NORTH DAKOTA BOARD OF MEDICINE
Established 1890

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WORKFORCE DEVELOPMENT COMMITTEE
FEBRUARY 13, 2025

TESTIMONY OF
NORTH DAKOTA BOARD OF MEDICINE
SENATE BILL NO. 2270

Chair Wobbema, members of the Committee, I'm Sandra DePountis, Executive Director of the North Dakota Board of Medicine, appearing on behalf of the Board to provide information and testimony in opposition of Senate Bill 2270.

The mission of the Board of Medicine is to protect the health, safety, and welfare of the citizens in North Dakota. One way it does so is by verifying that only qualified and competent individuals provide medical care to the citizens of North Dakota. As such, North Dakota law, in keeping with national standards, requires physicians to complete 3 steps before they are deemed safe to practice and obtain a medical license. #1: graduate from an acceptable, accredited medical school, #2 pass the appropriate examinations, and #3 complete a United States accredited post-graduate training program – commonly referred to as a residency program and referred to as such throughout this testimony. This step is the practical portion in which the physician proves competency that they can actually practice medicine in their specialty area (aka doing the surgery as opposed to just reading about how to do a surgery) while also learning to navigate U.S. healthcare systems. The bill affects this third step[1] in that it

[1] The United States already has ways to verify #1. United States medical education programs for an M.D. degree are accredited by the Liaison Committee of Medical Education (LCME). Internationally, the World Federation of Medical Education (WFME) and the Foundation for Advancement of International Medical Education and Research (FAIMER) vet the programs and issue a list of recognized and approved education programs in the World Directory of Medical Schools. The individual must graduate from a school on this list – and then be certified and sponsored by the Education Commission on Foreign Medical Graduates (ECFMG). Through the ECFMG – the physician can then be eligible to take the United States Medical Licensing Examinations (USMLE) and be eligible for a U.S. residency program.

takes away the requirement that the international medical practitioner (IMP) obtain United States accredited residency training, and puts the onus on the Board of Medicine to verify that the international training the IMP receives in a foreign country (which can vary from an actual residency program to an apprenticeship, and everything in between) is “substantially similar” to a U.S. residency training and the IMP is therefore safe to practice.

Arguably, the most prominent emerging issue in the world of medical regulation is the licensure of IMPs. The Board appreciates and recognizes the issue in asking a physician in a foreign country who has practiced for numerous years and may be at the top of their profession in that country, to now do a residency program to practice in the United States. The question then becomes, without the residency program, how can competency be verified? How do we verify the IMP is knowledgeable about the U.S. healthcare system so they can competently practice in the U.S.? What could this alternative pathway look like that protects patients in North Dakota?

This last year, board members and staff attended countless roundtables, conferences, and think-tanks on this topic and have been continually involved in finding a workable solution. While we actively engage in addressing this issue, the Board does not want to be in a position of rushing a process that would create more problems than solutions.

Unlike the organizations that vet medical education programs – there is not currently an established and accepted recognition system, accreditation system, or authority that is in a position to deem an international post-graduate training program to be “substantially-similar” to an ACGME-accredited program available in the United States. The North Dakota Board of Medicine is not in a position to review an international residency program and verify it has the same standards and requirements as a U.S. residency program – or that an IMP will be safe to practice in the U.S. with another country’s training. National entities devoted specifically to training programs have struggled with this issue and to suggest that the North Dakota Board of Medicine can obtain the information to verify that

training in a foreign jurisdiction – whether that be the U.K or Zimbabwe – is substantially similar to a U.S. residency program – is impractical. The Board does not have such resources or capabilities.

Even if foreign training competency can be verified, removing U.S. residency program training removes another key component – which is learning to navigate U.S. healthcare systems – so IMPs are competent to practice in the United States.

U.S. healthcare systems are nuanced, complex, and different from any other healthcare systems in the world. U.S. residency programs provide more than clinical skill training, they provide the training and tools to navigate the U.S. healthcare system, including acceptable U.S. ethical and professionalism principles; interpersonal and communication skills with patients, families, health professionals; U.S. insurance laws; billing processes; electronic record keeping; HIPAA laws; etc. During conferences, we heard from IMPs who reported feeling they were being set up for failure by just being thrown into the U.S. healthcare system without training, proctoring, or mentorship. This training is essential for the IMPs to practice competently in the U.S.

