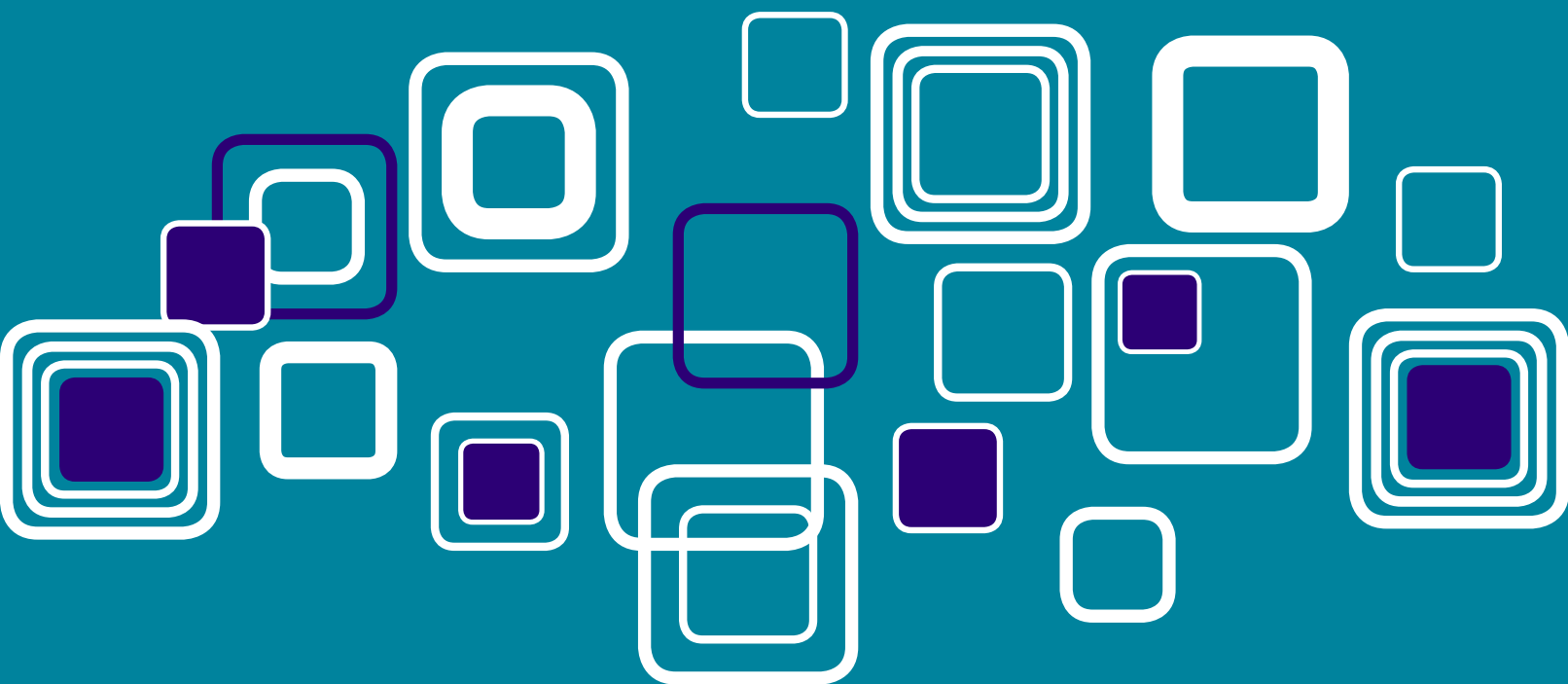


# CREDENTIAL RECOGNITION IN THE UNITED STATES FOR FOREIGN PROFESSIONALS

By Linda Rabben



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Linda Rabben

May 2013



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## Executive Summary

Foreign-trained professionals in the United States often encounter significant obstacles on the path to professional practice. Immigrants and refugees must not only acquire appropriate professional language proficiency, navigate differences in workplace culture and recruiting practices, and find ways to demonstrate the value of work experience and qualifications to local employers. In many occupations, they must also be formally recertified before they can legally practice their profession.

Because of the United States' decentralized federal system, no single structure governs professional certification in regulated occupations. A profusion of overlapping, sometimes contradictory, local, state, or national rules, procedures, and examinations makes it complicated, time-consuming, and expensive for immigrants and refugees to become recertified in the United States. The vast patchwork of organizations involved in the credential-recognition process — from professional associations and state or federal regulatory bodies to credential assessment services and private- or public-sector employers — requires considerable effort to understand and work with.

Some immigrants find it difficult to demonstrate the equivalence of formal academic qualifications, for example, because they cannot obtain the necessary documentation from a conflict-torn country of origin. However, gaining recognition for professional experience overseas is arguably the greatest barrier to professional practice. Employers frequently discount the value of overseas experience, and regulatory bodies often do not count it toward professional certification requirements. This means that experienced professionals may be required to return to entry-level positions to demonstrate their competence.

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Barriers to professional practice are particularly daunting in the medical profession. US physicians undertake a long, expensive, and highly structured training program before becoming fully licensed. Foreign-trained medical professionals must validate foreign academic training, prepare for and pass medical licensing examinations, and learn a new system of treatment methods and protocols, vocabulary, professional ethics, and workplace structures. Beyond that, they must generally complete a three- to eight-year residency, even if they had progressed well beyond this stage in their career abroad. For those able to take this step, the number of federally funded residencies is strictly limited; foreign professionals often face particular difficulties in navigating the residency application process.

In contrast to medical recertification, retraining in the United States is somewhat simpler for professionals in less heavily regulated fields, such as engineering. Foreign-trained engineers can work without professional licensing, even if it improves a candidate's résumé. As a result, the primary difficulty for many such workers is finding employers who recognize their foreign training and experience. To overcome this barrier, immigrants are often advised to apply for lower-level positions in the hope of gaining more skilled work over time.

