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Visa-Related Barriers for International Medical Graduates: How Immigration Policies Derail Medical Careers

Summayya Anwar, Hashim Al-Roubaie, Abhishek Thapa, Anum Naimat
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Abstract

International Medical Graduates (IMGs) make up a large portion of the physician workforce in the United States, Canada, and the United Kingdom, particularly in rural and underserved communities. Despite their critical role and essential contributions, IMGs face significant barriers to their entry and practice, including visa delays, restrictive policies, and travel bans.

These barriers not only affect physicians by disrupting their professional development but also the healthcare systems that rely on them, exacerbating the physician shortages, ultimately undermining healthcare access. This article sheds light on visa-related issues and how bureaucracy disrupts professional development, separates families, and compounds the worsening healthcare crisis. To address these concerns, this article proposes solutions such as the creation of a trilateral visa encompassing the US, Canada, and the UK. This would streamline application processing, prioritize family reunification, and place residency authorization directly in the hands of the training program or hospital involved. By doing this and removing immigration-related barriers, qualified IMGs could begin their training alongside their peers, without delays, combating the physician shortage, and strengthening healthcare systems.

Keywords: International Medical Graduates; Emigration and Immigration; Health Policy; Physician Shortage; Rural Health Services; Workforce

Introduction

"Will my future be decided by the bureaucracy instead of my educational skills and commitment to serving humanity?" This question continues to linger in the minds of every foreign doctor nowadays who aspires to work in more developed countries (1).

A feature on Forbes says, "1 in 4 pediatric residents in the United States are international medical graduate (IMG) doctors, and they are filling the spots in underserved communities that American graduates are not even applying to," says Sebastian Arruarana, a resident physician and advocate for IMGs at the Brookdale University Hospital and Medical Centre in Brooklyn, New York. "If this is not solved, then who will take care of our children?"

The temporary J-1 visa pause initiated on May 27, 2025, by the federal administration of the United States raised doubts, confusion, stress, and anxiety among foreign doctors. However, it was lifted on June 18, 2025. Many doctors couldn't secure a visa to begin their residency or to start a research position, which has affected them and their families, who sacrificed their time, effort, and money. These doctors have worked extremely hard for many years to achieve high standards and serve their communities with great care and dedication. The number of visa rejections is steadily increasing.

International medical graduates, also known as foreign medical graduates (FMG), are individuals who have received their medical degree in a country outside the region of interest (2). They constitute a significant number of U.S. graduate medical education (GME) trainees and medical specialists in different fields of medicine and surgery in the USA. They may be US-IMGs or non-US IMGs (2). The US-IMGs are those who have graduated from U.S. medical schools, and the non-US-IMGs are visa-requiring candidates struggling to enter the U.S. medical system to pursue their careers.

The Bureau of Health Workforce (BHW) estimated that by 2025, 37 states may face physician shortages in specific subspecialties (3). Similarly, the Association of American Medical Colleges (AAMC) estimates nationwide physician shortages of 17,800-48,000 in primary care, 15,800-30,200 in surgical specialties, and 3,800-13,400 in medicine by 2034 (4). Thus, in this context, IMG doctors serve as a vital backbone of the U.S. healthcare system, delivering care across diverse communities in the U.S. without discrimination. However, recent visa restrictions and barriers can jeopardize patient care and threaten public health.

In recent NRMP data, approximately 6,600 IMGs matched into residency in 2025. However, due to visa issues, many of these IMGs had their interviews delayed or rejected, resulting in a significant loss. "I do not want

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to give up," said a permanent Canadian resident who matched to the University of Pittsburgh Medical Centre Harrisburg but had her visa denied because she is a citizen of Afghanistan. She requested to remain anonymous for fear of reprisal. "But the situation also seems so helpless."

Without IMGs, many U.S. residency programs will suffer. They will have difficulty finding qualified candidates to fill the positions. There will be a gap in the number of physicians serving patients, threatening the quality and accessibility of medical care, especially in medically underserved communities (5).

Discussion

Key Obstacles Encountered by IMG Doctors

Match 2025 was a moment of joy for many doctors. However, over 300 IMGs faced uncertainty and anxiety due to visa backlogs, delays, and rejections, despite having job offers or acceptance into medical training. Forbes publisher Emma Whitford explains that part of this setback was due to President Trump's momentary pause on new visas, which is part of a larger effort to design protocols to screen newcomers' social media (6). This setback affects all types of visas, including but not limited to J1 visas, which the majority of IMGs depend on to begin their residency training.

Inconsistencies in immigration laws only serve to compound this problem. Let us take the U.S., Canada, and the U.K. as examples.

