Title: A New Process for Integrating Foreign Physicians into American Healthcare

Introduction:

The United States of America is a nation with a population of 328 million (US census Bureau). The latest reports by the American Association of Medical Colleges shows, however, that only 860,939 licensed and practicing physicians serve this large population. [37] These numbers articulate a ratio of one doctor for every 381 patients. By comparison, Cuba has an average of 591 physicians per 100,000 people, which translates to 169 people per physician. [9] These proportions illustrate how the United States is lagging behind on providing the American population with sufficient physicians to meet their medical needs. While this on its own is a serious issue, there's an added component because many of these physicians are not spread evenly across the fifty states. The ratio of physicians to people in a state such as New York is about 1 physician for every 200 people while in a rural state like Wyoming, there is about one physician for every 1,000 people. The ever-growing physician shortage in America is a pressing issue that has yet to be fully addressed by the US government or the medical profession.

Some reforms that have been promoted include an expansion of the physician assistant (PA) and nurse practitioner (NP) sector in healthcare. Graduates from these programs are generally able to act as primary care providers, assessing and creating treatment plans for patients. However, inconsistencies in regulations and limitations in the scope of practice of these professionals across the 50 states both limit these professionals and perpetuate many gaps in patient care. Thus, the lack of homogeny in the allocated autonomy of nurse practitioners and physician assistants across the United States contributes to the maintenance of an incohesive healthcare sector.

Autonomy and scope of knowledge for Physician Assistants and Nurse Practitioners

States can allocate a certain amount of autonomy to NPs and PAs, but many disagree in the scope of practice that they allow. For example, in Arizona a nurse practitioner is allowed to see patients and form treatment plans without the supervision of a physician. They can also prescribe medications from schedules II-V. Schedules are a form of classifying medications based on the potential for dependence. Schedule VI is over-the-counter medications, while schedule II has restricted medical use and high risk for addiction (US Controlled Substances Act). Other states, like South Carolina, require physician supervision and the NPs prescriptive authority is limited to levels V-III. [15]

In addition, the education that these healthcare providers receive is different than that of physicians. Nurse practitioners attend nursing school for four years to receive their bachelor's in nursing. From there, they must complete a two-year master's program to receive the title of nurse practitioner. Their education is much more parallel to that of physicians, since nursing school is different from a regular undergraduate degree in biology and incorporates many clinical hours of hands on patient care into the education. Nursing school is focused on gaining a deeper understanding of physiological processes in order to have a fortified background of medical knowledge for clinical diagnoses. PAs have a different course of study. They must first complete four years of broad undergraduate education in biology that lacks hands on patient care and is composed of general lecture-based classes. PAs then have to complete two years of graduate education, where they learn basic healthcare practices for common-case presentations. However, they do not receive an in-depth education of medicine nor of medical diseases, like nurse practitioners, since the first four years of PAs education does not include courses that are centered around their role as providers, but rather on basic concepts of biology. This makes this population of healthcare providers less adept to assist with complicated diseases and illnesses.

For this reason, PAs must work in all states under the supervision of a physician in the form of a collaborative agreement.

The Balanced Budget Act of 1997

Prior to 1997, all residency programs and slots were funded through Medicare and Medicaid funding. This funding took into consideration three things: the average amount of residents the hospital held; the "per-resident amount," which was calculated by dividing the costs of education for residents by the average amount of residents; and lastly, the "Medicare day ratio", which centered on the amount of Medicare patients the hospital saw per day.[12] Through these factors, Medicare calculated the funding per hospital for their residency programs. This funding was unlimited prior to 1997, allowing hospitals to continually expand the number of residency positions they held.

However, after the Balanced Budget Act of 1997, this expansion ceased. This piece of legislation was created due to a belief by the stakeholders of the graduate medical education program that there was an oversupply of physicians in the US. While it may have been plausible for that time, it is no longer applicable. [1] The legislation kept in place the amount of residency positions in hospitals across the U.S. that were required for the 20th century. However, the 21st century has brought expansive demographic shifts in the U.S. population, and the limitations set forth by Medicare's Balanced Budget act have impeded the adaptation of the healthcare system. In order to increase the number of funded residencies, hospitals have to accredit a new teaching program and establish their residency slots in that program within a period of five years in order to receive funding. Once those five years have passed the number is once again capped.