Only limited assistance is available to immigrants navigating the complex processes of recertification and finding professional employment in fields such as medicine and engineering. A number of private, public, and nonprofit programs have sprung up in the past decade, but all face the problems of small scale



and limited resources. The complexity of recertification procedures, coupled with the need to provide tailored, occupation-specific assistance, makes these efforts resource-intensive and limits the number of individuals they can help at current levels of funding. Meanwhile, huge pressure on state budgets limits their ability to bolster such programs.

Slow progress in breaking down the barriers to professional practice exacts both economic and social costs, as immigrants waste valuable skills and face earning constraints. In health care, concerns about intensifying physician shortages following the enactment of recent reforms (and in the context of limited domestic training capacity) make this waste of human capital all the more troubling. Progress in addressing this complex problem will require cooperation and coalition building among a range of stakeholders to simplify recertification processes, as well as long-term investments in a more comprehensive system of support for immigrant and refugee professionals.

## I. Introduction: The US “System” of Recertification

When foreign-trained professionals migrate to the United States, they often encounter significant obstacles on the path to professional practice. Although labor-market regulation is weaker in the United States than in other industrialized countries, an estimated 20 to 30 percent of US jobs require licensure or certification.<sup>1</sup> Because the US federal system is so decentralized, no single structure or system governs professional certification in regulated occupations. A profusion of overlapping, sometimes contradictory, local, state, or national rules, laws, procedures, and examinations makes it time-consuming and expensive for immigrants, refugees, and asylum seekers to integrate into US professions.

Many professions and occupations are licensed by the state, but not by the federal government. Every state has its own rules, regulations, and fees. State professional licenses often are not transferable to other states. Credential recognition, certification, and licensing procedures differ widely, depending on the profession. In addition to academic preparation, states often require professionals to serve internships, residencies, or apprenticeships or to obtain practical experience. Federal or federally subsidized programs, such as the Medical Residency Match Program, also present special challenges for foreign professionals, whose qualifications and experience may not be recognized.

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Professional associations and accreditation bodies play daunting gatekeeper roles in this complex system. Professional associations usually help map the path to professional certification. The state establishes professional licensing and oversight boards, but associations may control and administer the operations of these boards. Specialized, accredited educational institutions provide training and certify professional qualifications. These institutions may be private; but they, too, operate under state control and often

1 See Morris Kleiner and Alan Krueger, “The Prevalence and Effects of Occupational Licensing” (NBER working paper 14308), [www.nber.org/papers/w14308](http://www.nber.org/papers/w14308); and Morris Kleiner, *Licensing Occupations: Ensuring Quality or Restricting Competition* (Kalamazoo, MI: Upjohn Institute for Employment Research, 2006).



receive public funds, directly or indirectly. Credential assessment services, which provide certificates “translating” foreign qualifications into their US equivalents, may be private or public, nonprofit or for-profit. Unions may offer apprenticeships or special training programs. This vast patchwork of poorly articulated organizations requires considerable effort to understand and work with. Foreign-trained professionals may require years of special help to navigate this cumbersome system. As a result, many foreign-trained professionals who want to practice in the United States do not manage to attain their goal.<sup>2</sup>

Foreign-trained professionals are often advised to practice “career laddering:” progressing toward professional certification by retraining while working in a lower-level position. Countries including Canada, the United Kingdom, and Afghanistan have established special programs, such as mentoring, vocational English for Speakers of Other Languages (ESOL), and continuing education, to help these professionals integrate into their respective fields. It is difficult to find such programs in the United States.

This report examines barriers to recertification for foreign-trained professionals in the United States, focusing on two industries: health care, in which formal and informal barriers are highest, and engineering, in which there are few regulatory obstacles but informal barriers remain significant.

## II. Barriers to Recertification: The Health Care Sector

### A. Background

Health-related public and private institutions employ some 15 million workers in hundreds of occupations and professions in the United States.<sup>3</sup> Requirements for certification vary considerably among these occupations. Over time professional bodies have sought to standardize entry requirements and to control access to licensure, resulting in a long history of high barriers to practice, especially for foreigners.

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2 The US government does not publish data on the number of physicians, engineers, or other professionals who enter the United States each year as refugees, asylum seekers, or immigrants. The State Department and the Department of Homeland Security do collect statistics on refugees’ self-reported educational levels. Such data do not reveal whether a refugee who identifies himself or herself as a physician or an engineer with a bachelor’s or advanced degree has qualified to practice or has practiced his or her profession. From interviews with refugee and immigrant professionals, resettlement agency personnel, immigration advocates, and state and federal officials, it is clear that a substantial number of physicians have entered the United States in recent years. With the arrival of skilled refugees from Iraq since the mid-2000s, as well as continued inflows of family immigrants from countries ranging from Mexico to Cameroon to Iran, it seems plausible that thousands of immigrant and refugee physicians may have entered the United States in recent years.

3 Christine Brown-Mahoney, Mary A. Pittman, and Amy N. Nuttbrock, *United States Mobility of Health Professionals* (Oakland, CA: Public Health Institute, 2012): 10, [www.mohprof.eu/LIVE/DATA/National\\_reports/national\\_report\\_USA.pdf](http://www.mohprof.eu/LIVE/DATA/National_reports/national_report_USA.pdf).



With passage of the *Affordable Care Act* (ACA) in 2010, the sector is expanding to accommodate up to 30 million new customers who will gain increased access to medical insurance coverage and treatment. That means thousands of new physicians, dentists, nurses, analysts, researchers, technicians, educators, and administrative personnel may be needed in the coming years to provide patient care and services.

