

FAQs for Representing IMGs

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Representing international medical graduates (IMG) in immigration matters adds a layer of questions, legal issues, and acronyms that relate specifically to the medical field, training, and credentialing requirements, as well as regulatory requirements affecting physicians exclusively. Some practitioners shy away from diving into this area of immigration law practice because of these complexities. However, having the right tools at your disposal should demystify it, or at least de-code the acronyms and provide guidance in representing IMGs.

We now present frequently asked questions about representing international physicians in immigration matters. These are the fundamentals to know before advising an IMG, which should form a solid foundation for a more nuanced practice in this field.

WHAT IS AN IMG?

An IMG is not necessarily a foreign national. Rather, an IMG is an individual who graduated from medical school located outside the United States and Canada. According to the Educational Commission for Foreign Medical Graduates (ECFMG), an IMG is defined as:

[A] physician who received his/her basic medical degree or qualification from a medical school located outside the United States and Canada. The location of the medical school, not the citizenship of the physician, determines whether the graduate is an IMG. This means that U.S. citizens who graduated from medical schools outside the United States and Canada are considered IMGs. Non-U.S.

citizens who graduated from medical schools in the United States and Canada are not considered IMGs.¹

Conversely, a foreign national who graduated from a medical school located in the United States or Canada would not be considered an IMG, even though he or she may still require sponsorship for immigration benefits.

ASIDE FROM USCIS, WHAT OTHER REGULATORY SOURCES IMPACT IMG IMMIGRATION MATTERS?

One of the most challenging aspects of working with IMGs is that they have dual goals of working in rewarding, stimulating professional positions (after all, they have undergone an extensive period of education and training) while also achieving their desired immigration objectives. This, in turn, requires immigration counsel to keep in mind three separate but interrelated regulatory frameworks that affect the lives and careers of IMGs:

- Quality standards developed by the medical profession;
- State licensing regulatory bodies;
- Immigration adjudication framework that incorporates, to varying extents, the quality control standards established by the states and the profession that ensure a high standard of professional practice by physicians.

In terms of quality standards created by the medical profession to safeguard the welfare of the public by having physicians meet exacting practice standards, there are two basic sources for quality control:

- A special system to ensure that IMGs hold the knowledge and skills to succeed in the U.S. medical system; and
- The more general system established by the medical profession to ensure high professional practice standards.

The ECFMG was created by the medical profession to ensure that IMGs meet acceptable professional practice standards to work as a physician in the United States. The ECFMG performs the following functions:

- It devises and administers various examinations intended to judge the professional capabilities of IMGs;
- It issues the ECFMG certificate to IMGs who show a level of professional knowledge, English language facility, and cultural adoptability to work as a physician in the United States;²

¹ www.ecfmg.org/certification/definition-img.html.

² Possession of an ECFMG is the required credential both to enroll in an accredited program of Graduate Medical Education (GME), which is a prerequisite to medical licensure, and to apply for a J-1 visa in order to enroll in a GME program.

- It monitors the progress of an IMG in successfully completing the Graduate Medical Education (GME) program in a timely manner through the issuance of DS-2019 forms as required to maintain J-1 status.

But beyond the ECFMG, the medical profession has created other mechanisms to establish and ensure high professional standards. In particular, two schemas carry significant importance to IMGs:

- The Accreditation Council of Graduate Medical Education (ACGME), which accredits GME programs, and whose determinations are used substantially in issuance of a medical license; and
- The certification system of the various American Boards of Medical Specialties (ABMS), which certify the professional competence of both primary and specialty care physicians. In many instances, American Board Certification (or Eligibility) is a critical determining factor for working in the United States.

Somewhat related to the standards created by the medical profession, each state creates standards for the licensing of physicians. Without exception, each state requires completion of an ACGME-accredited program in GME. There are variations among the states in the number of years of required GME training, levels of experience, and special requirements for IMGs. But the key concept is that the states look to the standards developed by the medical profession to determine the professional practice capabilities of both IMGs and U.S. medical graduates.