Medicaid also allocates funding for residency programs, but each U.S. state has individual control over how it chooses to use this funding, if it chooses to use the funds for

residency slots at all. The allocation is very uneven within the states, and some states have chosen to diminish their use of these funds due to budget cuts.

The federal government has limited data on the use of the funding provided by the Medicare and Medicaid general medical education (GME) programs, with no clear source tracking where this money is going. In addition, positions that are unused such as those that arise when hospitals close down are able to be reallocated to hospitals that need the residency positions, although data on that process is not readily available, either. The last GME report was completed in 2012. [18]

While federal funds are the main source to fund the addition of residencies for hospitals, more affluent hospitals with more donors and in more urban areas have the capacity to increase their residency slots without government aid. In contrast, hospitals in rural areas have limited resources through which they can do this, not to mention that the amount paid per resident has to generally be higher in order to attract residents to these rural areas. Therefore, while we may have increasing numbers of medical school graduates, Medicare and Medicaid as well as the federal and state governments are not consistently increasing positions in the locations that are most in need. In addition, even though students complete their residencies all over the country, the current trends have indicated that they tend to go on to practice fully in more affluent locations, most probably to be able to pay off their acquired debt. Therefore, the implementation of a program that brings in foreign trained physicians that do not have the same amount of debt as U.S. medical students, and who are more likely to settle in rural areas, would aid in maintenance of a workforce in these rural and underserved areas.

Gaps in the Surgical Field

The United States has a limited amount of surgical residencies that are slowly if at all expanding. Moreover, nurse practitioners and physician assistants are unable to occupy these surgical positions. Thus, the relationship between newly graduated surgeons to retiring surgeons is linear and healthcare in this sector among others is at a standstill, while population growth is exponentially increasing. The limited residencies also mean that there are more patients per surgical resident, which translates to more for each graduated surgeon. In the United states, for example, there are currently 5,346 neurosurgeons, 4,485 cardiothoracic surgeons, and 25,254 general surgeons.[3] This means that on average a general surgeon would be expected to manage 12,896 potential patients (dividing population of US by number of general surgeons). That being said, not everyone requires surgery in the population at the same time, and some people go their whole lives without being in a surgical room. Nonetheless, the numbers are still disproportionate. The average number of surgeries a general surgeon has in a year is around 398. [32] That accounts for more than one procedure a day, on top of the surgeon's other duties (e.g. clinics and rotations).

Studies have shown that the long and intensive work hours that surgeons have to uphold leads to decreased job satisfaction and earlier retirement. [10] A national survey conducted by Michtalik et al. (2013) gathered data from 890 physicians on their perception of the safety of their clinical practices based off of their workload. They found that about 25% of physicians felt that they were "unable to fully discuss treatment options or answer questions" due to the lack of time per patient. In addition, about 10% of the cohort believed that their patients had been placed in upper level care (critical care) due to their lack of time with the patient. The Institute of Medicine acquired information of 33.6 million hospital admissions in 1997. This is one of the largest studies on death rates due to medical errors. The study found that around 98,000

Americans die in hospitals every year due to medical errors. [20] The issue is very real. As the population increases, the proportion of patients to physicians will keep increasing, as well, leading to diminished quality of care. There is already dissatisfaction with the increasing wait times and decreased face-to-face time with doctors in healthcare, and unless the issue is analyzed and various options are considered, the United States is looking at a possible epidemic of distrust in the healthcare system and increased treatment-related deaths.