Starting around 1980, the US medical profession projected a surplus of physicians by 2000. Admission to medical school became more difficult, and new medical schools were not constructed or opened during that 20-year period. Many foreign applicants were denied entry to US medical schools, and increasing numbers of US students went abroad to study. Meanwhile, physicians have flocked to specialties that pay better than primary care positions but for which more preparation time is required. These trends prompted widespread concerns about shortages of primary care physicians, general surgeons and other health care professionals, especially among certain underserved populations. Further, because the training period has extended considerably, it is becoming more difficult to address such shortages.<sup>4</sup>

As these shifts have transformed the US medical profession, the number of International Medical Graduates (IMGs) coming to the United States has increased. Today, more than 25 percent of physicians practicing in the United States are foreign trained.<sup>5</sup> Many are working as primary care providers, pediatricians, family physicians, and specialists, filling some — but by no means all — of the gaps in underserved areas.

## **B. Medical Training in the United States**

Since the 1950s, foreign-trained professionals have had to take special examinations or present special credentials to qualify to practice medicine, nursing, dentistry, and other health care professions in the United States. A large industry has developed to evaluate, test, and certify these professionals. In some professions, such as medicine, professional bodies control credential evaluation; in others, private, nonprofit, or for-profit agencies provide evaluation or testing services.

For technical occupations such as phlebotomist or sonographer, training and certification are relatively quick, ranging from six months to two years. Intermediate-range professions, such as physical therapist, require bachelor's (and increasingly master's) degrees. Licensure requirements for these occupations and professions vary by state. Qualifications for some professions, such as pharmacist or nurse practitioner, have been upgraded in recent years. Pharmacists now must obtain a PharmD (doctoral) degree, and nurse practitioners must have at least a master's degree. Foreign-trained pharmacists, nurses, and physicians may try career-laddering, starting out as technicians or assistants and working for years to acquire the necessary credentials and state licensure in their original profession. A sizable number of foreign-trained health care professionals, however, never manage to requalify in the United States; the exact number is not known.

Training for many health care professions is prolonged, expensive, and complex, and the sector is too large to be very agile in coping with change.<sup>6</sup> Unlike in many other countries, medical training in the United States takes place mostly at the postgraduate level. Students spend four years completing a bachelor's degree in another subject — usually in one of the sciences — before beginning medical school, which lasts another four years.<sup>7</sup> Medical school graduates then spend three to eight years as residents,

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4 George F. Sheldon, "Globalization and the Health Workforce Shortage," *Surgery* 140 no. 3 (2006): 354-58; Darrell G. Kirch and Edward Salsberg, "The Physician Workforce Challenge: Response of the Academic Community," *Annals of Surgery* 246 no. 4 (2007): 535-40.

5 Fitzhugh Mullan, "The Metrics of the Physician Brain Drain," *New England Journal of Medicine* 353 (17) (2005): 1810-18; Brown-Mahoney et al., *United States Mobility of Health Professionals*. According to the Educational Commission on Foreign Medical Graduates (ECFMG), about one-quarter of international medical graduates (IMGs) are US citizens who went to medical school abroad.

6 Patrick C. Alguire, Gerald P. Whelan, and Vijay Rajput, *Guide to US Medicine and Residency Training* (Philadelphia, PA: American College of Physicians, 2009).

7 A few medical schools in the United States and Canada have established a three-year course of study; Scott Jaschik, "The





acquiring clinical experience in primary care or one or more specialties. By the time they become fully licensed by the state, physicians may be in their mid- to late 30s.

The length and complexity of US medical training create special barriers for experienced health care professionals trained abroad. To obtain state licensure, physicians must take a series of US Medical Licensing Examinations (USMLEs) in medical sciences, clinical sciences, and care delivery. Exam fees range from \$500 to \$1,100 each, and applicants who fail any one of the exams must pay to take it again. Because of language and other difficulties, foreign-trained physicians have a significantly lower pass rate than US-trained medical doctors.<sup>8</sup>

To take the exams, IMGs must register with the Educational Commission on Foreign Medical Graduates (ECFMG), an independent, nonprofit credentialing body. To apply for a residency, IMGs must be certified by ECFMG. Certification is partly based on verification of transcripts and diplomas of graduates of foreign schools listed in the International Medical Education Directory, compiled by its affiliate the Foundation for the Advancement of Medical Education and Research. Certification may be impossible or delayed if

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ECFMG has trouble obtaining the required documentation from the foreign medical school. According to one Iraqi physician, after successive deans of his medical school were assassinated in the mid-2000s, ECFMG refused to recognize the signature of the then-current dean until it obtained official notification of his appointment, by which time he too had been killed.<sup>9</sup>

It is difficult to estimate how long ECFMG might take to receive and process an IMG's educational credentials. An ECFMG official said verification of credentials could take "hours to never," depending on both the home school's cooperation and on country conditions.<sup>10</sup> Once registered with ECFMG, IMGs have up to seven years to pass the licensing examinations. IMGs receive certification after ECFMG has approved their credentials and they have passed the first two steps of the exams. The average time between graduation from a foreign medical school and certification is four years.<sup>11</sup> For immigrant and refugee physicians it can take significantly longer.

In 2010, ECFMG announced that international accreditation standards for medical schools around the world would become effective by 2023.<sup>12</sup> It is too early to predict the effects of this sea change. In the meantime, improved electronic communications and procedures will probably increase the ease and

3-Year M.D.," *Inside Higher Ed*, March 25, 2012, [www.insidehighered.com/news/2010/03/25/threeyear](http://www.insidehighered.com/news/2010/03/25/threeyear).

8 ECFMG, *2011 Annual Report* (Philadelphia, PA: ECFMG 2012): 17, [www.ecfm.org/resources/ECFMG-2011-annual-report.pdf](http://www.ecfm.org/resources/ECFMG-2011-annual-report.pdf).

9 Confidential telephone interview of Iraqi physician with the author, 2010.

10 The Cuban government forbids its medical schools to provide transcripts and diplomas of asylum-seeking Cuban physicians to ECFMG. As a result ECFMG has instituted alternative credential-verification procedures for them; author telephone interview with William Kelly, Associate Vice President for Operations, ECFMG, May 18, 2012.

