2025 SENATE WORKFORCE DEVELOPMENT

SB 2270

2025 SENATE STANDING COMMITTEE MINUTES

Workforce Development Committee
Fort Lincoln Room, State Capitol

2270
2/13/2025

A BILL for an Act to create and enact chapter 43-17.6 of the North Dakota Century Code, relating to the licensure of international physicians.

9:00 a.m. Chairman Wobbema called the meeting to order.

Members Present: Chairman Wobbema, Vice-Chairman Axtman, Senator Boschee, Senator Larson, Senator Powers.

Discussion Topics:

- Role of Mentorship for international physicians.
- Education Standards

9:01 a.m. Senator K. Roers, District 27, Introduced the bill in favor and submitted testimony #37511.

9:03 a.m. Donna Thronson, ND Medical Association, testified in favor and submitted testimony #37496.

9:14 a.m. Mike Zimmer, Senior Policy Consultant, World Education Services, testified in favor and submitted testimony #37437.

9:20 a.m. Sandra DePountis, Executive Director, Board of Medicine, testified in opposition and submitted testimony #37500 and #37501.

9:35 a.m. Donald Mucara, Physician, testified in neutral.

Additional written testimony:

Justin Forde, Americans for Prosperity, submitted written testimony in favor #37404.

Victoria Francis, Deputy Director of American Immigration Council, submitted written testimony in favor #37491.

Cale Dunwoody, FMWF Chamber of commerce, submitted written testimony in favor #37574.

Andrew Ficek, Committee Clerk

February 13, 2025

In support of SB 2270

The United States is facing a critical shortage of physicians that is intensifying due to an aging workforce, growing population, and overburdensome licensure requirements. This national shortage of providers is affecting North Dakota, with over 180,000 state residents living in a health professional shortage area.[1] To begin addressing this shortage of providers, qualified foreign physicians that have been trained in comparable programs outside of the United States must be given a reasonable pathway to licensure as a physician in the state. The main hurdle to this solution is North Dakota's onerous state licensure requirements.

Residency programs train medical graduates to practice in different medical specialties and can last anywhere from three to seven years, often requiring long hours for lower rates of pay than fully licensed doctors receive. By default, foreign physicians are not exempted from the residency program requirement even if they have already completed the equivalent of that training and were successfully practicing as a physician in another country. Under this framework, there is no incentive for foreign trained medical professionals to come into North Dakota and redo years of training. To complicate matters further, the national residency program system is already overburdened with applicants and is unable to accommodate all the medical graduates that are educated in American schools. Every year, an estimated seven percent of United States medical school graduates are refused entry into a residency program and are thereby unable to continue their medical training to further help alleviate the provider shortage.[2] Requiring qualified foreign trained physicians to complete an additional residency training program is a waste of resources that can be better allocated to American medical students.

These onerous licensure requirements ignore the educational training and professional experience that foreign physicians have received abroad while also overlooking the high quality of care that these physicians give to American patients. In 2017, 25.4% of the United States' practicing physicians were trained abroad. Foreign physicians make up an even larger portion of the physician workforce in many in-demand medical specialties, like geriatrics (52.7%), oncology (34.4%), and cardiology (34.0%).[3] Foreign physicians who are not born in the United States are also more likely to serve in rural, low-income, or underserved communities.[4] Studies show that foreign physicians have the same, if not better, patient outcomes.[5]

S.B. 2270 would create an expedited licensure pathway for qualified foreign trained physicians who receive job offers from health care providers throughout the state. After working under the supervision of other physicians on a limited license for three years, these providers would be eligible for an unrestricted license to practice in North Dakota. Similar actions have been taken in 12 other states in recent years.

Foreign physicians are a valuable source of physician care for all patients—especially those in communities that are clamoring for care. To adequately address North Dakota's dwindling supply of physicians and ever-increasing demand for health care, we must allow qualified foreign trained physicians to practice without unnecessarily repeating their medical training. These providers should be welcomed into North Dakota for the benefit of patients in need.

Sincerely,

Justin Forde

Americans for Prosperity North Dakota

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[1] "Primary Care Health Professional Shortage Areas (HPSAs)," Kaiser Family Foundation, updated April 1, 2024.
[2] Brendan Murphy, "If you're feeling disappointed on Match Day, you are not alone," American Medical Association, April 8, 2024.
[3] "Foreign-Trained Doctors are Critical to Serving Many U.S. Communities," American Immigration Council, January 2018.
[4] Robbert J. Duvivier, Elizabeth Wiley, and John R. Boulet, "Supply, distribution and characteristics of international medical graduates in family medicine in the United States: a cross-sectional study," BMC Family Practice, March 30, 2019.
[5] Chris Fleming, "Foreign-Trained And U.S.-Trained Doctors Provide Same Quality of Care," Health Affairs, August 4, 2010; Yusuke Tsugawa et al., "Quality of care delivered by general internists in US hospitals who graduated from foreign versus US medical schools: observational study," BMJ, February 3, 2017; and Yusuke Tsugawa et al., "Comparison of Patient Outcomes of Surgeons Who Are US Versus International Medical Graduates," Annals of Surgery, December 2021.

NORTH DAKOTA TESTIMONY

Chair Roers Jones and Members of the Committee:

Thank you very much for affording World Education Services (WES) the opportunity to testify in strong support for SB 2270.

By way of introduction, WES is a non-profit, social enterprise that, for over 50 years, has been dedicated to helping international students, immigrant, and refugees achieve their educational and career goal in the US and Canada. We join with institutional partners, community-based organization and policy makers to help immigrant and refugeed utilize their talents and achieve their educational and career goals.

In recent years, we have provided technical advice and expertise to a number of states seeking to develop pathways to licensure for internationally trained healthcare workers. A large part of that focus has been internationally trained physicians.

By way of the national landscape, since 2022, 11 states have passed reforms creating pathway (WA, CO, ND, FL, IA, IL, WI, VA, LA, MA, and TN). This year, to date, pathway legislation for IMGs has been introduced in 18 more states (MT, OR, MD, NV, NM, HI, MO, KS, CT, RI, OR, ME, MN, TX, OK, IN, WY, AZ and now ND). WA and TN have legislation pending to expand their existing pathways. Legislation is expected to be introduced in at least 6 more states yet this year. As you can see, this list of states creating or working on pathway legislation includes all regions of the country and crosses the political spectrum.

The goal of all of this legislation, including SB 2270 in ND, is twofold: (1) to create a meaningful and workable pathway to harness the skills and talents of internationally trained physicians, and (2) to use that pathway to address healthcare workforce shortages.