Obviously, an IMG needs to possess valid immigration status in order to work in the United States. While the basic construct of employment-based immigration applies fully to IMG immigration, the practitioner needs to ensure that an IMG meets certain stipulated credentialing requirements. In particular, for H-1B cases, an IMG needs to possess the following credentials: 1) medical degree (M.D.) or a medical license abroad; 2) English language fluency through production of an ECFMG Certificate or graduation from an accredited medical school program (*i.e.*, U.S. or Canadian programs); 3) passage of all three steps of the U.S. Medical Licensing Examination (USMLE); and 4) a state license or authorization issued by the state to do the duties of the position. Similar special and stipulated credentialing requirements exist in the permanent resident context and the practitioner needs to ensure that the IMG meets fully these credentialing requirements.

WHAT EXAMS ARE IMGs REQUIRED TO TAKE IN ORDER TO QUALIFY FOR: A) H-1B STATUS; B) ANY OTHER NONIMMIGRANT STATUS; AND C) PERMANENT RESIDENCE? ARE THERE EXCEPTIONS?

H-1B

The H-1B regulations for physicians³ establish four basic requirements: a qualified medical education; fluency in English; medical knowledge; and a state license. The first two requirements are met either through ECFMG certification—which requires that the physician take a science

³ 8 CFR §214.2(h)(4)(viii)

and English test—or by graduating from either a U.S. medical school or a Canadian medical school accredited by the Liaison Commission on Medical Education (LCME).

The third requirement—medical knowledge—is established by documenting that the beneficiary passed all three steps of the U.S. Medical Licensing Examination (USMLE). Specifically, the regulation requires that beneficiary have passed the Federation Licensing Examination (FLEX), or an equivalent examination as determined by the secretary of the U.S. Department of Health and Human Services (HHS). FLEX is no longer given, and, in 1992, HHS established USMLE Steps 1, 2, and 3 as the “equivalent examination.”⁴

Finally, as with any H-1B specialty occupation that requires a license, the IMG must have a license or other authorization required by the state of intended employment to practice medicine. Many states do not require an individual license for those participating in training programs. Instead, they are covered by an institutional permit. Nevertheless, it is important to document the respective state’s licensure requirements in the H-1B petition.

Exceptions

However, it would not be an immigration issue without exceptions, namely: 1) the regulations explicitly excuse graduates of a United States medical school; and 2) physicians of national or international renown from the USMLE requirement. With regards to physicians of national or international renown, query whether the standard is higher or lower than the O-1, a subject for another day. Finally, H-1B petitions for physicians primarily engaged in teaching and research, and engaged in only incidental clinical care, also are not required to contain proof that the beneficiary passed USMLE steps 1, 2, and 3. Again, what constitutes *incidental* is another question for another day.

Other Nonimmigrant Options

ECFMG is authorized by the U.S. Department of State to sponsor J-1 Exchange Visitor physicians enrolled in accredited programs of graduate medical education or training, or advanced research programs (involving primarily observation, consultation, teaching or research). In fact, ECFMG is the sole sponsor of J-1 physicians in clinical training programs. It requires a physician to have obtained ECFMG certification, which includes a credentials review and satisfactory scores on the USMLE Step 1, Step 2 Clinical Knowledge, and Step 2 Clinical Skills.

There are no licensure or examination pre-requisites for other non-immigrant options, the most common of which in the IMG context are the E-3 or the O-1. Of course, all practicing physicians are bound by state licensure requirements and must comply with those requirements.

Permanent Residence

While the H-1B petition requires all three steps of USMLE, qualifying for permanent residence requires only the first two. This is because when the USMLE was developed, it was intended to

⁴ <http://archive.hhs.gov/news/press/1992pres/920916.txt>.

streamline the examination requirement for IMGs. Prior to implementation of the USMLE, IMGs were required to take two separate examinations; one to satisfy the requirements of immigration law and the other to satisfy the requirements of state licensing boards. USMLE was established to replace both these examinations. The federal examination, first the NBME and later the FMGEMS, was replaced by USMLE Steps 1 and 2. The state licensing requirement, FLEX, was replaced by USMLE Steps 1, 2, and 3. State licensure is not required to qualify for immigration.

WHAT IS THE TYPICAL CAREER AND RELATED NONIMMIGRANT STATUS TRAJECTORY FOR IMGs?