11 ECFMG, *2011 Annual Report*.

12 According to the ECFMG website, by 2023 "physicians applying for ECFMG Certification will be required to graduate from a medical school that has been appropriately accredited. To satisfy this requirement, the physician's medical school must be accredited through a formal process that uses criteria comparable to those established for U.S. medical schools by the Liaison Committee on Medical Education or that uses other globally accepted criteria, such as those put forth by the *World Federation for Medical Education*. ECFMG's Board believes that this additional requirement for ECFMG Certification, and the timing of its implementation, will stimulate the development of a meaningful, universally accepted system of accreditation for undergraduate medical education outside the United States and Canada." See ECFMG, "About ECFMG," last updated July 5, 2012, [www.ecfm.org/about/initiatives-accreditation-requirement.html](http://www.ecfm.org/about/initiatives-accreditation-requirement.html).



speed of ECFMG certification well before such standards are implemented.

ECFMG tries to provide special assistance to applicants for J-1 visas and other residency applicants through the IMG Advisers Network, which puts foreign-trained physicians in contact with volunteer mentors. ECFMG's Applicant Information Service "provides answers to specific questions about ECFMG Certification and related topics."<sup>13</sup> Some refugee or immigrant IMGs already in the United States and seeking credential verification have found it hard to obtain much help or information about their applications, however.<sup>14</sup> The process may be especially difficult for applicants who have limited English proficiency or are unfamiliar with American ways. Language and cultural factors are important obstacles for foreign-born physicians. IMGs must not only refresh their mastery of medical knowledge to pass qualifying exams; they must also learn a whole new system of medical practice, treatment methods and protocols, medical vocabulary, medical social organization, professional ethics, technology, and changing structures (such as new models of care, the private medical insurance system, malpractice insurance, and Medicare and Medicaid).<sup>15</sup>

Refugee physicians may have to cope with severe practical and emotional problems in exile. They may have fled extreme violence and persecution, only to find that their existence in the United States is precarious and their future uncertain. They arrive in debt for their transportation from the home country, sometimes with unrealistic expectations of the help they will receive. After six to eight months, they are no longer eligible for financial assistance from resettlement agencies. Finding work of any kind is difficult. Some face eviction when they cannot pay rent. Some suffer from post-traumatic stress or other serious health problems. ESOL courses may be unavailable or inadequate. Finding time and energy to study for and take licensing exams or to apply for residencies may seem impossible under such conditions.

The greatest barrier to recertification of foreign-born and foreign-trained physicians is the Graduate Medical Education system ("residency") itself. The American College of Physicians' *Guide to US Medicine and Residency Training* devotes some 50 pages to the daunting and costly GME application process, which takes at least a year.<sup>16</sup>

Annual competition for almost 27,000 residency positions is fierce and includes not only US- and foreign-trained, native-born physicians, but also immigrants, refugees, and J-1 and H-1B visa holders. A number of studies have found that native-born physicians with US medical degrees receive preferential treatment over IMGs in the residency match.<sup>17</sup> Recently arrived IMGs may be unable to present current professional references; write an effective personal statement in English; afford fees for externships, observerships, malpractice insurance, or travel to residency sites; or respond effectively to interview questions. On the other hand, hospitals may recruit recently graduated, foreign-born physicians with excellent academic records from outside the United States for certain residency programs.

The US Congress, which funds the residency system through state Medicare programs, has refused to increase the number of residencies. Some analysts insist, however, that there is no absolute shortage of residencies, but rather a misallocation of residencies among geographic regions and underserved areas, and between primary care and specialties. East and West Coast teaching hospitals, which predominate, tend to recruit specialists. As a result, medical graduates feel discouraged from training to be primary

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13 Alguire et al., *Guide to US Medicine and Residency Training*, 12.

14 Author interviews with IMGs, 2009-11. The interviews were conducted by the author as coordinator of the Refugee Professional Recertification Project of RefugeeWorks from 2008-10; as an independent consultant in 2011; and as part of a project under the auspices of the Iraqi Medical Sciences Association in 2011. Interviews on file with author.

15 About half the American College of Physicians' 230-page IMG guide is devoted to language and communication, American medical culture, patient care, the American medical system, and American popular culture. See also Peggy Guey-Chi Chen, Leslie Ann Curry, Susannah May Bernheim, David Berg, Aysegul Gozu, and Marcella Nunez-Smith, "Professional Challenges of Non-US-Born International Medical Graduates and Recommendations for Support during Residency Training," *Academic Medicine* 86 (2011): 1383-88.

16 Alguire et al., *Guide to US Medicine and Residency Training*.

17 See Norman A. Desbiens and Humberto J. Vidaillet Jr., "Discrimination against international medical graduates in the United States residency program selection process," *BMC Medical Education* (2010): 5 for an analysis of studies of Match application and selection processes.



care providers. Fewer such residencies are filled, and the pay for primary care providers is lower than for specialists. These realities reinforce the shortage of primary care providers in the United States.<sup>18</sup> In recent years IMGs have partially filled the gap, taking primary care positions in increasing numbers.

### C. Coming to the United States as a Nonimmigrant Physician

Since 1974, ECFMG has sponsored exchange visitor physicians for the US State Department. Exchange visitors come to the United States on temporary J-1 physician visas to enroll in GME or other clinical training programs. ECFMG sponsored 7,546 J-1 physicians during the 2010-11 academic year, plus 275 who sat for specialty board exams and 41 who conducted research.<sup>19</sup> These physicians came (in descending order) from India, Canada, Pakistan, Lebanon, the Philippines, Jordan, Syria, Peru, Nepal, and Thailand to train in internal medicine, pediatrics, family medicine, and other specialties in a number of states in particular — chief among them New York, Michigan, Texas, Massachusetts, Illinois, Ohio, Pennsylvania, New Jersey, Florida, and Maryland. J-1 physicians are expected to return to their home country for two years after completing their training, but their stay may be extended (with State Department approval) under certain circumstances.<sup>20</sup>