SB 2270 includes important provisions to safeguard the health and safety of the public while harnessing internationally trained physicians' skills. By requiring appropriate training and experience, by vesting the board with oversight, and by tying service with that provided at a fully licensed health care provider, the legislation contains important safeguards and standards. By including a pathway for eventual full licensure, the legislation would make ND an attractive place to locate, work and contribute.

Again, thank you very much for allowing me and WES to offer our strong support for these important bill.

American Immigration Council

February 14, 2025

To: Chair Wobbema and Members of the Senate Committee on Workforce Development

From: Victoria Francis, Deputy Director, State & Local Initiatives, American Immigration Council

RE: SB 2270: An act to create and enact chapter 43-17.6 of the North Dakota Century Code, relating to the licensure of international physicians.

Dear Chair Wobbema and Members of the Senate Committee on Workforce Development,

My name is Victoria Francis, and I am the Deputy Director of State and Local Initiatives at the American Immigration Council (the Council), an organization that works to advance positive public attitudes toward immigrants and create a more welcoming America—one that provides a fair process for immigrants and adopts immigration laws and policies that take into account the needs of the U.S. economy.

I am submitting this letter to express the Council's support for removing barriers that keep qualified North Dakotans from contributing to the state's workforce. To this end, I respectfully encourage the passage of SB 2270, which would establish a process for international physicians to obtain provisional and, eventually, full medical licensure in North Dakota, contingent on meeting specific educational, professional, and legal criteria.

My organization has worked with leaders in government, business, and civil society across the country to recognize the crucial role immigrants are playing in state and local economies in some of the fastest-growing and most in-demand fields, including healthcare. In order to remain competitive and meet critical healthcare workforce shortages, North Dakota will need to continue to implement policies that not only attract and retain immigrant talent that complements U.S.-born workers but also build career pathways for immigrants already living in the state. SB 2270 will do just that by expanding access to licenses to qualified internationally trained residents, thereby increasing economic opportunities for all residents and helping to meet the state's pressing workforce and healthcare needs.

To help illustrate why this measure is so important and why it makes sense to reduce barriers for all qualified North Dakotans, my organization has conducted quantitative research on the impact immigrants already have on the state and the growing demand for workers in North Dakota.[1]. What we found is striking.

[1] Available at https://map.americanimmigrationcouncil.org/locations/north-dakota/.

- **As of 2022, North Dakota is home to 31,500 immigrants, making up 4.0 percent of the state's population.** These residents are critical to addressing the state's workforce shortages across the skills and education spectrum, with 89.0 percent of immigrant North Dakotans being of working age (ages 16-64), compared to 61.6 percent of their U.S.-born counterparts.
- **Immigrants in North Dakota are contributing millions in taxes and consumer spending.** In 2022, immigrant households in the state earned $1.2 billion in income, with $190.3 million going to federal taxes and $84.6 million going to state and local taxes, leaving them with $942.6 million in spending power that can be reinvested back in the state.
- **North Dakota's immigrant population is already filling a critical need for workers.** In 2022, despite making up 4.0 percent of the state's total population, immigrants made up 5.6 percent of workers in the labor force.

As more North Dakotans reach retirement age and the state must address workforce shortages, retaining and leveraging the talent of all residents is critical. North Dakota is in a position to take decisive action to support and leverage the skills of the state's future workforce and advance opportunities that benefit all North Dakotans. I encourage the Senate Committee on Workforce Development to support the passage of SB 2270.

Thank you for your consideration,

Victoria Francis

Deputy Director, State & Local Initiatives
American Immigration Council

Senate Workforce Committee

SB 2270

February 13, 2025

Chairman Wobbema and Committee Members, I'm Donna Thronson and I serve as Communications Director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students. NDMA supports SB 2270.

NDMA strives to increase access to medical care in the state, and SB 2270 will help achieve this by promoting access to care by deploying the expertise of experienced international physicians.

As acute physician shortages continue to be a central concern for North Dakota and NDMA seeks out and advocates for new ways to make health care more accessible for all populations. We believe North Dakota should seize the opportunity to integrate qualified international physicians into the highest areas of need to help address the state's current and future provider shortages. These are experienced physicians who have been educated, trained, and obtained licensure or its equivalent outside of the United States. They have practiced medicine independently abroad, often for many years. However, international physicians face substantial barriers to healthcare workforce reentry in the United States. These obstacles include having to repeat years of postgraduate clinical training

(residency). Moreover, international physicians are largely unable to secure positions in residency programs because slots are severely limited and are designed for recent medical school graduates. Nationally, 22% of internationally trained immigrant physicians are underemployed, and 14.7% are working in jobs outside their field of training if not outside of health care altogether.

To address physician shortages and increase healthcare delivery, a growing number of states have made significant progress in developing alternative pathways to practice for international physicians.

SB 2270 would set North Dakota on such a path by allowing qualified international physicians who have been licensed or authorized to practice medicine outside of the United States to be issued a provisional license to practice medicine under the employment of a participating healthcare provider operating in our state. To be eligible, qualified candidates would need to complete all examination and credentialing requirements that are currently required for entry into a residency program and also have an offer of full-time employment from a participating facility. Program assessment and evaluation criteria would be developed and/or approved by the Board of Medicine to ensure program participants are qualified and meet appropriate standards to ensure patient safety and quality of care. This provisional license converts to a full medical license automatically after three years of active practice in this state.

NDMA recognizes that this legislation is not a perfect solution. For example, there are skills learned in residencies that are unique to the U.S. healthcare system. Therefore, we suggest that a mentorship or proctor requirement be added to the bill. A supervisor to

aid and monitor the international physician for a period of time, such as 2,000 hours of practice. The other suggested change would be to allow the Board to verify the training and the mentorship prior to the full license being granted.

NDMA has no objection to any of proposed amendments put forth by the Board to assure the international physician is competent to practice in North Dakota.

Thank you for the opportunity to address this committee. I would be happy to answer any questions.

NORTH DAKOTA BOARD OF MEDICINE
Established 1890

4204 Boulder Ridge Rd Suite 260
Bismarck, ND 58503-6162
Phone (701) 450-4060 • Fax (701) 989-6392
www.ndbom.org

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.

Advisory Commission on Additional Licensing Models
GUIDANCE DOCUMENT

Introduction

The *Advisory Commission on Additional Licensing Models*, co-chaired by the Federation of State Medical Boards (FSMB), the Accreditation Council for Graduate Medical Education (ACGME) and Intealth™ (which oversees the Educational Commission for Foreign Medical Graduates - ECFMG), was established in December 2023 to guide and advise state medical boards, state legislators, policymakers and others, to inform their development and/or implementation of laws specific to the licensing of physicians who have already trained and practiced medicine outside the United States or Canada. In this document, the commission offers its first set of recommendations for consideration by all relevant stakeholders.

