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LINGERING REGULATORY BARS TO LICENSING FOR INTERNATIONAL MEDICAL GRADUATES

THERESE BART *

INTRODUCTION

Medical licensing has been unequivocally acknowledged as a legitimate exercise of the state's police power.¹ Originally enacted in response to public outcry at shoddy medical education, the state licensing boards have successfully improved the quality of medical education and public health. Medical boards, however, have also used their relatively independent status to restrict competition within the medical field. Despite court cases in the 1970s establishing that state boards are subject to antitrust laws, many state boards continue to impose arbitrary requirements on foreign medical graduates beyond those normally imposed on graduates of American medical schools. These requirements are not only adopted by the federal government in its immigration policies, but in some cases, are exacerbated by home-stay requirements dating back to the Cold War. This combination reduces the number of foreign medical graduates who are able to compete effectively in the American medical field.

A. A BRIEF HISTORY OF MEDICAL LICENSING IN THE UNITED STATES

The medical profession in America originally was relatively unregulated. The first statutes governed fees and quarantines and were designed to regulate health care costs rather than quality of care.² Not until 1760 did New York ban the unlicensed practice of medicine.³ A rash of such regulations followed until by 1830, only Pennsylvania, North Carolina, and Virginia did not require state licensure.⁴ But regulation was short-lived. By the mid-1800s, most licensure laws were repealed as voters

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1. See *Gibbons v. Ogden*, 22 U.S. 1 (1824). See also Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201 (1999).

2. Gregory Dolin, *Licensing Health Care Professionals: Has the United States Outlived the Need for Medical Licensure?*, 2 GEO. J.L. & PUB. POL'Y 315, 316 (2004).

3. *Id.*

4. *Id.*

identified with Jacksonian democracy and its championing of the freedom to practice one's chosen profession and to select a doctor without state interference.⁵ Diplomas were widely regarded as sufficient proof of the physician's ability, while licenses were perceived as economic protection measures.⁶

However, the 1910 Flexner Report first systematically documented the problems with medical education and spurred legislators to reform.⁷ The report criticized medical schools as lacking standards and producing an excess of "uneducated and ill trained medical practitioners . . . in absolute disregard of the public welfare."⁸ The report viewed this result as the by-product of the schools' nature as commercial businesses, only able to provide the level of quality commensurate with their income.⁹ The report advised consolidating medical schools so as to pool their resources and produce medical professionals with a high quality education and up-to-date knowledge of medical advancements.¹⁰ In response to the report, legislators immediately began instituting state medical boards to oversee licensing. Several schools, unable to meet the new standards of medical education, were forced to close or merge. As a result, although 148 medical schools existed at the time of the report,¹¹ there are currently 134 LCME-accredited Medical Doctor programs in the United States,¹² up from the 125 medical schools operating in 2004.¹³

Benefits to Medical Licensing

Licensure had a variety of benefits. Licensure eliminated quackery, which was accomplished by closing sub-par medical schools and raising the standards of medical education. Individual patients were thus protected from incompetent medical treatment, the assumption being that medicine had advanced to such a point that they would be unable to distinguish between competence and incompetence for themselves.¹⁴ By improving

5. *Id.*

6. *Id.* at 317.

7. ABRAHAM FLEXNER, *MEDICAL EDUCATION IN THE UNITED STATES AND CANADA: A REPORT TO THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING* (1910) [hereinafter *THE FLEXNER REPORT*].

8. *Id.* at x.

9. And income was low—one medical school took in a mere \$10,000 in income, the report notes, which meant it was unable to provide laboratory training. *Id.*

10. *Id.* at xi.

11. *Id.* at 354.

12. *Directory of Accredited Medical Education Programs*, LIAISON COMMITTEE ON MEDICAL EDUCATION, <http://www.lcme.org/directry.htm> (last visited Feb. 22, 2011). This increase is due in large part to forecasted shortages of physicians, as will be discussed.