The Conrad 30 waiver program allows a J-1 physician to remain in the United States after he or she finishes training here to practice medicine in underserved areas for at least three years. The waiver is linked to a specific workplace and employer. At the end of service, the physician may apply for another temporary or permanent visa. Each state may recruit 30 J-1 physicians per year.<sup>21</sup>

Employers may apply to bring foreign physicians to the United States on H-1B visas — temporary work permits for workers in professional occupations. To qualify for the visa, physicians must “hold an unrestricted state license, registration or certification which authorizes [them] to fully practice the specialty occupation and be engaged in that specialty in the state of intended employment.”<sup>22</sup> That is, they must already have completed all training and be fully licensed in the United States. In 2011 about 8,600 physicians and surgeons received H-1B visas, in addition to over 9,000 other workers in health care occupations.<sup>23</sup>

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18 Testimony of David C. Goodman, Director, Center for Health Policy Research, the Dartmouth Institute for Health Policy and Clinical Practice, before the US Senate Committee on Finance, *Linking Workforce Policy to Health Care Reform*, 111<sup>th</sup> Cong., 1<sup>st</sup> sess., March 12, 2009, [www.finance.senate.gov/imo/media/doc/031209dgtest.pdf](http://www.finance.senate.gov/imo/media/doc/031209dgtest.pdf); Richard E. Reiselbach, Bryon J. Crouse, and John G. Frohna, “Teaching Primary Care in Community Health Centers: Addressing the Workforce Crisis for the Underserved,” *Annals of Internal Medicine* 152 (2010): 118-22.

19 ECFMG, *2011 Annual Report*: 27-29.

20 Ibid.

21 In 2006 some 1,000 waivers were granted to J-1 physicians practicing in underserved areas; Brown-Mahoney et al., *United States Mobility of Health Professionals*, 97.

22 US Citizenship and Immigration Services (USCIS), “H-1B Specialty Occupations, DOD Cooperative Research and Development Projects, and Fashion Models,” accessed December 7, 2012, [www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b-9ac89243c6a7543f6d1a/?vgnnextoid=73566811264a3210VgnVCM100000b92ca60aRCRD&vgnnextchannel=73566811264a3210VgnVCM100000b92ca60aRCRD](http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b-9ac89243c6a7543f6d1a/?vgnnextoid=73566811264a3210VgnVCM100000b92ca60aRCRD&vgnnextchannel=73566811264a3210VgnVCM100000b92ca60aRCRD).

23 USCIS, *Characteristics of H-1B Specialty Occupation Workers, Fiscal Year 2011 Annual Report to Congress* (Washington DC: USCIS, 2012), [www.uscis.gov/USCIS/Resources/Reports%20and%20Studies/H-1B/h1b-fy-11-characteristics.pdf](http://www.uscis.gov/USCIS/Resources/Reports%20and%20Studies/H-1B/h1b-fy-11-characteristics.pdf).



#### D. *Initiatives to Support Retraining*

Despite strong demand for qualified health professionals, including those coming from abroad on temporary visas, a significant number of immigrant and refugee physicians already in the United States confront sizable obstacles to recertification and licensure. This paradoxical situation leads to “brain waste” of valuable human resources.<sup>24</sup> Given the opportunity, these physicians could address shortages of primary care providers, improve treatment outcomes for minorities and the poor, replace retiring physicians, and diversify the medical profession. In recent years professional bodies such as the Council on Graduate Medical Education (COGME), the American Medical Association (AMA), and the American College of Physicians (ACP) have acknowledged that something must be done to confront these problems; still, programs to address them remain rare.<sup>25</sup>

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*A number of private, public, and nonprofit programs have sprung up in the past decade to assist immigrant and refugee health professionals.*

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For the most part professional associations, state medical boards, and ECFMG have not focused on the thousands of foreign-trained medical professionals already in the United States who are struggling to contribute their skills to US society. In 2010, however, the AMA responded to a resolution introduced by Med Chi, the Maryland medical society, calling for recognition of the situation of refugee physicians. The AMA’s board of trustees issued a report that recommended that the organization “support federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographic areas” — a small but significant step.<sup>26</sup>

A number of private, public, and nonprofit programs have sprung up in the past decade to assist immigrant and refugee health professionals (see Box 1). What almost all of them have in common is their small scale. Because of severely limited resources, they cannot address the magnitude of shortages of health care providers in the short term. They are training or assisting dozens of qualified health professionals at a time when the expanding health care sector is seeking thousands of new workers, and thousands of foreign-trained professionals are struggling to find opportunities.

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24 Jeanne Batalova, Michael Fix, and Peter Creticos, *Uneven Progress: The Employment Pathways of Skilled Immigrants in the United States* (Washington, DC: Migration Policy Institute, 2009), [www.migrationpolicy.org/pubs/BrainWasteOct08.pdf](http://www.migrationpolicy.org/pubs/BrainWasteOct08.pdf).

25 See Council on Graduate Medical Education (COGME), *Twentieth Report: Advancing Primary Care* (Rockville, MD: COGME, 2010), [www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf](http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf); American Medical Association (AMA), American Medical Association (AMA), *Report of the Board of Trustees, 20-A-10, Retraining Refugee Physicians* (Chicago, IL: AMA, 2010), [www.ama-assn.org/resources/doc/hod/a-10-bot-reports.pdf](http://www.ama-assn.org/resources/doc/hod/a-10-bot-reports.pdf); and M. Renee Zerehi, “The Role of International Medical Graduates in the U.S. Physician Workforce” (Policy monograph, American College of Physicians, Philadelphia, 2008), [www.acponline.org/advocacy/where\\_we\\_stand/policy/img\\_paper.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/img_paper.pdf).