Internationally-trained physicians (ITPs), as described in some of the state laws enacted to streamline medical licensure to increase access to care in undeserved and rural communities, are usually referred to as physicians educated and trained abroad who *must* also be licensed and have practiced medicine in another jurisdiction. This cohort of physicians represents a relatively small category of international medical graduates (IMGs), the broader term used to describe physicians who received their medical degree outside the United States. Individuals who are ITPs, in most legislative descriptions, *must* have previously completed graduate medical education (also known as postgraduate medical education or postgraduate training) that is "substantially similar" to that which is recognized in the United States.

The purpose of the commission's recommendations, those contained herein and those that may follow, is to support the alignment of policies, regulations and statutes, where possible, to add clarity and specificity to statutory and procedural language to better protect the public – the principal mission of all state and territorial medical boards – and to advance the delivery of quality health care to all citizens and residents of the United States. This guidance, which should not be viewed as an endorsement, is provided to support those states and territories implementing new licensure pathways where legislation has been adopted and where legislation has been introduced or is being considered for introduction.

This first set of recommendations is focused on eligibility requirements and related considerations for entry by an ITP into an additional licensure pathway. To ensure that physicians entering these pathways are ultimately ready to safely practice medicine in the United States, these additional licensing pathways should optimally include assessment and supervisory elements during the period of provisional licensure, for which additional

guidance from the commission to state medical boards and relevant stakeholders should be forthcoming later in 2025.

Background

There are two primary pathways by which international medical graduates (IMGs) are eligible for medical licensure from a state medical board in the United States and its territories:

1. Completion of one to three years, depending on the state or territory,[1] of U.S.-based graduate medical education (GME) that is accredited by the ACGME, accompanied by certification by ECFMG® and successful passage of all three Steps of the United States Medical Licensing Examination® (USMLE®), is the most common pathway to medical licensure for international medical graduates (IMGs) in the United States. In addition to expanding a physician's knowledge and skills in one or more medical or surgical specialties, U.S.-based GME affords time for participants (whether previously trained and licensed abroad or not) to acclimate to the U.S. health care system, culture and social norms, and the medical illnesses and conditions that are most prevalent (e.g., heart disease, cancer, accidents) among those residing in the United States.
2. "Eminence" pathways (for prominent mid-career physicians) have long existed in many states, typically do not require ECFMG Certification or successful passage of any Step of the USMLE, and are likely to continue to be an option for highly qualified and fully-trained international physicians. These pathways are most often used by individuals deemed to have "extraordinary ability," including those classified as "eminent specialist" or "university faculty" pursuing academic or research activities, and typically align with the O-1 (extraordinary ability) visa issued by the U.S. State Department.[2] Of note, most state medical boards also have statutes or regulations allowing for the licensing of IMGs at their discretion[3], though in practice these are not easy to achieve or commonly available. A few medical boards explicitly allow postgraduate training (PGT) – also known as graduate medical education (GME) or postgraduate medical education (PGME) –completed in specific countries, such as England, Scotland, Ireland, Australia, New Zealand and the Philippines, to count toward the U.S.-based GME requirement for licensure.

[1] International Medical Graduates GME Requirements, Board-by-Board Overview, FSMB

[2] https://www.uscis.gov/working-in-the-united-states/temporary-workers/o-1-visa-individuals-with-extraordinary-ability-or-achievement

[3] Several states have authority to issue licenses to internationally trained physicians though other innovative approaches. For example, New York offers licensure without requiring a provisional supervisory period to highly qualified IMGs. California offers a three-year non-renewable license for up to 30 Mexican physicians a year to work in community health centers. Washington has a "clinical experience license" to help IMGs compete for residency matching.

Since January of 2023, nine (9) states have enacted legislation creating additional licensing pathways for internationally trained physicians that does not require completion of U.S.-based ACGME-accredited GME training.

These additional licensing pathways are designed principally for ITPs who wish to enter the U.S. healthcare workforce.

A primary goal of these pathways in many jurisdictions, reflected in public testimony and written statements submitted by sponsors and supporters, is to address U.S. healthcare workforce shortages, especially in rural and underserved areas. It must be noted that U.S. federal immigration and visa requirements will impact the practical ability of physicians who are not U.S. citizens or permanent U.S. residents (Green Card holders) to utilize any additional licensure pathway. Furthermore, the ubiquity of specialty-board certification as a key factor in employment, hospital privileging, and insurance panel inclusion decisions is likely to impact the efficacy of non-traditional licensing pathways. States may, therefore, wish to consider other healthcare workforce levers that could be more effective in increasing access to care, such as advocating for increased state and Medicare/Medicaid funding to expand U.S. GME training positions, offering some means of transition assistance to IMGs, and expanding the availability and utilization of enduring immigration programs like the Conrad 30 waiver program, U.S. Department of Health and Human Services (HHS) waivers, regional commission waivers, and United States Citizenship and Immigration Service (USCIS) Physician National Interest Waivers.

While the additional pathway legislation recently introduced and enacted varies from state to state, the commission's consensus-driven guidance highlights areas of alignment and suggests specific considerations and resources for implementation and evaluation of these pathways, where that may be possible. The commission drafted its first set of recommendations based on areas of concordance in legislation already introduced and enacted, as well as expert opinion. The following recommendations are offered for consideration by state medical boards, state legislators, policymakers, and other relevant parties:

1. **Rulemaking authority should be delegated, and resources allocated, to the state medical board for implementing and evaluating any additional licensure pathways.**
2. **An offer of employment should be required for pathway eligibility. State medical boards should be authorized to define what is an appropriate clinical facility for the supervision and assessment of internationally trained physicians (ITPs) for their provisional licensure period.**
3. **ECFMG Certification and graduation from a duly recognized medical school should be required for pathway eligibility.**
4. **Completion of postgraduate training (graduate medical education) outside the United States should be required for pathway eligibility.**

5. **Possession of authorization from another country or jurisdiction to lawfully practice medicine in that country or jurisdiction, and at least three years of experience in medical practice should be required for pathway eligibility.**
6. **A limit on the physician's time "out of practice" that is consistent with that state's existing re-entry to practice requirements should be considered.**
7. **A successfully completed period of supervision and assessment by an employer should be required of ITPs to transition from provisional licensure to full licensure.**
8. **State medical boards should preserve their authority to assess each candidate for full and unrestricted licensure.**
9. **State medical boards implementing additional licensure pathways should collect and share data to evaluate the program's effectiveness.**

<u>Recommendations</u>

1. **Rulemaking authority delegated, and resources allocated, to the state medical board for implementing additional licensure pathways.**

Many states that have enacted additional pathway legislation have explicitly included and codified state medical board involvement in implementation and operational processes to ensure the ability of the state to support safe medical practice.