Integration of Foreign trained Physicians into American Healthcare

A possible solution to the lack of physicians in America is readily available. There are thousands of foreign-trained physicians (FTP) in American society, who are in occupations that don't take advantage of their knowledge or abilities and can serve the purpose of filling the gaps in the physician workforce. The issue is that many FTPs who immigrate to America are unable to regain their previous scope of practice. The integration of this group into American healthcare entails a rigorous, lengthy, and expensive process that hinders the incorporation of this population into the medical workforce. This process will be covered in this paper as well as a discussion of a stepwise plan that could simplify the process of foreign physician acquisition of a medical practice in America. Lastly, this paper will discuss the economic and social impacts that the utilization of this available talent would have in America.

CHAPTER 1: Current Options for Foreign Physicians

Migrating to a foreign country is a big risk that FTPs take in order to improve their lives or those of their children and family. Depending on the situation, FTPs have varying paths and challenges to overcome in order to gain their position as a physician in America. If an FTP comes without a family and no mastery of English, then the FTP will have to quickly become established financially, which would very likely entail acquisition of a position for which the

FTP was not trained. This often happens to many immigrants who end up working in manual labor jobs. Many foreign physicians can readily acquire a medical assistant license or phlebotomy license, if the foreign transcripts are translated. After this, the physician may begin the process of learning the English language more proficiently and proceed on the application path.

First, the FTP has to be allowed to take the USMLEs (United States Medical Licensure Examinations). There is a total of two USMLE examinations that are required for application to residency. The first examination costs $630, and the second examination costs $1,290. Not only is this a vast amount of money to attempt to take a test in a foreign language but FTPs must be able to get competitive scores in order to compete with American medical students for limited residency positions.

Before taking these examinations, they have to have their medical certificate and transcripts approved by an independent, non-profit agency called the Educational Commission on Foreign Medical Graduates. This agency has a list of schools that it considers to be accredited from all over the world. If an FTP can find their school on that list, then the FTP can have his or her medical transcript and certificate translated (prices vary from $24 to $40 per page). Issues may arise at this point. As described by Lidia Rabden, author of *Credential Recognition in the United States for Foreign Professionals*, it may be difficult for FTPs to get transcripts from their native countries. Cuba, for instance, does not allow its medical schools to release the transcripts of physicians who left the country permanently. In cases such as these the ECFMG has created alternate routes for these physicians. However, this lengthens the process and the time for recognition. Credential recognition by the ECFMG costs $125. Subsequently, FTPs can sign up for the USMLEs, but must receive a passing score on the first exam of 194, which falls around the 6th percentile. By passing this exam, the FTP is able to take the second USMLE. The score

on the first USMLE partially affects what residency the FTP will be able to acquire. An example of a competitive score is 243 for Family medicine (one of the least sought specialties), which falls into the 32nd percentile, and 245 for a more competitive specialty like general surgery.

Other factors play into the type of residency that FTPs get, including research experience. The playing field is highly skewed in this process because U.S. medical students are prepared throughout their undergraduate and graduate education to do well on both USMLEs and to acquire research experience. American medical schools, such as the University of South Florida Morsani College of Medicine, have their medical students take preparation exams for the USMLEs, beginning in their first year of medical school. Not only are the USMLEs in another, non-native language for FTPs, but many aren't used to the standardized test approach in America. Mastery of knowledge in other countries, such as Cuba and Hungary, is typically tested through verbal examinations. The timing and strategies of multiple-choice, standardized tests is something that is unfamiliar to FTPs. Many FTPs are also unable to develop their research background in America due to the lengthy process of re-establishment mentioned previously. Because of these factors and the limited residency seats in America, many FTPs do not achieve a match or obtain a match outside of the specialty established in their home country.

These issues are highlighted in the context of a typical FTPs path. To begin with, an FTP who comes to this country after having completed residency and fellowship in their home country is around 28 to 30 years old. That means that at the age of 30, and most likely having a family, the FTP has to redo a whole new residency program in America. The average hours a resident works is around 60 per week. Specialties like surgery range up to 80 hours per week. Residencies often pay residents around 40-50 thousand dollars per year. An FTP may have a very difficult time managing his or her home life with the new requirements of the residency program. In addition, prior knowledge may be put to waste as an FTP who may have been a

surgeon in another country, is unable to acquire that position here and is then forced to practice as a pediatrician or family-care physician. Such circumstances limit the number of FTPs who are willing to endure the path to re-establishment in America, and also place those whom do complete the path in a less than ideal position.

