Challenges in Removing US Residency Training Requirements for State Licensure

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Medical licensure is generally granted at the state level, and such licensure processes can vary from state to state. Despite the relative heterogeneity in state licensing laws, there has been a widely held consensus among all state governments to restrict licensure to physicians who have received some degree of Accreditation Council for Graduate Medical Education (ACGME)-certified residency training. In 2023, this unanimity was disrupted when the Tennessee state government passed Senate Bill (SB) 1451, allowing foreign-trained physicians (FTPs), international medical graduates (IMGs) who completed residency training outside of the United States, a new pathway to practice medicine.[1] The bill, which was enacted in July 2024, has opened the door for a slurry of similar state legislation in Virginia, Iowa, Florida, Wisconsin, Idaho, and Illinois.[1-7] In this perspective, we outline the general requirements set in place by these states for FTPs to practice medicine, along with the potential benefits and challenges posed by this new pathway in the United States.

Although laws vary by state, most FTP laws such as SB 1451 require physicians be licensed in their home country.[1-3] Many states also require a minimum number of years (often 3 to 5) of practice in their home country.[1,2] Usually, FTPs must also have job offers from select academic institutions or hospitals in order to operate under a valid provisional license.[1,3] One additional hurdle that FTPs face is obtaining Educational Commission for Foreign Medical Graduate certification, which requires the passage of the United States Medical Licensing Examination Step 1 and Step 2.[1-3] Following a specified amount of time practicing in the United States under a restricted license, FTPs may then be eligible to apply for an unrestricted license (TABLE).

Advocates of FTP legislation believe these bills will increase the number of practicing physicians in their state.[8] Many of these bills have been introduced in states currently experiencing or facing future physician shortages. It is the hope of these legislators that these bills will address physician shortages that are disproportionately experienced in rural and other medically underserved areas (MUAs).[8] While these bills are likely to increase the number of physicians statewide, it is unclear whether these FTPs will address states' issues related to the maldistribution of their physician workforce. Tennessee, for example, requires FTPs to practice during their first 2 years at hospitals with ACGME-certified residency programs while operating under their provisional license before being granted an unrestricted license.[1] Many of these qualified institutions, however, are located in urban and suburban areas where there is less of an immediate need for practicing physicians. Once granted an unrestricted license, FTPs are allowed to practice anywhere in the state of Tennessee.

Another potential unintended consequence of this new pathway may be seen with the effect on our current visa system. Traditionally, noncitizen IMGs who wished to complete US residency training used the J-1 or H-1B visa pathways, with the J-1 Exchange Visitor Program being the most frequently used path.[9] Usually, J-1 visa holders must return to their country of origin after residency training for a minimum of 2 years. However, this requirement can be avoided through the Conrad 30 waiver program that requires 3 years of medical practice in an MUA within their state.[10] The Conrad 30 program has provided a steady influx of former J-1 visa holders to underserved areas where participants have provided care to over 4 million rural Americans.[9] With the implementation of Tennessee SB 1451 and other laws, IMGs may now be incentivized to forgo US residency training with J-1 visas in favor of completing their residency training abroad, effectively bypassing the Conrad 30 program.

The domestic resident physician workforce could also face significant challenges if IMGs increasingly utilize alternative pathways to practice medicine without completing US-based residency training. Currently, IMGs constitute 25% of the US resident workforce, with many serving in primary care specialties that are often left unfilled by domestic medical graduates.[11] Among internal and family medicine residents, 39% and 32% are IMGs, respectively.[11] A decline in the number of IMGs filling these roles could lead to shortages that negatively affect resident workload, graduate medical education environments, and perhaps a lower bar for admittance

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TABLE
Years of US Practice Needed Before Unrestricted Licensure Eligibility by State

State	Years
Florida	2
Illinois	2
Tennessee	2
Idaho	3
Iowa	3
Wisconsin	3
Virigina	4

into training programs with less competition that may lead to resident quality deficiencies.

The introduction of FTP laws raises significant concerns regarding potential international exploitation. The United States has a history of attracting talented international professionals across various fields.[12] These laws escalate this practice by leveraging the health care training resources of foreign, often developing, countries to meet domestic needs. This mass migration of health care professionals from low-income to high-income countries is known as "brain drain."[12] This can result in the depletion of essential medical personnel from nations that already experience shortages, such as India, Pakistan, Mexico, and the Philippines.[9] To address the physician shortage responsibly, the United States as a whole, both in the form of government and private industry efforts, should invest in and fund its own domestic training programs, ensuring that solutions do not come at the expense of other countries' health care systems.

Moreover, transparency with patients regarding the training background of their physicians should be afforded to patients. Clear guidelines at the state level would benefit patient-informed consent and autonomy regarding the differences in training between FTPs and domestically trained physicians as patients likely have come to expect autonomous physicians providing their care to have been trained within a US residency program accredited by the ACGME. These proposed guidelines would be in line with similar mandates that require US-trained resident physicians to disclose their level of training and education to patients.[13]

While FTPs may demonstrate similar levels of clinical competency, studies have yet to show this equivalent degree in quality of care with limited prior experience of FTP practice.[14,15] While previous studies investigating the quality of care of IMGs have shown equivalent or even better patient outcomes for IMGs compared to US medical graduates, it is important to note that these studies only investigated the IMG subset that graduated from an international medical school and graduated from a US residency. Findings related to the quality of care delivered by IMGs cannot necessarily be applied to FTPs who did not complete their residency training within the United States.[14,15] Most important, studies comparing US graduates and IMGs with US residency training are biased because residency programs apply heightened scrutiny to IMG candidates, interviewing and ranking only those with top examination scores, strong letters, and extensive research and publications.[16,17] This same degree of selection bias may also apply to employers hiring FTPs, but whether this is the case remains uncertain.

Overall, while FTP legislation offers a potential near-term solution to the current US physician shortage, it may not address the maldistribution of US physicians. Proven strategies, such as the recruitment of medical students from rural communities and exposure to rural practice during medical training, are likely to be more effective, as FTPs with unrestricted licenses have no obligation to remain in underserved areas.[18] At the national level, expanding the National Health Service Corps (NHSC) Scholarship Program could play a pivotal role. By funding medical school tuition and associated costs in exchange for a commitment to practice primary care in MUAs, the program helps address critical workforce gaps. However, the program's high competitiveness, driven by its limited positions, excludes approximately 90% of applicants.[19] Expansion of the NHSC would allow more medical students to participate, strengthening the health care workforce in MUAs. To complement this expansion, states could implement targeted initiatives to address the NHSC's limitations, such as its limited focus on primary care. A state-level program modeled after the Health Professions Scholarship Program used by the Armed Services could serve as a blueprint.[20] Such a model would provide financial support for medical education without the need for prohibitive student loans while ensuring a steady pipeline of both primary care physicians and needed specialists.

The new state laws allowing FTPs to practice could also have long-term consequences for US graduates who incur substantial expenses for education. US graduates may face reduced practice opportunities upon completion of their training, as FTPs are not required to remain in a specific practice or area after gaining an unrestricted license. Further, while the limits of our current graduate medical education system currently act as a bottleneck for the physician supply chain, the decades to come could reveal that bypassing our domestic system has led to an oversupply of physicians, especially in areas home to large academic medical centers. Future studies regarding the new state laws must examine physician practice locations and effects on patient access to care, before and after

unrestricted licensure of FTPs. Moreover, research comparing the impacts of FTP laws on patient quality of care and overall health costs, as well as US medical school graduates, is needed to understand short- and long-term benefits of these programs.

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