Additional licensing pathways will likely incur increased time and resources for state medical board personnel. State legislatures should consider additional funding and resources that may be allocated through state appropriations to implement, operationalize, and evaluate any additional pathway for medical licensure. Insufficient financial resources to support such additional licensing pathways risks inadequate resources and expertise that may lead to rushed or incomplete licensure eligibility decisions, risking the admission of underqualified practitioners or delays in integrating ITPs into the healthcare workforce.

States evaluating how to proceed may wish to consider first authorizing their state medical boards to establish a smaller pilot program, with primary care specialties that typically require a shorter period of GME that is more comparable internationally, and which may serve to better help increase access to care in rural and underserved areas. Such an approach may also enable state medical boards and private partners to build the necessary infrastructure and trust for adoption of the pathways and to evaluate the supervisory provisional licensure period before a substantial increase in applicants, or expansion to other specialties, takes place.

***Recommendation 1a*: States should empower their medical boards to promulgate rules and regulations should they choose to enact additional licensure pathway requirements for qualified, internationally trained physicians.**

Recommendation 1b: **State legislatures should ensure state medical boards have the necessary resources to fully implement, operationalize, and evaluate any new, additional licensure pathways, including the ability to hire or assign staff with knowledge and understanding of licensing international medical graduates.**

2. **An offer of employment prior to application for an additional pathway.**

Internationally-trained physicians (ITPs) applying for a license to practice medicine under newly enacted licensure pathways are being required by statute to have an offer of employment from a medical facility that can assure supervision and assessment of the ITP's proficiency. All states that have enacted additional pathway legislation at the time of this document's writing have included such a requirement, whether it is employment at a hospital that has an associated ACGME-accredited residency program, a Federally Qualified Health Center (FQHC), a Community Health Center (CHC), a Rural Health Clinic (RHC), or other state-licensed clinical facility that has the capacity and experience with medical education and assessment to shoulder the supervisory responsibility. The employer should in all cases be an entity with sufficient infrastructure that allows for supportive education and training resources for the ITP, as well as supervisory and assessment resources that include, but are not limited to, peer-review. For this reason, offers by individual physicians in solo or group practices to serve as employers for ITPs eligible for these pathways are not advisable as such settings may not have the capacity to provide supervision, the breadth and depth of exposure to a variety of clinical experiences may be limited, and because this may raise conflict of interest concerns related to the employer-employee relationship.

Recommendation 2a: **States in consultation with state medical boards should require internationally-trained physicians applying under an additional licensure pathway to have an offer of employment from an appropriate medical facility.**

Recommendation 2b: **States in consultation with state medical boards should define which medical facilities are able to supervise and assess the ITP's proficiency and capabilities (e.g., a facility with an ACGME-accredited program, an FQHC, a CHC, an RHC or other medical facility that has capacity and experience with medical education and assessment).**

3. **ECFMG Certification and graduation from a duly recognized medical school.**

Internationally-trained physicians applying under an additional licensure pathway should be graduates of a duly recognized medical school. All states that have enacted pathway legislation at the time of this document's release have included such a requirement.

Recognition or inclusion of medical schools in directories from organizations such as the World Health Organization (WHO) or the *World Directory of Medical Schools* (*World Directory*)[4] may serve as a useful proxy for this requirement. The latter compendium, launched in 2014 and updated continuously, is jointly managed and operated by the World Federation for Medical Education (WFME) and FAIMER® (a division of Intealth.)

Recommendation 3: **States should require ECFMG Certification for internationally-trained physicians to enter an additional licensure pathway**.
Traditionally, IMGs have been required to obtain ECFMG Certification, a qualification that includes verification of their graduation from a *World Directory*-recognized medical school, passage of USMLE Steps 1 and 2, and demonstration of English language proficiency via the Occupational English Test (OET) Medicine.

State medical boards may also wish to require IMGs to provide additional supporting materials of the medical education they have undertaken outside the United States. In such instances, primary source verification and review of credentials that utilizes resources such as Intealth's Electronic Portfolio of International Credentials (EPIC℠)[5] may be useful.

4. Completion of post-graduate training (PGT) outside the United States.

Most states that have enacted additional pathway legislation have included a requirement that applicants must have completed PGT that is "substantially similar" to a residency program accredited by the ACGME in the United States. There is significant variability, however, in the structure and quality of international PGT. The degree of clinical exposure may be variable and inconsistent across programs. Too, there is not currently an established and accepted recognition system, accreditation system or authority that is in a position to deem an international PGT program to be "substantially similar" to an ACGME-accredited PGT program available in the United States. Most state medical boards, for their part, have limited capacity, resources, or expertise to assess international programs for this purpose.

Until a formal recognition or accreditation system for PGT is created, the term "substantially similar" will need to be defined and determined by state medical boards.[6]

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[4] https://www.wdoms.org/. Many states that have enacted pathway legislation have included language that the applicant ITP have received a "degree of doctor of medicine or its equivalent from a legally chartered medical school recognized by the World Health Organization" as a requirement. However, the WHO no longer maintains an active list or directory of international medical schools. The "California List" may also be referenced (https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Apply/Schools-Recognized.aspx), however, the California list utilizes the World Directory mentioned above.

[5] https://www.ecfmg.org/psv/

[6] The World Federation for Medical Education (WFME) is developing a program to recognize international accreditation systems for PGT. While a comprehensive list will not be available for several years, this

Arriving at definitions and determinations of substantial similarity, in turn, will have significant implications for state medical boards to plan for and obtain additional resources, support, and expertise to evaluate international training programs that generally have significant variability in structure, content, and quality. In the absence of resources to assist state medical boards in making determinations of substantial equivalency, state medical boards may be asked to make licensure decisions without adequate data on physician training, a challenge that may put patients at risk.

Recommendation 4a: **Completion of formal, accredited PGT outside the United States should be a requirement for entry into an additional licensure pathway.**

Formal postgraduate training and accreditation is not available in all countries and jurisdictions. In its absence, some states and territories may be inclined to consider alternative forms of training abroad. We advise doing so only on a case-by-case basis. The circumstances and experiences involved in these types of training – including apprenticeship, clerkship, or observership models – also differ widely in objective measures of quality (when fellowship training is not involved) and sometimes involve quasi-residency arrangements that may or may not adequately support, in whole or in part, an international physician's ultimate eligibility for a full and unrestricted licensure in a jurisdiction of the United States.