Chapter 2: Prerequisites for Candidacy in a New Program for FTPs

This essay proposes a program that would entail FTPs taking a language comprehension exam or passing composition 1 in a college or university with a B or above. In addition, the FTP would serve in a rural or underserved area for a designated period of time in the specialty of their native country, receiving the same pay that a resident would. Once they complete their time at a rural or underserved area, they would then be able to choose where to work as an established physician in America.

In order to better utilize this population of FTPs a singular program must be created to make the process simple and efficient. Two routes could be taken in the creation of such a program, federal control or private industry control. [22] If the US government took charge of spearheading the program, the benefits would include nationwide adherence to the program, and federal funding. However, this option would also be at risk for frequent modifications per presidential term, unless put into legislation. On the flip side, if a program were led by an independent agency, such as the AAMC (American Association of Medical Colleges), it may serve to create a more direct and stable program, since the AAMC creates the USMLEs and is the mediator through which students apply to both medical school and residency. However, it may be difficult to establish the program with all states. For the purpose of this thesis, the proposed framework for linearization of FTPs path into reestablishment would be mediated through and independent agency, such as the AAMC. [26]

A possible argument against the establishment of a program such as this, would be the possible loss of medical students competing for a seat in an American Medical school. This argument proposes what is already occurring. Many American students are already offshoring their medical education to other countries, most notably in the Caribbean. In 2014, the number of licensed physicians in America who went to medical school in the Caribbean was 25,562. [37] The main cause of this exodus is the ever-increasing demands that U.S. medical schools are placing on applicants. In highly populated and competitive states like California, the average grade point average (GPA) of a matriculated applicant is 3.7 with a medical college admissions test (MCAT) score of 511, which is at the 84th percentile. [23] Caribbean schools have much lower requirements for entry. However, those who do attend Caribbean schools tend to not do as well on the USMLEs as students that had an education in America (where the curricula are more geared towards high USMLE scores and pass rates), and so are at a disadvantage when competing for medical residencies. This diverts many American students from applying to Caribbean schools, which tend to have higher costs of tuition and, of course, the added difficulty of being in a foreign country.

The limited number of medical residencies is the main issue accounting for the shortage of physicians in America. While residencies are growing at a rate of 2.55 slots per year, they are not growing fast enough to keep pace with the number of graduates, much less for the total physician shortage that has grown since passage of the Affordable Care Act (ACA). That being said, in order to specialize in America, residency must be completed in the U.S. Thus, there are too few physicians in America, but nothing is being done to address the problem

Using FTPs, who have completed their residency in another country and practiced as an attending physician (official specialist), is the ideal solution. FTPs would not be competing for residencies with American medical school graduates, but they would be filling the ever-growing

need for physicians in America, especially in rural areas. At the same time, the number of American students outsourcing their education would not increase due to this program because in order to qualify as an FTP, one would have to complete residency in another country, a task that is quite arduous and would put an American student at an even greater disadvantage.

Chapter 3: Language Comprehension Exam or Completion of Composition 1 at the College Level

Many foreign nations, like Finland, have a growing need for physicians and have established a route for foreign physicians to enter the Finnish healthcare system. The country's program entails passing a certification exam and being able to speak Finnish proficiently. In order to test for mastery of the Finnish language, FTPs either have to take and pass courses or take and pass a language assessment. The certification exam itself has three parts that test: basic healthcare and medical knowledge, knowledge of the Finnish healthcare system, and a clinical skills assessment. Through this process, Finland has been able to slowly increase the numbers of FTPs in its system and fill healthcare gaps. [22]

This model is conceivable for the growing physicians demand in America. After approval of the his or her credentials, the FTP would have to complete either a language comprehension exam, similar to that given by the College Board for Advanced Placement classes, or complete Composition 1 with a B or above at the college level. The College Board examinations are specific to the topic they test, and they offer examinations that are for Composition 1 and Composition 2. The Composition 1 class teaches students how to master critical reading skills and hone in on their writing abilities.