13. Dolin, *supra* note 2, at 317.

14. See *Dent v. West Virginia*, 129 U.S. 114, 123 (1889) (the U.S. Supreme Court's adoption of this view).

medical care for individual patients, the public health was protected from the spread of infection.¹⁵

Medical Licensing as Restricting Competition

Since the ability to license was located primarily in the hands of the medical profession, licensure also became a means to restrict entry into the market. Allopathic physicians dominated the state boards, which led to the closing of medical schools that, although reputable, taught medicine from the perspectives of homeopathy, chiropractics, or osteopathy.¹⁶ Licensure in itself creates entry barriers to competitors, which keeps prices higher and reduces access to care, resulting in a “population that is sicker and, in the long run, more costly to treat.”¹⁷

Regulation traditionally benefits “entrenched groups” to the detriment of “outsiders.”¹⁸ According to Austin McGuan, in the early 1900s, “[m]edical boards also sought to limit the profession to white males and to those doctors who would not compete with existing doctors. Accordingly, medical boards used oral interviews to restrict competition and to exclude candidates on the basis of sex, race, and religion.”¹⁹ Overt discrimination was dealt a blow in 1975 when the United States Supreme Court ruled in *Goldfarb v. Virginia State Bar* that legal boards were not exempt from federal antitrust laws.²⁰ Doctors who had hitherto been denied hospital privileges could now sue in federal court alleging violation of federal antitrust laws.²¹ Litigation surged, and states reacted by requiring more neutral state oversight over medical boards.²²

B. LICENSING OF INTERNATIONAL MEDICAL GRADUATES

Although discrimination is no longer explicit in state regulation of medical licensing, foreign-trained physicians are forced to meet requirements beyond those imposed on United States medical graduates (USMGs).

15. See Dolin, *supra* note 2, at 320–22.

16. *Id.* at 322–23. N.B., Dolin observes that courts have condemned allopathic medicine boards for acting arbitrarily and capriciously in refusing licenses to non-allopathic practitioners.

17. *Id.* at 324.

18. *Id.* at 326 (discussing George Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3 (1971), which theorizes that, as a general rule, regulation is designed for the benefit of existing industry).

19. Austin McGuan, *One and Done: How Ohio's One-Year, Nonrenewable Visiting Medical Faculty Certificate is Harming the State's Economic Recovery*, 19 J.L. & HEALTH 371, 379 (2004–05). As an example, in note 58 of his article, he cites Cleveland's Mt. Sinai as being founded to provide a place for Jewish physicians to work, who were otherwise unable to obtain full hospital privileges in Cleveland.

20. *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 792–93 (1975).

21. McGuan, *supra* note 19, at 381.

22. *Id.*

History and Current State Requirements

Licensing of international medical graduates (IMGs)²³ has posed unique problems. While state boards began expressing concerns about the difficulty of assessing the quality of foreign medical education as early as the 1930s,²⁴ boards took little action for fifty years. In the early 1980s, the United States Postal Service discovered a network that was distributing “several thousand fake medical degrees from schools in the Caribbean area.”²⁵ Boards realized that they were not only unable to evaluate the quality of foreign medical education, but also unable to verify the authenticity of the supposed IMGs’ credentials. The marked increase of IMGs receiving state licenses in 1983 led state boards to impose the Federation Licensing Examination (FLEX) in 1985.²⁶

Today, most states require IMGs to pass the FLEX or an equivalent medical competency exam.²⁷ In addition, they must pass the Educational Commission for Foreign Medical Graduates (ECFMG) examination (often as proof of English proficiency).²⁸ Many states also require that the IMGs have graduated from a state-approved foreign medical school.²⁹ Several states require that two or three years of general medical education be performed in the United States, while requiring USMGs to complete only one. Additionally, over half of the states require an interview or oral examination, which would test both the subject matter and the IMGs’ English competency.³⁰

Immigration Requirements

The government has adopted several of these provisions in its immigration code, requiring that IMGs seeking an H-1B visa pass the FLEX exam (or its equivalent), complete the English proficiency test given by the ECFMG, and obtain the state-issued license.³¹ Since the number of available H-1B visas is capped each year, the majority of IMGs enter on a

23. “International medical graduate” refers here to both U.S. citizens trained abroad and foreign nationals trained abroad.