State medical boards may make use of a variety of existing proxies for determining that a PGT program completed outside the United States is "substantively similar" for purposes of additional licensure pathway eligibility for ITPs, including whether the program has been accredited by *ACGME International* (ACGME-I) and/or whether the ITP has completed an ACGME-accredited fellowship training program in the United States. Boards may also wish to ask the ITP to submit their training program's curriculum (and case requirements, for surgical specialties) for consideration and review.

A "number of years in-practice" threshold in a given specialty, in place of a requirement for formal PGT, is not recommended. However, it may be considered on a case-by-case basis by the state medical board as an alternative metric, only if it includes additional requirements and safeguards, such as ECFMG Certification and passage of all three Steps of the USMLE program. Where boards have access to, or can partner with, organizations with relevant experience and expertise, they should seek to determine the nature of such practice, including degree of clinical exposure, interaction with patients, and performance of procedures; where applicable, this information is likely to be valuable in making determinations of competence and practice readiness. Again, it is important to note that many state medical boards lack the resources and expertise to make such determinations themselves.

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voluntary program, launching in mid-2025, will allow accreditation agencies to apply for recognition. Those meeting predefined criteria will be listed on the WFME website as recognized systems.

5. **Possession of a license/registration/authorization to practice medicine in another country or jurisdiction and medical practice experience.**

Most states that have enacted additional pathway legislation have included a requirement that applicants be licensed or authorized to practice medicine in another country. Practice experience requirements in current legislation for additional pathways vary from three to five years. Such legislation typically also includes a requirement that the license obtained overseas be considered "in good standing" and that an attempt be made by the state medical board to verify the physician's disciplinary and criminal background history. State medical boards should consider primary source verification of any documentation from applicants related to licensure, employment and practice history.

Recommendation 5: **States should require internationally trained physicians applying for a license under an additional licensure pathway to be fully licensed, registered, or authorized to practice medicine in another country or jurisdiction and to provide evidence of medical practice experience of at least three years.**

6. **A limit on "time out of practice" before becoming eligible to apply for an additional licensure pathway.**

An internationally-trained physician's time out of active practice before applying for an additional licensing pathway is limited by statute in a number of states, in line with extant guidelines required for medical licensure renewal of current licensees, whether U.S. graduates or IMGs. "Time out of practice" is a challenge and concern for state medical boards in terms of assuring patient safety and public protection, regardless of where the training occurred or where the initial licensure was obtained, given that the practice of medicine changes rapidly. Many state medical boards already recommend a formal re-entry process when a licensed physician has been out of practice for more than a certain number of years (the most often cited period of time in statutes and regulations is two years).[7]

Recommendation 6: **States should consider limits on "time out of practice" for internationally-trained physicians that are consistent with existing re-entry to practice guidelines for other physician applicants and licensees within their jurisdiction.** States that have enacted additional licensing pathway legislation have listed varying ranges for the number of years of ITP practice that will or should be required, ranging from continuous practice preceding application to within the preceding five years. States should be cognizant that requiring continuous practice may be difficult for many applicants to manage and/or demonstrate, especially if they have to navigate the U.S. immigration system, adjust to displacement, and/or face any number of non-immigration barriers also

[7] board-requirements-on-re-entry-to-practice.pdf (fsmb.org)

faced by domestic physicians, such as time away from active practice, including but not limited to, for sickness, caregiving or raising children.

7. **A requirement for a period of supervised provisional licensure by an employer in the United States.**

All of the states that have enacted additional pathway legislation as of the date of this writing explicitly require ITPs eligible for additional pathways to first complete a temporary supervised period of provisional licensure.

The word "supervision" is mentioned as a part of this provision by some states, and a few states will allow ITPs to practice "under the supervision of a licensed physician for two years" as part of their pathway. Supervision and support for internationally-trained physicians are crucial to navigate and bridge cultural differences, and to enable qualified ITPs to learn the practical, technical and operational sides of the U.S. health care system, including cultural diversity, health system variabilities, billing processes and use of an electronic health record. Such supervision and support are also essential for public protection. Examples of supervisory structures that could be helpful to require of ITPs include a collaborative practice arrangement, preceptorships and/or more formalized training models that include opportunities for progressive assessment of the ITP's caseload and practice. States may also choose to require a "declaration of fitness" that is made by one or more supervising physicians or verification of compliance with a state's continuing medical education (CME) requirements in order to progress to full and unrestricted licensure.[8]

The advisory commission is exploring resources available to assist state medical boards with the potential structure of a meaningful and reasonable assessment program during the period of supervised provisional licensure and anticipates proposing a set of recommendations on this matter by the end of 2025.

***Recommendation 7a*: States should require a period of temporary provisional licensure for qualified internationally trained physicians.**

***Recommendation 7b*: During their period of temporary provisional licensure, applicants should be supervised by licensed physicians within the same specialty as the applicant's intended practice.**

***Recommendation 7c*: During this period of temporary provisional licensure, applicants should undergo assessment (as authorized by statute and defined by the state medical boards) and be provided adequate support by the employer to help the**

[8] Continuing Medical Education, Board-by-Board Overview, FSMB

international physician navigate and bridge cultural and boundary differences, including understanding billing, coding and electronic health records.

States have taken a variety of approaches in specifying the duration of provisional licensure, with two or three years being the most common time periods cited in legislation. However, there have been some legislative proposals for a two-step progression, by which an IMG first becomes eligible for a restricted or limited license after at least two years of provisional licensure, but still practices in areas or specialties with the greatest medical need.

8. **Eligibility for a full and unrestricted license to practice medicine.**

All states that have enacted additional pathway legislation have included a provision that at the conclusion of the provisional or restricted licensure period, the qualified international physician should become eligible to apply for a full and unrestricted license to practice medicine. There is a small but meaningful linguistic divergence in the legislation, however, with wording indicating that state medical boards *may* or *shall* grant a full and unrestricted license to the IMG applicant.

State medical boards ordinarily and typically retain the authority to make licensure decisions for all licensees, even after a period of provisional licensure. Automatic transition to full and unrestricted licensure, by contrast, is neither ordinary nor typical. State medical boards may wish to consider working with their legislatures to retain the ability to exercise their due diligence and the ability to assess each applicant on their merits before determining whether they meet the state's criteria for full licensure.

