decisions were reached, the offsetting concept of “brain push” was also closely examined. “Brain push” is said to occur when the country from which a physician is migrating is unable or unwilling to address the legitimate needs of its physicians.8 Thus, the physician is “pushed” out to seek an improved personal and professional life. The responsibilities of less developed countries are focused on the need to make a priority of problems in their health care systems and coordinate government, medical education, and health care delivery in response. This will improve outcomes for the good of the population and improve the quality of life for health care providers.

These complex issues and all of the questions raised here render this a complicated series of considerations. U.S. policy-making authorities must take these issues into account when considering IMGs as a solution for physician workforce issues.

**NOTES**


2. The ECFMG’s comprehensive examination and medical education requirements can be found at www.ecfmg.org.


6. Ibid., 611.
