

## CORRESPONDENCE



## Denying Visas to Doctors in the United States

**TO THE EDITOR:** In an embarrassed tone, an 87-year-old patient with end-stage chronic renal disease who is now receiving palliative care asked one of us, “Will you be able to stay in the United States for a few more months? I don’t want to change my physician during the last few months of my life.” He was expressing concern about the impact of statements made by President Donald Trump about immigration and immigrants. Since the November election, both of us have received similar expressions of concern from other patients as well.

During the presidential campaign, President Trump and his nominee for Attorney General, Senator Jefferson Sessions (R-AL), proposed stricter regulations regarding the issuing of work visas, including eliminating H-1B visas — the visa that allowed us and many other international medical graduates (IMGs) to come to the United States for training and practice. The possibility of these administrative changes has made us and many IMG physicians who require a visa feel insecure about our future here in the United States. Muslim IMGs are particularly concerned because of President Trump’s statements suggesting that Muslim immigrants may be temporarily banned from the United States. Will the renewal of our visas be denied? Will we be required to leave the country, even though we are residing here legally? This uncertainty undermines confidence in the health care system and potentially erodes the trust that physicians have established with their patients.

IMGs compose almost one quarter of the physicians working in the United States,<sup>1</sup> and in the past many have been able to work because of work visas. Many IMGs like ourselves work in underserved communities, and if we are required to leave, qualified replacements will be in short

supply. Moreover, we expect that many residency positions will go unfilled if there are no applicants because they require visas.<sup>2</sup> Such a move would adversely affect patient care in the United States for years.

Previous nativist and xenophobic movements in the United States were expressed as anti-Semitism or anti-Catholicism. Such biases hurt scientific development and clinical practice for decades by marginalizing many talented physicians. It is imperative to learn from this history. We ask the medical community to stand in support of physicians who require visas, and we ask the government to continue to allow qualified IMGs to enter the United States. American people deserve the best physicians to take care of them, regardless of their country of origin or religious background.

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1. Educational Commission for Foreign Medical Graduates; ECFMG 2015 Annual Report. April 2016 (<http://www.ecfm.org/resources/ECFMG-2015-annual-report.pdf>).

2. Mullan F, Salsberg E, Weider K. Why a GME squeeze is unlikely. *N Engl J Med* 2015;373:2397-9.

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## Semaglutide and Cardiovascular Outcomes in Patients with Type 2 Diabetes

**TO THE EDITOR:** In reporting the results of the Trial to Evaluate Cardiovascular and Other Long-term Outcomes with Semaglutide in Subjects with Type 2 Diabetes (SUSTAIN-6), Marso et al. (Nov. 10 issue)<sup>1</sup> describe a lower rate of cardiovascular events among patients with type 2 diabetes mellitus who received the glucagon-like peptide 1 (GLP-1) analogue semaglutide than among patients who received placebo. Their results are consistent with those in the Liraglutide Effect and Action in Diabetes: Evaluation of Cardiovascular Outcome Results (LEADER) trial,<sup>2</sup> which assessed the effects of another GLP-1 analogue, liraglutide.

In SUSTAIN-6, the use of insulin at trial entry was similar between the two groups. However, during the LEADER trial, the use of insulin was approximately two times higher in the placebo group than in the liraglutide group, and during SUSTAIN-6, the use of insulin was approximately three times higher in the placebo group than in the semaglutide group. The significantly greater use of insulin in the placebo groups in these two trials may, at least in part, explain the increase in the risk of death from any cause as well as the increase in the risks of heart failure, cardiovascular events, renal failure, and hypoglycemia in these two groups. Hazard ratios for these events associated with increased use of insulin range from 1.23 to 4.57, as shown in two cohort studies in primary care.<sup>3,4</sup> Thus, we wonder whether the greater use of insulin in the placebo groups than in the liraglutide and semaglutide groups during these trials may have amplified the beneficial effects of liraglutide and semaglutide.

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2. Marso SP, Daniels GH, Brown-Frandsen K, et al. Liraglutide and cardiovascular outcomes in type 2 diabetes. *N Engl J Med* 2016;375:311-22.

3. Hippisley-Cox J, Coupland C. Diabetes treatments and risk of heart failure, cardiovascular disease, and all cause mortality: cohort study in primary care. *BMJ* 2016;354:i3477.

4. Hippisley-Cox J, Coupland C. Diabetes treatments and risk of amputation, blindness, severe kidney failure, hyperglycaemia, and hypoglycaemia: open cohort study in primary care. *BMJ* 2016;352:i1450.

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**TO THE EDITOR:** Marso et al. report diabetic retinopathy complications in patients with type 2 diabetes who received semaglutide; this raises the possibility that GLP-1-receptor agonists could cause progression of diabetic retinopathy. The authors cite seminal studies involving patients with type 1 diabetes and suggest that progression of diabetic retinopathy is due to the glucose-lowering effect of treatment.<sup>1</sup> Studies involving patients with type 2 diabetes,<sup>2,3</sup> albeit smaller and retrospective, also have shown similar find-