Both the career and the immigration trajectory of an IMG start with gaining the credentials needed to practice medicine in the United States. This journey starts with the need of an IMG to enroll in an ACGME-accredited program in Graduate Medical Education (GME), as this is a baseline requirement to gain state licensure. Normally, an IMG will enroll in a basic primary care program of training—*i.e.*, Internal Medicine, Family Practice, Pediatrics, or OB/GN.

Thereafter, the IMG may either go into the physician workforce or go on for advanced fellowship training in specialty care medicine. Such programs vary substantially in length of time and can receive recognition from an American Board or be non-accredited, which essentially refers to highly focused or cutting-edge, emerging fields of medicine. There are potential complexities for IMGs for visa status purposes who desire to enter non-accredited programs.

In terms of long-term career development, one of the primary demarcations exists between academic medicine and private practice. The immigration practitioner needs to be aware of the long-term career objectives of the IMG and the various immigration options presented by differing types of medical employers. Specifically, practitioners should take the time and trouble to understand the long-term career objectives of their IMG clients, as in most cases, the IMG has an equal interest in a suitable immigration outcome and a challenging professional future.

WHAT ARE THE PROS AND CONS OF J-1 STATUS VERSUS H-1B STATUS FOR COMPLETING GRADUATE MEDICAL EDUCATION (GME)?

While the J-1 Exchange Visitor program is generally used for programs in GME, the position of Medical Resident or Clinical Fellow has been designated as a “specialty occupation,” so as to qualify for H-1B Temporary Worker status. Given that the employing institution controls the H-1B sponsorship process, many training programs opt for the J-1 sponsorship option in order to avoid the expense, trouble, and legal exposure inherent in the H-1B process, as well as to emphasize its commitment to international exchange. After all, the ECFMG provides a rather economical and efficient sponsorship alternative to the H-1B Temporary Worker classification.

The general opinion held by the overwhelming number of IMGs is to seek H-1B status for GME purposes so as to avoid the two-year home residence obligation. On closer examination, this may not always serve the IMG’s long-term professional and immigration interests.

If an IMG intends to pursue a primary care course of training and then enter the job market, he or she will generally use up three (sometimes four) years of H-1B status. This would preserve a

sufficient period of remaining H-1B eligibility to find a job and undertake the permanent resident process.

But if the IMG intends to pursue a program in specialty care medicine, then there is a real possibility that the IMG will use up the full six-year term of H-1B eligibility so as to forego the possibility of pursuing permanent residence based on employment. Or even worse, the IMG may find that he or she does not have a sufficient period of H-1B eligibility to engage in a full course of specialty care training, given that many subspecialties require periods of training well in excess of six years. The ECFMG has declared that, once an IMG starts GME under H-1B status, the ECFMG will not issue a DS-2019 form for J-1 sponsorship purposes. Furthermore, while the J-1 physician program is normally limited to seven years, many IMGs under the “exceptional circumstances” exception are able to get extended period of J-1 sponsorship that will let them complete advanced periods of GME and position themselves quite favorably for J-1 waivers. As such, those physicians who wish to pursue advanced specialty training that may last six years or longer should consider the J-1 as a viable option.

CAN A J-2 DEPENDENT SPOUSE PURSUE GME WITH AN EAD?

There is no prohibition on J-2 spouses pursuing residency training on an EAD. In fact, many IMG couples make the strategic decision for only one spouse to take the J-1, and for the other to pursue residency in J-2 status. The advantage is that, should the couple decide to remain in the U.S. post-training, only one spouse would require a waiver of the two year home residency requirement of INA 212(e). The disadvantage, however, is that, should the J-2 spouse wish to continue training or residency beyond the J-1’s training period, he or she may find it challenging to obtain another NIV status.⁵

WHAT ARE THE SPECIAL CONSIDERATIONS APPLYING TO CANADIAN PHYSICIANS IN PURSUING IMMIGRATION STATUS BASED ON EMPLOYMENT?