24. U.S. DEP’T OF HEALTH AND HUMAN SERVS., OFFICE OF THE INSPECTOR GEN., MEDICAL LICENSURE AND DISCIPLINE: AN OVERVIEW 2 (1986).

25. *Id.* at 3.

26. *Id.* at 3, 5, 7.

27. Though each state determines what it considers “equivalent,” some examples include the United States Medical Licensing Examination (USMLE), the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), and the National Board of Medical Examiners Examination (NBME).

28. NB, the ECFMG certificate, is not required by California or West Virginia for licensure, though it is required by the INS for a visa. AMERICAN MEDICAL ASSOCIATION, STATE MEDICAL LICENSURE REQUIREMENTS AND STATISTICS 2011, at 15, 113 (2011) [hereinafter AMA].

29. Each state develops its own list.

30. AMA, *supra* note 28, at 15. For a list of specific states, see Table 5. *Id.* at 16.

31. 8 C.F.R. § 214.2(h)(4)(viii)(B)(2) (2011).

J-1 visa to complete their graduate medical education (GME) in the United States. The testing requirements are similar: ECFMG certification,³² passage of the USMLE or its equivalent,³³ and “adequate prior education and training.”³⁴ The application, however, also requires a statement of need from the government of their last legal permanent residence³⁵ and an agreement with a United States medical school to provide the applicant with his GME.³⁶

Unlike the H-1B visa, the J-1 visa is limited to seven years or the time required to complete the GME.³⁷ Once the visa has expired, the physician is required to return to his home country for a period of two years.³⁸ Waivers of this requirement are available only to those physicians who can find a federal or state agency to sponsor them in exchange for their commitment to work in an area designated as having a “shortage of health care professionals.”³⁹

This two-year home-stay requirement was imposed in 1976 under the Health Professions Educational Assistance Act (HPEA).⁴⁰ Home-stay requirements date back to the exchange visitor programs created in 1948 under the Smith-Mundt Act. The requirements were designed to promote soft diplomacy and encourage exchange students and researchers to “impart their substantive skills and cultural insights to their home countries.”⁴¹ But until 1976, the two-year requirement had never been imposed on physicians. Congress officially declared that the HPEA was meant to improve “the availability of high quality health care,”⁴² but its primary intent was to restrict the number of foreign physicians entering the American market. As the bill itself stated, “there is no longer an insufficient number of physicians and surgeons in the United States such that there is no further need for affording preference to alien physicians and surgeons in admission to the United States.”⁴³

32. NB, only the ECFMG is able to sponsor J-1 physicians. 22 C.F.R. § 62.27(b) (2011).

33. *Id.* at § 62.27(b)(5).

34. *Id.* at § 62.27(b)(1).

35. *Id.* at § 62.27(b)(6), described as providing “written assurance, satisfactory to the Secretary of Health and Human Services, that there is a need in that country for persons with the skills the alien physician seeks to acquire.”

36. *Id.* at § 62.27(b)(7).

37. *Id.* at § 62.27(e)(2).

38. 22 C.F.R. § 62.27(g)(1) (2011).

39. Immigration and Nationality Act of 1952 § 212(e), 8 U.S.C. § 1184(l)(1)(D) (2006).

40. Health Professions Education Assistance Act, Pub. L. No. 94-484, 90 Stat. 2243 (1976).

41. ROBERT D. ARONSON & DINESH P. SHENOY, IMMIGRATION BRIEFINGS, ZENO’S REVENGE: THE PARADOXES OF INTERESTED GOVERNMENT AGENCY J-1 WAIVERS FOR PHYSICIANS, PART I 4 (2004).

42. *Id.*

43. Health Professions Education Assistance Act § 2(c).

The Current Physician Shortage

Over thirty years later, the need for medical physicians has increased dramatically.⁴⁴ The American population continues to grow and age—a trend that will require far more health professionals, who are also aging and retiring. As health care costs rise, so do the rates of uninsurance, and the likelihood that illnesses will progress further before being treated, resulting in even more costly treatment. The cost of a medical education has pushed more and more medical students into opting for specialties rather than primary care, so as to maximize the return on their investment. The recently passed health care bill will add nearly 32,000,000 Americans to the ranks of the insured.⁴⁵ Together, these factors indicate an expected shortage of physicians by 2025 of anywhere between 124,000⁴⁶ and 312,000.⁴⁷

The Association of American Medical Colleges (AAMC) has already proposed that medical schools increase enrollment by 30% over the next decade.⁴⁸ However, an increase in enrollment will only partially address the immediate and future need.