There are other nuanced concerns with the bill. At this time, if an individual does not complete U.S. residency training, they are not eligible to obtain certification from the American Board of Medical Specialties (ABMS), which is a requirement by numerous healthcare facilities to privilege and credential the practitioner. It is unclear whether the IMP can participate in federal/state Medicare/Medicaid programs. Immigration laws and obtaining federal immigration status is also an unsettled area at this time – how does the Board verify that an individual "is eligible to obtain appropriate federal immigration status for medical practice" as required by the bill.

There is progress in this area – and solutions are underway – but we are not quite there yet. The Board did not bring forth a bill this legislative session on this issue as it felt premature. World Federation of Medical Education announced in 2024 it will be implementing a program to

vet international training programs – but it will take some time to implement and process the vetting of the international programs.

In the past year, the Federation of State Medical Boards (FSMB) began a taskforce on issuing model guidance for legislation of alternative pathways to licensure of IMPs, so that there is consistency among states in addressing this issue. North Dakota has been actively involved in this taskforce. FSMB's Initial Guidance was just finalized and issued on February 4, 2025. I urge you to review this guidance as several of the key components to safely license IMPs are missing from this bill. On top of this list, is a key requirement that the medical facility offering employment must provide direct supervision and assessment of the IMP's competency and proficiency, while also providing training on U.S. healthcare systems. FSMB's Guidance outlines what is an appropriate medical facility, which should not be solo practitioner practice or purely telemedicine practice, but instead be a facility that has the capacity and experience with medical education and assessment to shoulder the supervisory responsibilities and with sufficient infrastructure that allows for supportive education and training for the IMP (examples include facilities with ACGME-accredited residency programs, a North Dakota licensed health care facility, a Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), etc. – located in North Dakota).

In addition, the guidance continually reiterates how many state medical boards lack the capacity, resources, and expertise to make a "substantial equivalence" determination, leaving the boards in the position to make licensure decisions without adequate data on physician training that ultimately puts patients at risk. States would need significant funding to implement such a division that is knowledgeable and understanding of licensing IMPs to review international medical training.

The North Dakota Board of Medicine is therefore requesting holding off on passing such legislation during this session. In two years when session reconvenes, many of these issues will hopefully be worked out – with appropriate safeguards in place to verify that only

appropriately trained IMPs are providing healthcare services to the citizens of North Dakota – and there is appropriate infrastructure and resources in place to aid IMPs to competently transition to U.S. practice.

Please note that the Board already has a recognized pathway for physicians who otherwise do not meet all technical requirements for licensure including attending U.S. residency – through a "uniquely qualified license."[2] The law requires the Board to take into account the nature and length of medical practice, training, licensure in another state, any disciplinary actions or malpractice judgements/settlements, etc. This pathway has worked well and can continue to work well in the interim while the above gets further developed.[3]

In the event this bill moves forward – there are numerous amendments that would need to be made in order for this to be workable and safe for North Dakota patients.

Page 1 lines 9-13 and page 2 – line 17 – definition of "health care provider" and offer of employment requirement. (There is also reference to the "sponsoring facility" on page 3 line 13. Would recommend the language be consistent throughout.) The Board requests that definition of health care provider who provides the offer of employment be updated to a medical facility that can assure supervision and assessment of the IMP's proficiency – with sufficient infrastructure that allows for education and training, as well as supervisory and assessment resources. It should be at a facility "located" in North Dakota (versus just 'operating') and the supervisor should be a North Dakota licensed physician who practices in the same specialty area as the IMP. The facility must provide supervision of the temporary licensure which is crucial to navigate and bridge cultural differences and train the IMPs on the U.S. health care system. The supervision structure may include a collaborative practice arrangement,