26 AMA, *Report of the Board of Trustees*.



### Box 1. Programs Supporting Foreign-Trained Health Professionals in the United States

The comprehensive IMG Program of the UCLA Medical School offers two to three years of medical instruction, USMLE preparation, ESOL courses, clinical observership, and match counseling to Latin American physicians who are US citizens or lawful permanent residents. The program's purpose is to train bilingual, bicultural, Spanish-speaking physicians who will practice medicine for two to three years in underserved, predominantly Hispanic, rural and urban areas in California after completing family medicine residencies in the state. The program is privately funded; it provides stipends to the students; pays for students to attend Kaplan's USMLE preparatory courses; collaborates with a local community college to provide ESOL courses; and has produced 43 family medicine residents since 2006, 24 of whom have started residencies since 2009. The program is limited to Spanish-speaking California residents. Likely the only such program in the United States, it could provide a model for future initiatives in other states.\*

The Welcome Back Initiative (WBI), which started in San Francisco in 2001, provides retraining for immigrant health professionals. Nine Welcome Back Centers around the country "provide orientation, educational counseling and support to internationally trained health professionals. ... In the process of receiving support in obtaining the appropriate professional credentials and licenses for their health professions, Welcome Back participants are also presented with other viable options or alternatives to consider."\*\* Welcome Back Centers now operate in San Francisco; San Diego; Boston; Providence, RI; Puget Sound, WA; suburban Maryland; Alamo Area, TX; New York City; and Denver. Free services include an intake interview; assessment; educational case management; courses and workshops, including English for Health Professionals and Introduction to the US Health Care System; job fairs; exam preparation resources; networking opportunities; and mentoring. The Welcome Back Centers collaborate with community colleges, state agencies, and nonprofit organizations. They receive public and private funding and are the only such initiatives operating on a wide, interstate scale.

Upwardly Global describes itself as "a national nonprofit organization that helps work-authorized, skilled immigrants rebuild their professional careers in the U.S." Its free services include a pretraining meeting, jobseeker training, and post-training coaching, including introductions to Upwardly Global's employer network. Privately funded and partnered with employers and nonprofit partners, Upwardly Global has offices in San Francisco, Chicago, and New York. It plans to expand to three more metropolitan areas by 2015.

Several Area Health Education Centers (AHECs) — federally subsidized agencies around the country — are engaged in helping foreign health professionals navigate the complexities of recertification. The Central Louisiana AHEC collaborates with the Louisiana Hospital Association and the Louisiana Primary Care Association to help IMGs. The Central AHEC of Hartford, Connecticut, has set up an International Health Professionals Bridge program that provides services to refugees and immigrants.\*\*

\* UCLA IMG Program, "Welcome," [http://fm.mednet.ucla.edu/IMG/img\\_program.asp](http://fm.mednet.ucla.edu/IMG/img_program.asp).

\*\* Welcome Back Initiative, "Description of Services," <http://welcomebackinitiative.org/wb/participant/description.html>.

\* Upwardly Global website, "For Job Seekers," [www.upwardlyglobal.org/job-seekers-for-jobseekers](http://www.upwardlyglobal.org/job-seekers-for-jobseekers). Upwardly Global and the Welcome Back Initiative are past recipients of the Migration Policy Institute's *E Pluribus Unum Prize* recognizing exceptional immigrant integration initiatives.

\*\* Linda Rabben, "How AHECs Can Help Refugee and Immigrant Health Professionals," *Journal of the National AHEC Organization* 27 (2011): 10-2.



### III. Barriers to Recertification: Engineering

#### Background

Retraining and credentialing of foreign engineers differ greatly from processes in the health care sector. Usually engineers have a bachelor's degree, although research positions may require graduate training. Most degrees are in electrical, electronic, mechanical, or civil engineering, but graduate engineers often work outside the field in which they trained. Universities and community colleges also offer engineering technology (ET) degrees, and graduates are considered to be midway between technicians and engineers. Those with advanced degrees — MSc, MEng, or PhD — may work on more theoretical problems in an office or laboratory, while BSc graduates tend to work on applied or practical problems. Engineers with doctorates also teach at universities and community colleges.

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*Immigrants are heavily represented in US engineering occupations, making up about one-quarter of the engineering workforce.*

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Many engineers in the United States are not licensed by any state.<sup>27</sup> However, employers often encourage or expect them to take the Principles and Practicing of Engineering (PE) exam administered by the National Council of Examiners for Engineering and Surveying (NCEES). An engineer must have a PE to stamp and seal designs, bid for government contracts, own an engineering firm, perform consulting services, advertise services to the public, or testify as an expert witness. To obtain a PE the engineer must earn a bachelor's or master's degree from an accredited engineering program; pass the Fundamentals of Engineering (FE) exam, usually as a student; gain four years' professional experience, often under a PE's supervision; and pass the PE exam. The NCEES evaluates and certifies educational credentials of foreign-trained engineers and passes the results to state licensing boards as part of the PE process. The exam is offered in several foreign countries, including Canada, Egypt, Japan, Saudi Arabia, South Korea, and Turkey. Those who pass the exam may be more likely to find employment in the United States.

Immigrants are heavily represented in US engineering occupations, making up about one-quarter of the engineering workforce.<sup>28</sup> Many are trained in the United States and thus have qualifications that US employers can recognize easily: international students earn almost three-fifths of all engineering doctoral degrees granted in the country and have accounted for most of the growth in doctoral graduations in the field.<sup>29</sup> Tens of thousands of engineers holding H-1B visas have entered the US labor market over the past decade, including graduates of US schools and foreign-trained workers coming directly from abroad. Immigrants now make up about one-third of computer hardware and software engineers and one-quarter of electrical engineers.<sup>30</sup>

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27 Musselman (2010) estimates that about 20 percent of those who have graduated from engineering programs in the United States are licensed as professional engineers; of the remaining 80 percent, some are working unlicensed as engineers, while some leave engineering entirely and work in other fields. Craig Musselman, "The 80 Percent Myth in the Engineering Profession," National Society of Professional Engineers, September 13, 2010, <http://community.nspe.org/blogs/licensing/archive/2010/09/13/the-80-myth-in-the-engineering-profession.aspx>.