Physicians in the American healthcare system need to be comfortable with reading complex scientific material. A popular trend in American health care currently is the use of evidence-based practices. Evidence-based practices apply to everyone in the healthcare setting,

from nurses to physicians. Evidence-based practices indicate that it is the provider or healthcare employees' responsibility to be aware of the latest findings that may aid in improving patient outcomes. Evidence-based practices are widely used in the hospital setting due to a shift in the CMS' (Centers for Medicare and Medicaid Services) inpatient prospective payment system. In 2014, hospitals under the inpatient prospective payment system IPPS (~4,000) were informed that those that had the most hospital-acquired infections (central line associated blood infection, and catheter associated urinary tract infection) would face a 1% cut on reimbursement. [14] This came about through scholarly papers examining the prevalence of complications and death due to avoidable hospital acquired infections. Physicians working with Medicare and Medicaid will need to maintain their vigilance on how they are treating patients' illnesses and what the scientific backing is behind their treatments.

In addition, since the proposed program would entail FTPs practicing in rural or underserved areas, their mastery of the English language would be vital. It is paramount that physicians are able to have clear discourse with their patients in order to properly serve the population. A great part of medicine is being able to inform patients of their illness and their treatments so that they can be involved in healthcare decisions and be able to advocate for themselves. These reasons support the need for language proficiency for FTPs, who would need to be evaluated in this manner prior to being integrated into the US healthcare system.

Chapter 4: Successful Completion of the USMLE Step 2

Successful completion of the USMLE Step 2 entails taking both the clinical knowledge portion (CK) and the clinical skills portion (CS) of the exam. The clinical knowledge portion is the online section of the exam that gives test takers various clinical cases revolving around the subjects, such as obstetrics and gynecology, internal medicine, pediatrics, and psychiatry. This section is taken in a day, over a nine-hour period, and that has eight sixty-minute sections. This

portion asks test takers to give either a diagnosis, prognosis, mechanism of the disease, or future and preventative care indications for a given scenario.

The CK test requires mastery of the English language and the ability to work well under timed circumstances, and of course the stamina to focus for all eight sections. This is often where many FTPs fail. The multiple-choice standardized test approach is not common in many foreign countries, where tests entail more short answers and verbal sections. Thus, it takes time for FTPs to get accustomed to the standardized test format, and to be able to read quickly and efficiently. Being able to develop one's skills to the level of this part of a nationwide exam takes time, which many FTPs don't have as newly arrived immigrants, often with families to support. Due to the barriers of this section and its cost ($610-630, NBME.org) many FTPs are shying from attempting the exam.

Rather than the CK part of the USMLE Step 2, the USMLE clinical skills (CS) section would be a more ideal assessment of language proficiency, medical knowledge, as well as the clinical skills of FTPs. The clinical skills exam has three subcomponents: spoken English proficiency, communication and interpersonal skills, and integrated clinical encounter (USMLE.org). This section simulates the kind of patient interaction that a resident would have. Tests takers have a set number of mock patients portrayed by actors, for an allotted time. Test takers are required to diagnose the patient, provide emotional support and education, as well as complete a note with each patient's history, examination, diagnosis, and treatment. This section, while difficult, tests the real-world application of medicine and is much more helpful in identifying whether a person is ready to treat patients. It's understandable why recently graduated medical students would have to take both parts of the USMLE Step 2, since they do not have any prior clinical experience. However, FTPs do, and while the clinical knowledge (Step 1) section tests the understanding of medicine, it does not simulate the real-world use of

that knowledge under pressure. Experience, alone, allows that to be solidified for a physician. For these reasons, the clinical skills portion of the exam, $1,285, would be a better exam to identify the capabilities of an FTP.