States may also consider additional explicit requirements for provisional licensees before being granted eligibility for full licensure, such as passing Step 3 of the USMLE (already a requirement for all other IMGs for licensure), passing the employer's (or facility's) assessment and evaluation program, and having neither disciplinary actions nor investigations pending over the course of the provisional licensure period. Most states that have enacted pathway legislation have required a combination of these steps, and there have been some proposals to include a letter of recommendation from the applicant's supervising physician, as well.

***Recommendation 8a*: State medical boards in states that have enacted legislation to create additional licensing pathways for internationally-trained physicians should work with their legislatures, where permitted, to retain their historic and statutory ability to exercise their due diligence and assess each applicant on their merits before they progress from provisional to full and unrestricted licensure.**

***Recommendation 8b:* State medical boards should add a requirement for passing USMLE Step 3 (as already required of all IMGs) for a full and unrestricted license and a**

***proviso* that the applicant not have any disciplinary actions or investigations pending from their provisional licensure period.**

9. **State medical boards implementing additional licensure pathways should collect and share data to evaluate their effectiveness.**

Data collection and dissemination related to additional licensure pathways is going to be critical for state medical boards, state legislators, and other stakeholders to better understand the impact of these legislative efforts. Significant questions remain about the efficacy of these additional pathways to address U.S. health care workforce shortages, in underserved areas and otherwise. Much of the legislation introduced thus far does not address what may be significant barriers to employment and the ability to practice with a full license in other jurisdictions. These questions include whether physicians entering a pathway will be eligible for specialty board certification, whether malpractice insurers will cover their practice, and whether payors will enable reimbursement for the services provided by these physicians.

***Recommendation 9*: State medical boards, assisted by partner organizations as may be necessary, should collect information that will facilitate evaluation of these additional licensure pathways to make sure they are meeting their intended purpose.**

To help answer questions about the efficacy of additional licensure pathways, state medical boards should consider collecting data that includes:

- the number of applicants
- the number of individuals receiving provisional licensure under the pathway and the number denied provisional licensure under the pathway
- the number of individuals achieving full and unrestricted licensure,
- the percentage of individuals that stay and practice in their specialty of training and in rural or underserved areas
- the number of complaints received and disciplinary actions taken (if any)
- the practice setting and specialty of individuals entering additional pathways
- the number of individuals licensed through additional licensure pathways who ultimately remain in the United States versus returning to their home countries
- the number of individuals achieving specialty board certification
- the costs to the board of operating an additional licensing pathway

Conclusion

These recommendations focus largely on additional pathway eligibility requirements and related considerations for entry into an additional licensure pathway. To ensure that international-trained physicians entering these pathways are ultimately prepared to safely practice medicine in the United States, additional licensing pathways should optimally

include assessment and supervisory elements during a period of provisional licensure, for which additional guidance is planned by the commission in the months ahead.

Advisory Commission on Additional Licensing Models
GLOSSARY

The Advisory Commission presents the following glossary to support a common interpretation among stakeholders of key terms related to additional licensing models:

"additional pathway" is a colloquial, broad term referring to states that have proposed and/or passed legislation that, while differing in details, creates a *new* pathway to full medical licensure for internationally-trained physicians, a pathway that distinguishes itself by not requiring U.S.-based or Canadian-based GME, in contrast to the typical IMG licensure pathway, but begins in the U.S. with a provisional licensure period, which may eventually be converted to a full license.

"board certification" is a voluntary process by which a physician demonstrates expertise in a specific medical specialty or subspecialty by meeting standards set by a specialty certifying board. It typically involves completing specialty-specific training and passing comprehensive exams, signaling a higher level of proficiency beyond basic medical licensure. The American Board of Medical Specialties requires successful completion of an ACGME-accredited residency training program in the United States as a prerequisite for physicians to become eligible for board certification.

"graduate medical education" (GME) refers to the period of didactic and clinical education in a medical specialty, subspecialty, or sub-subspecialty that follows completion of undergraduate medical education (i.e., medical school) and which prepares physicians for the independent practice of medicine in that specialty, subspecialty, or sub-subspecialty. Also referred to as residency or fellowship education, GME builds a physician's knowledge and skill, and teaches cultural and societal norms. GME is frequently used synonymously with PGT by state medical boards, although PGT may include a broader range of activities. In the U.S., GME is regulated by the Accreditation Council for Graduate Medical Education (ACGME). Medicare is the principal funder of GME training slots, and Medicaid also contributes, although the level varies state-by-state.

"Educational Commission for Foreign Medical Graduates" (ECFMG) refers to the division of Intealth that assesses the qualifications of international medical graduates (IMGs) who wish to pursue residency or fellowship training and eventually practice medicine in the United States.

"ECFMG certification" is a required credential among IMGs matriculating to United States or Canadian medical licensure along the traditional IMG pathway. ECFMG Certification is required for entry into ACGME-accredited US GME and for licensure in the United States. To be eligible for ECFMG certification, an IMG must 1) graduate from a medical school that meets ECFMG's requirements (schools that meet ECFMG's requirements will be listed in World Directory of Medical of Medical Schools with an ECFMG Sponsor Note) , 2) meet the

medical examination requirements, currently fulfilled by passing USMLE Steps 1 and 2 ; 3) meet the clinical skills and communication requirements (including English language proficiency), currently met by completing ECFMG's Pathways, which includes attaining a satisfactory score on the Occupational English Test (OET) Medicine. Many states that have enacted additional pathway legislation have included ECFMG certification among their requirements for provisional license applicants.

"eminence pathways" refers to pathways to licensure that exist in almost all states for ITPs with "extraordinary ability," are renowned specialists, or are recruited to be university faculty, including those pursuing academic or research activities. Such physicians typically align with the O-1 (extraordinary ability) visa issued by the U.S. State Department.

"international medical graduates" (IMGs) are graduates of a medical school outside the United States and Canada, but who may not *necessarily* be licensed to practice medicine in a foreign country. The location of the medical school, not the citizenship of the individual, is what determines whether they are IMGs. In the traditional IMG pathway, ECFMG-certified IMGs come to the United States for required GME, for a time period that varies from state-to-state, prior to full licensure eligibility.

"international medical programs" are the medical programs from which IMGs were taught. In states that have enacted additional pathway legislation, they have alternatively been defined as a medical school, residency program, or entity that provides physicians with a medical education or training that is "substantially similar" to that received in the United States or Canada; or as a medical school, residency program, or entity approved by the ECFMG.