28 US Census Bureau, American Community Survey (ACS) 2009-10.

29 National Science Foundation (NSF), *Science and Engineering Indicators 2012* (Arlington, VA: NSF), [www.nsf.gov/statistics/seind12/](http://www.nsf.gov/statistics/seind12/).

30 Migration Policy Institute (MPI) calculations from ACS 2009-10.



Despite high demand for foreign engineers, some immigrants already in the country — particularly refugees — have had difficulty entering the labor market. Current labor-market prospects in engineering are much better than in many other occupations, but workers with bachelor's degrees in engineering have lower incomes and are more likely to be unemployed if they are immigrants (6 percent in 2009-10, compared with 4.4 percent for the US born).<sup>31</sup>

Multilateral initiatives to improve the ease with which educational credentials can be recognized are more developed in engineering than in other fields. In 1989, the United Kingdom, Ireland, the United States, Canada, Australia, and New Zealand signed the Washington Accord Agreement on Engineering. Under the agreement, regulatory bodies responsible for professional registration recognize accredited engineering programs from other signatory countries as equivalent to their own, without requiring detailed scrutiny of curricula or retraining.<sup>32</sup> Since the mid-1990s, Hong Kong, South Africa, Japan, Singapore, Taiwan, Korea, Malaysia, and Turkey have joined the agreement. India, Pakistan, Bangladesh, Sri Lanka, Germany, and Russia have attained provisional status.

There is little evidence whether such agreements enhance immigrants' job prospects. A major limiting factor is the relatively small number of countries to which the agreement currently applies. Moreover, foreign-trained engineers can work without having the PE designation, even if it improves their chances of being hired. Unlike in the medical

### Box 2. Programs Supporting Foreign-Trained Engineers in the United States

In collaboration with New York's Cooper Union, the Bnai Zion Foundation's Retraining Program for Immigrant Engineers provides free professional courses and job placement assistance to foreign engineers who have been in the United States for less than three years, many of whom are impoverished and unemployed. To qualify for the program, they must have professional experience in their home country, permanent resident status, and work authorization.

The Bnai Zion program started in 1987 to help immigrant engineers from the former Soviet Union. Nowadays the students come from Africa, Latin America, and Asia as well as Russia. They take continuing education courses for two semesters and receive counseling from job developers who follow their progress over a three-year period. In the spring 2012 semester, 126 students were taking evening and weekend courses ranging from chromatography to structural analysis. The program does not offer PE exam preparation, although the courses may cover PE exam material. About 200 people a year receive assistance from the job developers. Since its inception, the program has taught some 3,800 students and placed more than 2,000 in jobs.

The Refugee Recertification Program (RRP) of Lutheran Social Services of the National Capital Area (LSS-NCA) assists engineers and other "highly skilled refugees and asylees who hold a bachelor's degree or higher from outside the US . . . by translating credentials, providing specialized advice and financial assistance."<sup>33</sup> Clients who obtain recertification are then enrolled in another LSS program that helps them find jobs in their profession. RRP provides referrals and modest financial assistance for credential evaluation, study materials, vocational English courses, and exam fees, but no training. Thirty-three professionals were enrolled in the first cohort, which included engineers, accountants, teachers, IT specialists, lawyers, nurses, a radiology technician, and a teacher. Because of the complexity, expense, and length of the medical licensure process, RRP cannot help refugee physicians achieve recertification.

Applicants to the program must have lived in the United States for more than eight months and less than five years, and have at least a bachelor's degree, work experience in their field, and strong English proficiency, including reading and writing abilities. LSS-NCA hopes to expand the RRP to serve 80 professionals, and is seeking to diversify its funding to ensure sustainability.

<sup>33</sup> Author interview with Elizabeth Frank of Lutheran Social Services-National Capital Area, April 24, 2012.

<sup>31</sup> In 2009-10, immigrants in the United States with engineering majors earned a median income of \$75,000 (in 2010 dollars) compared with \$89,000 among the US born; MPI calculations from ACS 2009-10.

<sup>32</sup> Washington Accord. Other international agreements include the Sydney Accord on engineering technologist accreditation (2001) and the Dublin Accord on engineering technician accreditation (2002). Information about and texts of these agreements may be found at [www.washingtonaccord.org](http://www.washingtonaccord.org).



profession, where formal licensing and training requirements represent the major barriers to practice, the primary difficulty for many of these workers is finding *employers* who recognize their skills and experience. They often face the old conundrum: You can't get a job without (US) experience, and you can't get (US) experience without a job.

The role of immigration in the engineering profession is controversial and has spurred considerable political debate. Employers have argued that the caps on the H-1B skilled worker visa should be lifted, allowing more engineers and other science and technology professionals to work in the United States. By contrast, some professional associations have opposed this proposal and regard the influx of technical professionals with alarm. Others have pointed to the dwindling share of US citizens in graduate science and engineering programs and proposed that more native-born students be encouraged to study engineering. The role of refugee and immigrant engineers already living in the United States has not appeared at all in this debate.

## IV. Conclusions

What features of particular occupations make it easier or harder for foreign professionals to gain access to them? Engineering and medicine have very different certification regimes. Obtaining medical licensure is extremely time-consuming, expensive, and complex, making it unreachable for the many foreign physicians who lack financial resources or time to study for and take the USMLE examinations or to apply for and serve long residencies. Recently arrived refugee and immigrant physicians confront years of struggle to master English, find suitable employment, support themselves and their families, and integrate into US society. They may also face discrimination by national origin or immigration status in the all-important residency match and certain federal training programs.<sup>33</sup>

More profoundly, US professions tend to be difficult for outsiders to penetrate owing to restrictive licensing regimes, exclusionary requirements, special educational qualifications, language proficiency requirements, high costs, and other barriers. As a result, breaking into the US professional labor market is challenging for any foreign worker (and for many native-born workers), especially during hard economic times.