In studying for this exam, an FTP would fortify his or her medical knowledge, learn how the patient/physician relationship is in America, and be aware of the documentation process that is established in American healthcare. Upon successful completion of the USMLE Step 2 CS, the FTP would then be eligible to apply through the AAMC for a position in a rural or underserved location that is in need of that FTP's specialty. For example, many rural areas are in need of physicians in the primary care setting, yet there are also shortages of surgical and trauma specialists. This leads into the next portion of the program.

Chapter 5: Working in an Underserved Area

While all of America feels the lack of primary care physicians, rural areas are hit hardest of all. Many medical graduates are choosing to practice in metropolitan areas rather than rural locations. In fact, the more specialized a physician, the less likely that he or she will practice in a rural location. [33] A retrospective population-based study by Aboagye, Kaiser & Hayanga (2014), *found* significant differences in the amount of general surgeons in rural areas (4.82 physicians /100,000 people) compared to urban areas (8.48/100,000). Gastroenterology was another vastly disproportionate specialty, with 3.9 physicians per million population in rural areas and 25.5 per million population in urban areas ($p<0.001$ for both). Brining FTPs into rural areas would help create a constant influx of physicians for these underserved populations.

One of the main reasons that access to care in rural areas is so sparse is the lack of state funding for hospitals. Upon the implementation of the "Medicare Rural Hospital Flexibility Program" in 1997, states were allotted grants towards building their healthcare system. This program also permitted hospitals that met certain requirements of size and location to be

categorized as critical-care hospitals (CCHs). Critical-care hospitals are specialized to meet the needs of the community around them, not to provide every kind of physician or care. Critical-care hospitals are also limited in size and can have only up to 25 beds in order to meet Medicare's criteria. These hospitals are the ones that thrive in rural areas because they are allotted a 100% reimbursement for their services from Medicare. However, funding through the Medicare program is not sufficient to be able to fund salaries of medical specialists, and the number of physicians in CCHs is not sufficient to meet the demands of the population. Having an independent agency create programs with these hospitals to train FTPs and allow them to serve for a designated period of time for half the price of a nurse practitioner or physician assistant, would both help bring better access to care for rural communities and possibly increase the number of physicians who choose to stay in the area.

The proposed program (presented in this thesis) for FTP training would include working in these rural areas for a designated period of time, based on the specialty of the FTP. The payment of these FTPs would be through the federal government or through the hospital itself. Legislation must be implemented to establish a flow of funding into states that are in need of physicians, or through the allocation of Medicaid funds, specifically for this program. Since FTPs serving in the program would not be considered autonomous providers, they could receive the same salaries that current residents make (50-60,000). General family medicine practitioners and pediatricians would serve 3 years in these locations. Clinical specialties, such as allergy and immunology, cardiology, oncology, neurology, as well as general surgery; would serve 4 years. Specialized surgery specialties such as cardiothoracic, neurovascular, urogenital, and others; would serve 6 years. There are two reasons for these specific time frames, the first being that the residency time for primary care residencies is 3 years. Primary care residencies are those of pediatrics, family practice, and internal medicine. Specialties beyond that often require one to

two years of extra residency, thus leading to the 4-year policy for specialties outlined above as cardiology, oncology, neurology etc. Lastly, surgery specialties often require 7 years of residency, however since FTPs are already experienced physicians 6 years should be ample time to adapt to the American Health care system. The second reason for these time frames is that they allow the FTP and their family to become accustomed to life in the rural or underserved area. A shorter time frame would not be sufficient to develop the sort of connections that would motivate and FTP and their family to stay in a location after the completion of training. Upon completion of their time, physicians would be able to practice autonomously in America. However, since many FTPs have families, it can be predicted that they will stay in these rural locations since their families have established themselves during the long rural clerkship period.

Chapter 6: Will the FTPs Stay?