Interestingly, graduates of Canadian medical schools are not considered IMGs, and therefore do not require ECFMG certification. However, to qualify for an H-1B, they nevertheless must have passed all three steps of the USMLE. As noted above, only the first two requirements of 8 CFR §214.2(h)(4)(viii) can be met graduating from either a U.S. medical school or a Canadian medical school accredited by the Liaison Commission on Medical Education, and only graduates of U.S. medical schools are explicitly exempt from the USMLE requirement.

Canadian trained physicians entering the United States for teaching and research only, may qualify for a TN.

WHAT ARE THE WINNING ARGUMENTS FOR CLAIMING AN H-1B CAP EXEMPTION FOR IMGs WORKING AT TEACHING HOSPITALS?

In order to fulfill their missions of providing GME, university medical programs enter into stipulated, formal, and public affiliations with academic hospitals, known as Teaching Hospitals.

⁵ “AILA Memorandum on Eligibility of J-2 Derivatives to Obtain Nonimmigrant Classifications,” (May 15, 2013), AILA InfoNet Doc No. 13051601.

These relationships are publicly acknowledged and understood and create certain mutual obligations, including the necessity of the Teaching Hospital to build into its clinical treatment programs stipulated educational and training opportunities either to Trainees enrolled in its own program or Trainees rotating through who are enrolled in another affiliated program. This in many ways is the essence of Graduate Medical Education – that is, infusing the didactic teaching of medicine with hands-on clinical experience.

Despite the fact that there are formal, public affiliation agreements with designated hospitals, U.S. Citizenship and Immigration Services (USCIS) has been resistant to extending H-1B cap exemption to university-affiliated Teaching Hospitals, given that they fail to meet the standards of “shared ownership/common control.” Under the Aytes Memo “Guidance on the Requirement of a Permanent Offer Employment” for Outstanding Professors and Researchers” of June 6, 2006;⁶ as supplemented by the USCIS Press Release “H-1B Cap Exemptions Based on Relation or Affiliation” of March 18, 2011,⁷ many Teaching Hospitals are essentially grandfathered for H-1B cap exemption purposes owing to previous H-1B approvals, particularly as granted prior to March 18, 2011. However, in the main, Teaching Hospitals continue to be subjected to the H-1B cap, despite their clear and acknowledged affiliated relationship with a cap-exempt institution of higher education.

Interestingly, the Department of Labor extended cap-exemption recognition for ACWIA wage determination purposes to a widened scope of Teaching Hospitals in “In the Matter of Children’s Hospital Corporation,” BALCA Case No. 2011-PER-01338.⁸ BALCA concluded that the affiliation agreements are public and universally understood; there is a high level of overlap between university faculty and the medical staff at Teaching Hospitals; there is an underlying mandate for Teaching Hospitals to contribute to the training of physicians; and the nature and degree of training needs meet standards set by the ACGME.

To date, USCIS has not uniformly embraced this rationale, although there have been isolated instances in which USCIS has held that a Teaching Hospital fulfills the standards required for affiliation for H-1B cap exemption purposes. But this remains a viable issue for advocacy and liaison as by multiple standards, Teaching Hospitals are affiliated to university medical programs and as such, should qualify for H-1B cap exemption status.⁹

WHAT ABOUT PHYSICIANS WORKING “AT” A CAP-EXEMPT INSTITUTION BUT “FOR” A CAP-SUBJECT EMPLOYER?

It is not uncommon for a physician to work “at” a cap exempt institution, while working “for” a cap-subject employer. Consider, for example, that many private practice groups are incorporated as “for profit” entities, but their employees work at a university or university-affiliated non-profit

⁶ USCIS Memorandum, M. Aytes, “Guidance on the Requirement of a Permanent Offer Employment (June 6, 2006), AILA InfoNet Doc. No. 06060860.

⁷ “USCIS Addresses H-1B Cap Exemption for Nonprofit Entities Based on Relation or Affiliation” (updated May 24, 2011), AILA InfoNet Doc. No. 11031760.

⁸ “BALCA Reverses PWD, Discusses ‘Affiliated Nonprofit Entity’ under ACWIA” (Nov. 15, 2011), AILA Infonet Doc No. 11111665.