Currently, IMGs represent nearly 25% of the physician workforce in the United States⁴⁹ and nearly 28% of residents in GME programs.⁵⁰ Nonetheless, their entry into the market is hampered by additional training requirements arbitrarily imposed by each individual state. The Federation of State Medical Boards expressed its disapproval with the varying requirements in 1996:

Twenty-five (25) states currently require three (3) years postgraduate training for graduates of foreign medical schools to obtain initial licensure while only one (1) state has the same requirement for graduates of U.S. and Canadian medical schools.

44. See R.A. Cooper, *There's a Shortage of Specialists. Is Anyone Listening?*, 77 ACAD. MED. 761 (2002); COUNCIL ON GRADUATE MED. EDUC., U.S. DEP'T OF HEALTH AND HUMAN SERVS., PHYSICIAN WORKFORCE POLICY GUIDELINES FOR THE U.S. FOR 2000–2020 (2005); CTR. FOR WORKFORCE STUDIES, ASS'N OF AM. MED. COLLS., RECENT STUDIES AND REPORTS ON PHYSICIAN SHORTAGES IN THE U.S. (2010), <http://www.aamc.org/workforce/recent-workforcestudies.pdf> [hereinafter CWS].

45. CONG. BUDGET OFFICE, LETTER TO THE HONORABLE NANCY PELOSI: PRELIMINARY ESTIMATE OF THE DIRECT SPENDING AND REVENUE EFFECTS OF THE RECONCILIATION ACT OF 2010 (Mar. 20, 2010) (tbl. 2).

46. MICHAEL J. DILL & EDWARD S. SALSBERG, CWS, ASS'N OF AM. MED. COLLS., THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS THROUGH 2025, at 24 (2008).

47. *Id.* at 69.

48. *The Physician Workforce: Position Statement*, ASS'N OF AM. MED. COLLS., <http://www.aamc.org/workforce/workforceposition.pdf>.

49. AMA, AMA-IMG SECTION GOVERNING COUNCIL, INTERNATIONAL MEDICAL GRADUATES IN AMERICAN MEDICINE: CONTEMPORARY CHALLENGES AND OPPORTUNITIES, 3 (2010); Ass'n of Am. Med. Colls., CWS, 2009 STATE PHYSICIAN WORKFORCE DATA BOOK, 6 (2009) (“In 2008 . . . [n]ationally 24.2 percent of the physician workforce was IMGs.”).

50. 2009 STATE PHYSICIAN WORKFORCE DATA BOOK, *supra* note 50, at 34 (citing 2009 AAMC/AMA National GME Census).

The three-year requirement would alleviate concerns of discrimination as related to physician licensure and establish uniform standards for all applicants for licensure.⁵¹

Foreign national IMGs face additional roadblocks on their path to licensure, the most insidious of which is the outdated two-year home-stay requirement for J-1 visa holders. Although the home-stay requirement does not bar licensure, it prevents many foreign physicians from establishing a successful career in the United States immediately after finishing their GME. Those who opt to obtain a state license and then complete the two years in their home country have difficulty maintaining their license and fulfilling their continuing medical education requirements while abroad.

CONCLUSION

Throughout the long and complicated history of medical licensing, the concern of the medical industry has vacillated between improving the quality of medical treatment and reducing competition. The current health care shortage, which could shortly escalate into a near drought, demands that the medical field make use of all available personnel. Towards that end, the remaining vestiges of its anti-competition policy aimed at IMGs should be eliminated, in both federal immigration requirements and state-imposed regulations, leveling the path to equal access to state licensure.

51. See *Position of the Federation of State Medical Boards: In Support of Postgraduate Training and Licensure Standards*, FED'N OF ST. MED. BOARDS (1998), http://www.fsmb.org/pdf/1998_grpol_Postgraduate_Training_Licensure.pdf.