The U.S. Census Bureau's American Community Survey of 2010 noted a significant shift in the U.S. states where immigrants settled Prior to 2010, the majority of immigrants settled in states located along the northeastern coast of the United States (New York, New Jersey, Rhode Island, and Maine). Other major spots included Florida, with around 8% of the foreign-born population (FBP), and California, with 8.8% of the FBP. The Midwestern states, including Colorado, Nebraska, and Kansas; only had an average of about 1-2% of the FBP. However, after the survey was conducted, the percentages in the Midwest increased dramatically. Kansas went from having 1.2% to 6.5% of the FBP, and Colorado went from 2.7% to 9.8% (Census.gov). Thus, integration of FTPs into these areas would not only help serve the needs of the greater population in these health deserts but would also provide minorities in these areas with physicians who speak their language. or are part of their in-group. Increasing this physician-patient concordance is a point that will be discussed later in the paper.

A study by the American Immigration Council found that FTPs are more likely to serve and stay in rural and underserved areas than native-born physicians. In fact, the study stated that around 33% of FTPs practice in areas where about a third of the population is below the federal poverty line, and over half practice in areas where per capita income is 30,000 or less.[13] What may attract these FTPs to these areas is the autonomy that comes with being one of a handful of physicians in the area or the lack of debt that they have in comparison to native physicians, who on average have a debt of $243,000 for four years of medical school. In comparison, only about 9% of native physicians work in rural areas, since most complete residency and choose to move to more affluent areas, most likely to be able to pay off their acquired student debt.[33]

Chapter 7: Economic Benefits of FTP Recertification Program

Between 1990 and 2000, the immigrant population in the United States expanded by 58%. This equates to around 11 million. [25] The U.S. Census Bureau's American Community Survey of 2010 showed that within the legal immigrant population, a net of 68% of immigrants age 25 and older have a high school degree. Of those, 27% have a bachelor's degree or higher. Taking into consideration the growing immigrant population, that adds up to millions of educated immigrants whose knowledge and education is not being utilized properly. In fact, out of the whole population of immigrants in 2010, 69% were working in labor jobs, though only 32% qualify as unskilled (i.e. with less than a high school degree).

Immigration tends to be viewed in a negative light, and immigrants as well, since many Americans think of immigrants as uneducated. The issue, though, is that the American system makes it very difficult for immigrants to effectively integrate themselves into American society and to utilize their native countries' education. This resistance pushes educated immigrants to work in labor jobs in order to make ends meet and reduces the gains that America's economy could have from an influx of educated immigrants.

The establishment of this program for FTPs would help bring experienced medical professionals to rural areas for about half the cost of a physician assistant (average salary of $104, 760) or nurse practitioner (average salary of $106, 000), or about a quarter of the cost of an established American primary care physician (average salary of $195,000) (aafp.org). This program proposes for these FTPs to be paid the same rate as would a resident at the hospital of choice (average salary of $50,000). It is also plausible that with the establishment of such a program, as well as the reputation of the FTPs that come with it, patients may move closer to hospitals that foster the program or to private offices set up by FTPs. This would ultimately result in greater economic growth for the areas near these hospitals or FTPs.

Chapter 8: Social Benefits of FTP Recertification Program

In 1970, the American Association of Medical Colleges (AAMC) created a model called the Physician-Population Parity model. The purpose of this model was to promote the creation of a physician workforce that modeled the population of the United States. Efforts towards this model were inadequate and in the 1990s the AAMC initiated another project for a similar purpose. Based on the 2018 U.S. Census Bureau's population estimates, the United States population is comprised of 13.4% African Americans or Black, 5.8% Asians, and 18.1% Hispanic or Latino.[35] The current physician workforce is, however, only about 9.4% Hispanic or Latino, and 8.7% African American or Black.[34] From these numbers it is clear as to why the AAMC would pursue efforts to make those numbers align more. However, it is up to medical schools to accept a diverse class of students, without excluding any one race because of overrepresentation. Increasing the amount of FTPs in the healthcare sector would aid in achieving the goals that were set forth by the Physician-Population Parity model.