"internationally-trained physicians" (ITPs) or "international physicians" are IMGs that must already be licensed *and* practicing in a foreign country, as contrasted with an IMG, who may not necessarily be licensed or practicing, but *possess* a medical degree from a school outside of the United States and Canada. This distinction is key in the advisory commission's guidance, although the terms (ITP and IMG) are often used interchangeably in legislation. Among the states that have enacted additional pathway legislation, some have included in their definition of ITPs requirements that the licensee must be in good standing, have a minimum amount of practice experience, and have completed a residency in their resident country, among other requirements.

"postgraduate training" (PGT), a term that is also known as postgraduate medical education (PGME) outside of the United States and Canada, is often used interchangeably with graduate medical education (GME), but may include a wider range of activities (e.g., academic or nonclinical training). In additional pathway legislation, PGT is the term most commonly used by legislators and regulators.

“practice of medicine” is the investigation, diagnosis, treatment, correction, or prevention of, or prescription for, any human disease, ailment, injury, or other condition, physical or mental, by any means or instrumentality that involves the application of principles or techniques of medical science.

“re-entry process” is a formal, structured curriculum that includes clinical experience and prepares a physician to return to clinically active practice following an extended period of clinical inactivity (the most often cited acceptable period of time in most statutes, before further assessment may be necessary, is two years). Physician Reentry Programs follow, and are informed by, a comprehensive assessment of the physician’s competence in order to determine educational needs.

“state medical board” (SMB) is a regulatory body, whose members are usually appointed by the state or territory’s governor, that oversees the practice of medicine within its jurisdiction. Its responsibilities include licensing physicians, creating and revising rules to implement laws enacted by the legislature, ensuring they meet educational and professional standards, investigating complaints of misconduct, and taking disciplinary actions when necessary. The board statutorily aims to protect public health and safety by ensuring that medical professionals provide competent and ethical care.

“substantially similar” is a description used by many states that have passed additional pathway legislation to describe a threshold, when compared to United States or Canadian medical education and residencies, that applicant ITPs must meet, and may refer to the medical school or PGT. “Substantially similar” education or training is generally considered a lower bar than “substantially equivalent” education or training, can be defined as comparable in content and experience, but may differ in format or method of delivery. The term implies reasonable confidence that the international program has prepared its graduates to begin professional practice at the entry level, and is comparable to a program in the United States or Canada. Proxies for determining substantial similarity include accreditation by ACGME International (ACGME-I) and/or whether the IMG has completed an ACGME-accredited fellowship training program in the United States. Many states that have enacted additional pathway legislation have explicitly tasked their medical board with defining “substantially similar” in the context of the legislation.

“supervision” means a medical board-mandated process whereby an experienced supervising physician who meets requirements set forth by the state medical board observes a physician for a defined period and provides feedback, education, and clinical support. Supervision and support for IMGs is crucial to navigate and bridge cultural and boundary differences.

“traditional IMG pathway” describes the typical pathway by which IMGs become fully licensed to practice medicine in the United States and Canada.[9] IMGs are usually required to obtain an MD degree or equivalent from an international medical program, pass USMLE Steps 1 and 2, obtain ECFMG certification, and a visa to enter or stay in the United States, if necessary. The minimum amount of accredited GME varies by state,[10] but typically, the IMG is required to complete one to three years of residency training to be eligible for full licensure.

“United States Medical Licensing Examination” (USMLE) is a three-step standardized test that assesses a physician's ability to apply knowledge, concepts, and principles necessary for safe and effective patient care. Passing all three steps is required for medical licensure in the United States.

[9] https://www.fsmb.org/SysSiteAssets/usmle-step3/pdfs/pathway-to-licensure.pdf
[10] https://www.fsmb.org/siteassets/advocacy/policies/img-gme-requirements-key-issue-chart.pdf

Advisory Commission on Additional Licensing Models

Members[11]

Humayun Chaudhry, DO (co-chair)
Federation of State Medical Boards

John Combes, MD (co-chair)
Accreditation Council for Graduate Medical Education

Eric Holmboe, MD (co-chair)
Intealth

Helen Burstin, MD
Council of Medical Specialty Societies

Robert Cain, DO
American Association of Colleges of Osteopathic Medicine

Sanjay Desai, MD
American Medical Association

Rich Hawkins, MD
American Board of Medical Specialties

Oliver Kim, JD
Virginia Board of Medicine

Nicole Krishnaswami, JD
International Association of Medical Regulatory Authorities

Yolanda Lawson, MD
National Medical Association

Genevieve Moineau, MD
World Federation for Medical Education

Shannon Scott, DO
American Osteopathic Association

Alison Whelan, MD
Association of American Medical Colleges

[11] Organizational affiliations are presented for purposes of identification and do not imply endorsement of any draft or final version of this report.

Danny Takanishi, MD
Hawaii Medical Board

Tim Terranova
Maine Board of Licensure In Medicine

Ex Officio

George Abraham, MD
FSMB Chair-elect, Board of Directors

Thomas Nasca, MD
Accreditation Council for Graduate Medical Education

Katie Templeton, JD
FSMB Chair, Board of Directors

Debra Weinstein, MD
Accreditation Council for Graduate Medical Education

Staff Support

Federation of State Medical Boards
John Bremer
Andrea Ciccone, JD
David Johnson, MA
Lisa Robin, MLA
Andrew Smith, MPP
Mark Staz, MA

Intealth
Lyuba Konopasek, MD
Kara Oleyn, JD
Matthew Shick, JD
Jessica Salt, MD
Tracy Wallowicz, MLS

Accreditation Council for Graduate Medical Education
Kristin Hitchell, JD
Lauren Holton, EdD
Mary Klingensmith, MD

Appendix 1. Visa Options for Physicians

Non-U.S. citizen international medical graduates (IMGs) seeking to engage in clinical training or provide clinical patient care in the United States have several visa options, each with specific requirements.

- **J-1 Visa**: This is the most common visa for physicians participating in clinical training programs. The J-1 visa is issued under the U.S. Department of State's BridgeUSA Program, and are sponsored by Intealth, the sole sponsor in the United States for this visa classification for physicians. While there is a two-year return home commitment for physicians holding this visa classification, there are options for waivers of this two-year requirement under specific circumstances, such as working in medically underserved areas.
- **H-1B Visa**: The H-1B visa is an employment-based visa for foreign nationals working in specialty occupations, including clinical patient care and training. It requires sponsorship from a U.S. employer, who must file a petition on behalf of the physician and pay all associated fees.
- **Other Common Visa Options**: In addition to J-1 and H-1B, there are other visa categories that allow physicians to engage in clinical training or patient care:
    - **O-1 Visa**: For individuals with extraordinary abilities, including highly qualified physicians.
    - **Employment Authorization Document (EAD)**: Available for certain individuals with dependent visa statuses (e.g., J-2, H-4) or other immigration statuses, such as those with Temporary Protected Status (TPS), DACA, or asylum, allowing them to work or engage in clinical training.