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[2] North Dakota Century Code section 43-17-18(4) and North Dakota Administrative Code 50-02-02-01(2).
[3] According to FAIMER, ECFMG, and Intealth, North Dakota is one of ten states above the national average of international medical graduates licensed. The National Average is 25% and there are 10 states with higher national averages including: New Jersey (39%), New York (36%), Florida (35%), Connecticut (31%), Illinois (29%), Michigan (28%), Nevada (28%), Delaware (28%), North Dakota (27%), Maryland (27%), and West Virginia (27%).

preceptorships, or a formalized training model, but must include opportunities for progressive assessment of the IMP's caseload and practice. Assessments should be reported to the Board at least every 6 months with the supervisor ultimately reporting to the Board that the IMP is "fit for practice" before the license changes to a full, regular physician license – with the Board implementing by rule what needs to be attested to in the fitness to practice. There should also be a reporting requirement in the law requiring the health care facility and IMP to immediately report directly to the Board if there are concerns or if they cease employment with the IMP. Finally, there should be some barometer of number of hours worked each year (so that the IMP is not just logging in 40 hours a year for three years).

Page 1 line 23-24 – change to "no discipline within the last five years immediately proceeding the application AND no pending discipline" (and change "medial" to "medical").

Page 2 lines 4-5 – require that the seven years of practice occurred within the last ten years. This is to assure that clinical skills are maintained – and that the individual practice 20 years ago, hasn't practiced since, and that the over 20 year old practice would count. The Board would therefore recommend that the seven-year practice needed to occur within the last ten years.

Poage 2 line 11 – demonstrates English language proficiency. The Board requests "as approved by the Board" be added to this provision so the Board can determine whether the test for English proficiency is sufficient.

Changing the word "provisional" as the designated licensure type. A "provisional" license is an already utilized term in the Board's Medical Practice Act and relates to a license issued in-between board meetings. The license issued under this bill instead seem to fit more into a "conditional" or "restricted" licensure status – and should be designated as such. There is also another bill, SB 2395 – requiring boards to issue provisional licenses between Board meetings for routine, unencumbered applications. This license will need its own designation.

Page 2 line 18 – “is eligible to obtain appropriate federal immigration status for medical practice.” The Board is not sure how such eligibility would be proven. Instead, the Board requests changing to “possesses federal immigration status allowing practice as a physician in the Untied States.”

Page 2 lines 25 - 31 – revocation or discipline of the license. The Board request this license be subject to the same laws and procedures as any other physician license issued by the Board – including the same grounds for discipline under N.D.C.C. § 43-17-31, the same investigatory process under N.D.C.C. chap. 43-17.1, and the same process for discipline under N.D.C.C. chaps. 43-17 and 28-32.

Page 3, lines 1-2. Remove that the license “automatically” converts to a full license after 3 years. Instead, have requirements from the facility and supervisor attesting to the IMP’s fitness to practice independently before a full license is issued. Also allowing the Boards to consider any discipline, complaints, substandard care, or malpractice (or any other grounds for denying a license of other physicians under N.D.C.C. § 43-17-31) during the 3-year period as a potential basis to deny the license. The Board also would request that it may require the IMP to take and pass a U.S. recordkeeping course approved by the Board before they can become fully licensed, to verify competency in this specific area.

Page 3, line 4 under additional provisions in which the Board may verify training, review examination results, etc. – the Board requests an amendment clarifying that the verification allowed under this section can be done BEFORE issuing a license.

The Board requests an amendment adding an additional requirement to the definition of an “international physician” under 43-17.6-01(4) or under 43-17.6-03 that the Board may require the IMP to pass a competency examination at a facility approved by the Board. Until such time as international training and practice can be thoroughly vetted by appropriate agencies, such a test will verify competency of the IMPs, which will, in turn, protect the citizens of North Dakota to know that even without U.S. residency training, the individual is competent to provide clinical

medical services. There are several entities that provide such competency examinations the Board already utilizes, and the Board can direct the individuals to these entities.

The Board would request that the IMP be subject to the same process for complaints and investigations of all other professions as authorized in accordance with N.D.C.C. chap. 43-17.1.

Finally, the Board would need rulemaking authority to implement the law.

Thank you for your time and attention and I would be happy to answer any questions.