In addition, research has shown that when there is physician-patient concordance, in terms of race, ethnicity or culture, patients from minority groups are much more likely to comply

with treatments. [5] Language barriers are also something to take into consideration. While many medical students may be racially and ethnically diverse, they may not necessarily be bilingual and/or fluent in the language of their race or ethnicity. Thus, graduated medical students that complete residencies in areas where there exists a minority patient population, may not necessarily be able to help with this issue if they do not speak the population's native language. This is a real cause of concern because for Hispanic patients, specifically, research has found that if their physician does not speak Spanish, as well, they are more likely to omit information from their providers. [19] However, FTPs lived in their native country and are fluent in that language and with the culture. Having FTPs working in hospitals where there is a population of minorities would help improve the health outcomes of that population.

On the professional side, a paper by Chao, Kung, and Yao (2015) points out that working with a multicultural team fosters creativity and generativity. Furthermore, having FTPs working in hospitals in rural or underserved areas will allow for the transfer of medical knowledge between experienced providers. Unlike new residents, FTPs have years of experience in the medical field in their native countries and can offer novel ideas on how to treat patients that are different from those that are taught at American Medical schools. Since many FTPs come from developing countries, they have experience with identifying patient illnesses and treating them with limited resources. This ingenuity may be very beneficial to rural hospitals. In fact, a series study demonstrated that being immersed with multiple cultures was associated with people having unconventional ideas and fostering those of others. [27,28]. Cultural competence is also one of the more prominent topics in healthcare disputes, especially since the enactment of the Affordable Care Act (ACA) in 2010. The ACA called for introduction of cultural competence into the curriculum of healthcare professionals, as well as in the training of primary care providers. [4] The Liaison Committee for Medical Education has even implemented specific

requirements that U.S. medical schools must meet in cultural competence in order to achieve accreditation standards. With all of these efforts being made to improve the cultural competence of the primary-care providers work force, it makes sense that integrating FTPs into rural hospitals, where physicians who have been practicing and may not have had to take any courses in relation to cultural competence, would address the issue directly. There is no better way to become culturally competent than by having to work side by side with peers from other cultures, racial, or ethnic backgrounds. In fact, this has been shown in a study by Johnson, Leanortwicz & Apud (2006).

Lastly, since many rural areas of the United States still display large proportions of homogeneity, in terms of the population being mostly Caucasian, the introduction of well-educated immigrants into these communities could aid in changing these population's views of immigrants. The physician-patient relationship is a very vulnerable one that requires reciprocity of trust: The patient must trust the provider's judgment and the provider must trust the patient to follow their treatment plans. The vulnerability of a patient seeking aid would provide a unique environment for discourse between a Caucasian patient and a foreign-trained physician. The development of a relationship between these two, in this setting, is ideal for fostering bilateral acceptance of each group. Adoption of multicultural views in these homogenous areas of America would enable multiculturalism to flourish in a pluralist society. Research shows that the formation of links between different cultures, races, or ethnicities promotes feelings of security of one's own culture being accepted and increased openness to that of others. [6]

Conclusion

America in the twenty-first century is a country filled with diversity of thought and culture, bound with a coherent sense of patriotism and pride. However, today Americans face

uncertainty in their access to modern high-quality healthcare. In addition, in recent years heterogeneity has risen in American society, and in and out group stances are being taken. This country has the potential to set the standard of both healthcare and unification in the world. The program proposed in this thesis offers a unique perspective on actions that both private industries and the American government can take to address both of these issues simultaneously, while at the same time benefiting the economy. The fact of the matter is that America is a nation comprised of immigrants, and constantly accepting more. Without thoughtful consideration into how to open paths for these citizens to utilize their full potential for the improvement of American society, we effectively choose to remain stagnant. A linear reintegration of foreign trained physicians into American healthcare will serve to increase the amount of proficient healthcare providers in the nation, improve accessibility to quality care across the whole nation, promote multiculturalism in rural settings, and provide the opportunity for a whole subset of the population to utilize their education to make the largest impact. It's a simple solution. The steps are clear. It is now up to us to start the spark.

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