TABLE 1: Comparison of J-1 and H-1B for Physicians

	J-1	H-1B
Prerequisite Examinations	USMLE Step 1, Step 2	USMLE Step 1, Step 2, Step 3
Sponsor	Intealth (ECFMG)	Employing hospital
Cost to Hospital	$0	$3000 - $10,000+ per physician
Wage Requirements	None	Prevailing wage*
Dual Intent?**	No, with exceptions	Yes

** The "prevailing wage" is the minimum wage an employer must pay the foreign worker, based on the average wage for similar positions in the job's geographic area. Employers must confirm they will meet or exceed the prevailing wage.*

*** Dual intent refers to a provision in U.S. immigration law that allows a foreign national to enter the U.S. on a nonimmigrant visa while simultaneously seeking to become a permanent resident (green card holder).*

TABLE 2: Other Common Visa Types for Physicians

Visa	Eligibility Criteria	Duration
O-1A	Individuals with an extraordinary ability in the sciences, education, business, or athletics	3 years (1 to 3-year extensions possible)
J-2 EAD/ H-4 EAD	Spouses of J-1/H-1B visa holders	Subject to primary visa holder's status
Temporary Protected Status (TPS)	Nationals of specifically designated countries who are already within the US	Typically assigned this designation for 18 months, but may be extended
Deferred Action for Childhood Arrivals (DACA)	Individuals who were physically present in the United States on June 15, 2012 with no lawful immigration status after having entered the country as children at least five years prior	2 years (renewable)
Asylum	Individuals already in the US seeking protection because they have suffered persecution or have a well-founded fear that they will suffer persecution in the home country	No expiration and can be converted into a green card

Legislative Assembly

North Dakota Senate

STATE CAPITOL
600 EAST BOULEVARD
BISMARCK, ND 58505-0360

Senator Kristin Roers
District 27
4378 Estate Drive South
Fargo, ND, 58104-3318
kroers@ndlegis.gov

COMMITTEES:
Human Services
State and Local Government (Chair)

2/13/2025

Mr Chair and members of the Senate Workforce Committee:

I will start by admitting that I am not the expert on this bill - there are others here that can speak more eloquently about how this bill can work - but let me tell you how it came to my attention.

As many of you know, I spent about a year helping recruit and welcome Internationally Educated Nurses to my hospital and community - through that, I became very passionate about the processes we use to recruit and retain talent into our state - especially in the healthcare space. The first time I heard about this topic was at a conference - probably in 2021 or 2022. Then, I was invited to the North Dakota Medical Association's meetings in Fargo 2 times in 3 years - and both times, this topic has come up. The physicians in the room asked if we could pursue this process - a new way to allow for internationally educated physicians to become licensed in our state - to ensure that we adequately vet their education, but don't require them to completely redo their residency. Fast forward to the beginning of session this year and a fellow legislator approached me to see if I had capacity to prime sponsor this idea and I chose to introduce it.

Again, I am not an expert on the logistics of how this works - but I believe that we need to be creative in how we recruit new physicians into North Dakota. To ensure they are trained and safe, without erecting any unnecessary barriers to entry.

THE CHAMBER
FARGO MOORHEAD WEST FARGO

Letter of Support – SB 2270

Thursday, February 13, 2025

Chairman Wobbema and members of the Senate Workforce Development Committee,

For the record, my name is Cale Dunwoody, and I have the distinct pleasure of serving as the Vice President of Public Policy for the Fargo Moorhead West Fargo Chamber of Commerce (FMWF Chamber). On behalf of our over 1,700 members, I respectfully offer testimony in support of Senate Bill 2270.

At the FMWF Chamber, our mission is to protect and promote business, inspire individuals, cultivate communities, and influence action. Across the nation, employers are struggling to attract and retain employees. As of November 2024, North Dakota's Labor Force Participation rate trends well above the national average at 68.9% and our state unemployment rate is among the lowest in the nation at 2.4%. Our low unemployment rate, coupled with high labor force participation rates, suggest that most individuals who are able and willing to work are already employed, amplifying the challenge for employers seeking to fill the thousands of jobs across the state.

Given these challenges, our state must work alongside the private sector to identify and create innovative and multi-pronged solutions. We believe this pathway to licensure for international physicians is one of those innovative solutions needed to address workforce shortages in the healthcare industry. Often, individuals possess the knowledge and skill sets needed to work as a physician in healthcare, but the licensure requirements can be complex and may not recognize their international education and training. This bill would recognize the education and training received globally and further establish a pathway to physician licensure, without diminishing the quality and safety of our healthcare system.

As the 69th Legislative Assembly considers this legislation, we respectfully urge the committee to give Senate Bill 2270 a DO PASS recommendation to further establish a robust workforce pipeline for careers in our healthcare industry.

Sincerely,

Cale Dunwoody
Vice President of Public Policy
Fargo Moorhead West Fargo Chamber of Commerce

2025 SENATE STANDING COMMITTEE MINUTES

Workforce Development Committee
Fort Lincoln Room, State Capitol

SB 2270
2/20/2025

Relating to the licensure of international physicians.

9:40 a.m. Chairman Wobbema called the meeting to order.

Members Present: Chairman Wobbema, Vice-Chairman Axtman, Senator Boschee, Senator Larson, Senator Powers.

Discussion Topics:

- Evaluation of available programs
- Licensing pathway
- Granting rates in other states

9:51 a.m. Senator Axtman moved Do Not Pass.

9:51 a.m. Senator Larson seconded the motion.

Senators	Vote
Senator Mike Wobbema	Y
Senator Michelle Axtman	Y
Senator Josh Boschee	Y
Senator Diane Larson	Y
Senator Michelle Powers	Y

Motion passed 5-0-0

Senator Powers will carry the bill.

9:53 a.m. Chairman Wobbema closed the hearing.

Andrew Ficek, Committee Clerk

REPORT OF STANDING COMMITTEE
SB 2270 (25.1190.01000)

Workforce Development Committee (Sen. Wobbema, Chairman) recommends **DO NOT PASS** (5 YEAS, 0 NAYS, 0 ABSENT OR EXCUSED AND NOT VOTING). SB 2270 was placed on the Eleventh order on the calendar. This bill affects workforce development.