In the U.S., for a non-US IMG to begin their residency training, it is not enough for them to gain acceptance (i.e., "match") into the program of their choice. Per the American Medical Association (AMA), they must apply for an H1B visa, a J-1 visa (which may be waived), or a green card; however, some states allow IMGs to practice without needing to complete U.S. residency training (7, 8). The impact on personal lives is also significant. Out of eight doctors interviewed by NBC News, one doctor who matched into a rural pediatric residency program professed thoughts of giving up after learning that their home country was among those listed in the travel ban (11). A particularly distressing story is that of Dr. Khaled Almilaji, a Syrian physician studying at Brown University, who had his U.S. visa revoked during a trip abroad due to the 2017 travel ban. Separated from his pregnant wife in New York for six months, he had no choice but to relocate to Canada to reunite with her and complete his training in Toronto (12).

In Canada, policies differ from province to province; IMGs must first become Canadian citizens or permanent residents before they can participate in the Canadian Resident Matching Service (CaRMS). Like the U.S., Canada offers IMGs the option to bypass residency by applying through the Practice Ready Assessment (PRA), provided they are a citizen or permanent resident (9).

The U.K. previously allowed IMGs to practice without needing a visa or citizenship; however, on April 3rd, 2006, a policy was passed requiring NHS trusts to prove that a qualified UK or EU national is unavailable (10).

These individual experiences add a necessary human dimension, but they must be interpreted alongside broader datasets to capture the systemic scope of the problem. For example, NRMP data show that approximately 6,600 IMGs matched into residency in 2025, yet hundreds faced significant disruptions due to visa complications. Surveys from professional organizations like the AMA and CaRMS similarly highlight how widespread these delays are (16,17), grounding anecdotal stories in a measurable evidence base.

Impact on Healthcare Systems and Humanitarian Cost

The problem extends beyond the individual. Healthcare systems around the world rely heavily on IMGs to serve in critical roles, especially in rural and underserved areas. In the U.S. in 2023, 24.7% of all active physicians were IMGs (13). Furthermore, foreign-trained physicians make up at least half of the physician workforce in federally designated shortage areas, serving more than 20 million people (7). These figures underscore the indispensable role of IMGs and complement the personal accounts presented earlier.

Despite these needs, estimates show that the U.S. may face a shortage of up to 124,000 physicians by 2034 (14). Additionally, the World Health Organization warns that the shortfall of health workers could reach 10 million by 2030 (15). Blocking qualified physicians from entering healthcare systems that are already overstretched is not only inefficient but also unethical. While it is important to emphasize the profound emotional and personal toll visa barriers impose on IMGs, grounding these stories in large-scale data ensures a balanced narrative that appeals to both policymakers and academics.

Call for Change: What Needs to Happen

We propose the creation of a trilateral visa specifically designed for licensed physicians. Although this is a huge ask, we firmly believe a visa of this kind would eliminate many of the injustices encountered by IMGs. This kind of visa would enable doctors to practice, train, or temporarily serve across the U.K., the U.S., and Canada in a more streamlined and collaborative framework.

Key Features

- **Dedicated portal:** A shared, secure digital platform for verifying education, standardized exam results, and licensing credentials.
- **Speeding up the process:** Improving application timelines for IMGs entering residency programs or practicing in underserved areas.

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- **Prioritizing family reunions:** Reducing stress by reuniting families as soon as possible.

- **Single authority:** Placing residency programs and hospitals as the central approving body, bypassing unnecessary political barriers.

Contextualizing Feasibility

While the trilateral visa proposal is bold and original, we ought to question its feasibility. Ideas akin to this proposal already exist. For example the European Union's Blue Card system (18) or mobility provisions under NAFTA/USMCA (19), show that multilateral cooperation on skilled labor migration is not only possible but already in practice. Providing this comparison helps position the trilateral visa as an upgrade of existing precedents rather than new wishful thinking thus strengthening this proposal's credibility.

How This Empowers Institutions

Residency programs often lose eligible IMGs to visa complications beyond their control, with the travel ban being a clear example. A unified visa would give these institutions more control in onboarding candidates without being delayed by government approval processes. This type of visa would undoubtedly improve recruitment in rural and underserved areas.

Conclusion

Qualified and talented doctors are not being kept out of our healthcare systems because they lack skill or compassion; instead, they are excluded simply for being born in the wrong country. The result? Families are separated, careers stalled, and underserved communities left without adequate care. We are in a healthcare crisis, yet we are turning away from the very people who could help solve it. These qualified doctors have already proven themselves. They want the chance to heal people where they are needed most. It is time for real change. We are in the 21st century, an era of rapid technological growth and development that no generation has seen. Advances in the medical field are moving forward rapidly, with researchers finding cures for previously incurable diseases. We need immigration policies that prioritize skills over paperwork and systems that value what these doctors can contribute instead of obsessing over where they came from. If possible, a different category visa for healthcare, a trilateral visa, modeled on existing multilayered labor-mobility frameworks, offering a feasible and forward-thinking solution. If the healthcare system is to meet the challenges of this century, immigration policy must evolve to recognize and support the global medical workforce. How many more brilliant minds will we force to drive taxis while emergency rooms overflow, and patients die waiting for care we could have provided? Not one more.

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Emails: Summayaa.anwar@gmail.com, Doctorhashim12@gmail.com, anumvirk593@gmail.com, thap.abhi007@gmail.com