### *Simplifying Recertification*

In spite of systemic obstacles, gatekeepers could develop effective ways to ease credential recognition and licensure processes, particularly in health fields where the barriers are most formidable. As a central actor in medical certification and licensure, ECFMG works closely with other professional bodies and the US government. The organization already recognizes that some foreign physicians (especially refugees and asylum seekers) have special problems in fulfilling certain of its requirements, but it could do even more to help them clear these and other hurdles. ECFMG announced in 2010 that it would create a Certificate Holders Office (ECHO) to “provide services to international medical graduates who have been certified by ECFMG and those nearing certification.”<sup>34</sup> ECHO could also offer special help to refugee and immigrant physicians already in the United States.

Other professional bodies, such as state medical boards, the American Association of Medical Colleges,

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33 For example, see Alguire et al., *Guide to US Medicine and Residency Training*, 22, which reports that “residency positions that are directly appointed by the Veterans Administration are not available to non-US citizens regardless of visa status.” See also Chen et al., “Professional Challenges of Non-US-Born International Medical Graduates and Recommendations for Support during Residency Training.”

34 ECFMG, *2011 Annual Report*, 4.





COGME, and the AMA could promote and coordinate special efforts for foreign physicians already in this country to address shortages of primary care providers. The AMA board of trustees' 2010 recommendation was a very modest step in that direction, but much more remains to be done.

In recent years the US Congress has refused to increase funding for medical residency programs or to authorize additional residency positions. Yet policymakers must respond soon to the unprecedented challenges posed by the expansion and reform of the US health care system. Modest measures, such as expanding and restructuring residency waivers and the National Health Service Corps to include refugee and immigrant physicians, would strengthen the primary care workforce and the provision of care to underserved populations and areas. Political will and coalition building are necessary to ensure that the oft-stated recognition of the primary care shortage will be translated into effective action.

The National Residency Match Program could be reformed to make access to residencies easier for immigrants and refugees willing to train as primary care providers and work in underserved areas. Additional residencies could be established at Community Health Centers, which are expanding significantly under the recent health care reform act.<sup>35</sup> They will need residents and attending physicians to provide primary health care to some 30 million new patients in the coming years. New federal, state, and private programs also could be established to recruit immigrant and refugee physicians, dentists, and other health care professionals to serve underserved populations (including immigrants).

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*In spite of systemic obstacles, gatekeepers could develop effective ways to ease credential recognition and licensure processes.*

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In the face of such a convoluted system with so many entrenched interests, where can the work of reform begin? Stakeholders — including patients, foreign-trained physicians, GME institutions, state medical boards, state and federal regulators, medical associations and societies, immigrant- and minority-advocacy groups, and many others — must cooperate to encourage the transformation of old regimes and the creation of new ones. Bringing together such diverse actors is a challenge; but health care reform has added a sense of urgency to the need for systemic change.

Although more lightly regulated occupations such as engineering do not present significant formal obstacles such as those found in health care occupations, many immigrants struggle to obtain professional training and employment. Thus, their skills and experience may go to waste, even as substantial new flows of immigrant professionals enter the US labor market through employment-based visa channels. Projects such as the Bnai Zion Refugee Retraining Program and LSS-NCA's Refugee Recertification Program could be replicated and expanded to redress this balance.

Who will create and maintain the networks and coalitions that will help make these changes happen? Several initiatives have already started to point the way.<sup>36</sup> For example, representatives of diverse sectors and professions recently founded IMPRINT, a coalition of nonprofit organizations and community colleges that promotes the retraining of immigrant and refugee professionals. Pilot projects, such as LSS-NCA's Refugee Recertification Program, provide models or templates for future initiatives. But they are too small, their resources are too limited, and they move too slowly to have much effect in the short term.

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<sup>35</sup> Reiselbach et al., "Teaching Primary Care in Community Health Centers: Addressing the Workforce Crisis for the Underserved."

<sup>36</sup> The first National Conference on Refugee Professional Recertification (organized by RefugeeWorks, a program of the Lutheran Immigration and Refugee Service) brought attention to the situation of refugee and immigrant professionals in 2009 and led to further initiatives, such as IMPRINT.



Special programs with adequate federal, state, or private funding are needed to produce thousands of recertified foreign professionals in the coming years.<sup>37</sup>

A few state governments have recognized the need to advance the integration of immigrant professionals. A recent study found that between 2005 and 2010 five states “reexamined the re-credentialing needs of highly educated and highly skilled immigrants. . . . Maryland . . . urged the creation of ‘a credentialing office for foreign-trained professionals staffed with specially trained professional navigators.’ Washington State. . . called for the state’s higher educational institutions to establish tailored educational programs to enable skilled professionals to transition into their respective fields.”<sup>38</sup> Direct support for organizations that help immigrants get recertified and find jobs could complement these efforts. In the current economic and political climate, however, states may not be able to fund such programs at an adequate level anytime soon.

The international migration of skilled professionals is unlikely to ebb in the foreseeable future. The political debate on skills and immigration continues to focus on work visas, a category that seems likely to expand even further in coming years. Meanwhile refugee and immigrant professionals already living in this country, often in poverty, need special assistance to attain their goals. Because the nation needs the skills of these foreign-born professionals, it is in the United States’ best interest to enable them to contribute their skills and knowledge to US society.

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*The international migration of skilled professionals  
is unlikely to ebb in the foreseeable future.*

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37 It is particularly challenging to provide language training appropriate to an immigrant’s profession in a cost-effective manner. Therefore, funding for innovative models, such as scatter-site language classes bringing together students from different areas, could help address this need.

38 Nicholas V. Montalto, *A History and Analysis of Recent Immigrant Integration Initiatives in Five States* (Cranford, NJ: Diversity Dynamics, 2012).



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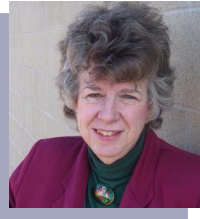
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