⁹ See “Practice Pointer: Cap Exemption for Nonprofits Affiliated with Qualifying Institutions of Higher Education,” (Dec. 29, 2014), AILA InfoNet Doc No 14122941.

hospital. A June 6, 2006 memorandum by USCIS Associate Director of Domestic Operations, Michael Aytes, recognizes that petitioners that are not themselves qualifying institutions may, in certain instances, claim an H-1B cap exemption.¹⁰ The memorandum makes clear that it is not merely the act of working “at” the qualifying institution that exempts the petition from the cap. Rather, that the petition must also demonstrate that the beneficiary’s job duties directly and predominately further the normal, primary, or essential purpose, mission, objectives or function of the qualifying institution, namely, higher education or nonprofit or governmental research. Specifically, the memorandum requires that the petitioner establish that there is a “logical nexus” between the work performed by the beneficiary and the normal, primary, or essential work performed by the qualifying institution. In the case of the private practice group, this argument can be successfully made where the beneficiary will assist in the training of medical residents, or is involved with institutional research.

The memorandum refers to petitioners in this situation as “third party petitioners,” so it may be necessary to also include with the petition proof of the employee-employer relationship. This may include contracts or agreements between the petitioner and the qualifying institution detailing the terms by which employees work at the institution, as well as details regarding the supervision of the beneficiary.

IF AN H-1B PHYSICIAN CHANGES FROM A CAP-EXEMPT TO CAP-SUBJECT, WHAT ARE THE OBSTACLES?

In a recurrently encountered situation, an IMG enters the United States to undertake a program in GME in H-1B status at a university institution, thereby qualifying for H-1B cap exemption. At the end of the program of GME, the IMG then pursues employment at an employer that does not qualify for H-1B cap exemption.

Obviously, the new employer can simply file a cap-subject H-1B petition so as to fall subject to the H-1B lottery.

Also, depending on a variety of factors, including whether or not the employment site is located in a designated medically underserved area and the physician’s country of nationality, the IMG could conceivably file a Physician National Interest Waiver¹¹ along with a concurrently filed I-485 adjustment of status application, thereby avoiding entirely the uncertainty of pursuing H-1B status.

But there may be some other options that might enable the case to be filed as a cap-exempt basis, including:

- Structuring the employment so that part of the IMG’s services is performed “at” an H-1B cap exempt institution. As discussed, USCIS has been requiring that the IMG perform

¹⁰ USCIS Memorandum, M. Aytes, “Guidance Regarding Eligibility for Exemption from the H-1B Cap Based on §103 of the American Competitiveness in the Twenty-First Century Act of 2000 (AC21) (Public Law 106-313)” (June 6, 2006), AILA InfoNet Doc No. 06060861.

¹¹ §203(b)(2)(B)(ii) of the Immigration and Nationality Act of 1952 (INA), Pub. L. No. 82-414, 66 Stat. 163 (codified as amended at 8 USC §§1101 *et seq.*).

services that advance and support the educational activities of the university or university-affiliated institution. We would note that this additional requirement that focuses on the substantive activities of the H-1B beneficiary is not a provision of the Statute, but rather has arisen as a function of USCIS adjudication policy.

- Concurrent employment involving a cap-exempt employer, thereby requiring the filing of two separate H-1B petitions. In a more aggressive approach, it would be possible to file concurrent H-1B petitions in which the employment duties at the cap-exempt employer will be conclude at a point of time earlier than for the cap-subject employer. This strategy would make any further H-1B extensions quite problematic.
- While USCIS has tightened up considerably the standards of “affiliated” for H-1B cap exempt purposes, it is critically important to inventory thoroughly the entity’s previous history of H-1B submissions to see whether it successfully gained cap-exempt recognition, when the standards of “affiliation” were more liberal.
- If the IMG’s spouse is in J-1 status, there may the option to changing into J-2 status and then applying for employment authorization.
- In select instances, it may be possible to qualify the IMG for O-1 status as an “alien of extraordinary ability.”

There are many other questions that are encountered by immigration practitioners who regularly represent IMGs, and the authors have covered just a few basics in this article. Clearly, representation of physicians is a niche area of immigration law and involves a clear understanding of not only immigration laws and policies, but also how they interact with the norms of the medical profession and the specific requirements that the medical field places on IMGs.