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Solve imminent physician shortage by licensing foreign doctors

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When the COVID-19 pandemic struck, several of the hardest hit states temporarily suspended state licensing requirements, allowing practitioners licensed in any other state to come to the aid of their residents. This was a tacit admission that state medical licensing laws block the free flow of practitioners to patients in need.

Unfortunately, when this crisis is over the old regulations will go back in effect. But the problem is bigger than limitations on U.S. doctors — these same boards restrict doctors from abroad.

Given that the Association of American Medical Colleges projected a total physician shortfall of 90,000 in 2020, and between 40,000 and 122,000 over the next decade or so, we need to rethink our licensing regimen. This is especially urgent now that some say the shortage may be as high as 139,000 in 2033, which is only exacerbated by the pandemic.

And as we've seen in recent months, shelter-in-place orders, restrictions on non-emergency treatment and fear of contagion are leading many small medical practices to close. We could stave off a deadly shortage by allowing the large pool of experienced and motivated health care practitioners from other countries who are eager to come here and willing to provide care to underserved communities in poor or remote areas of this country, but they are blocked by outdated state medical licensing regulations.

State licensing boards require international medical school graduates who have completed post-graduate specialty training and are licensed to practice in other countries to repeat their entire post-graduate training in an accredited U.S. institution before receiving a state medical license. As a result, many experienced foreign-trained doctors take positions in ancillary medical fields such as nursing, lab technicians and radiology technicians instead of starting all over again. Some even work as waiters or taxi drivers.

As a general surgeon I remember how Jamil, an operating room technician from Syria, impressed me with his knowledge and focus on my operations as he would pass me instruments. He often politely offered excellent suggestions or insights when I wrestled with a difficult intra-operative decision. One day he told me he was a general surgeon in Syria before he came to the U.S. With a family to support, he was unable to go through an entire 5-year residency program in order to practice here. So he worked part-time as an OR tech to maintain a connection to the field he loved while starting up a small Middle Eastern diner.

To be sure, the quality and approach to the practice of medicine varies in different parts of the world. In some countries doctors treat a different constellation of health problems than those that

exist in the U.S. Some also may have less exposure to the technological advances that abound in the U.S. health care system.

There may also be cultural differences that affect their understanding of and communication with American patients. For this reason, private certification organizations like the Educational Commission for Foreign Medical Graduates (ECFMG), specialty boards (e.g., American Board of Surgery, American Board of Internal Medicine), as well as rating and evaluation services play an important role in providing critical information to consumers of health care.

In Canada, like states in the U.S., provinces have domain over medical licensing. Several provinces grant licenses to experienced immigrant physicians who have completed postgraduate training residencies in 29 approved foreign jurisdictions without them having to repeat postgraduate training in Canada. Instead, they are simply required to pass a "practice readiness assessment," a relatively short (usually a few months) process involving supervision by a licensed practitioner who must clear them as competent.

In Nova Scotia, non-specialty general medical practitioners from other countries may practice under the supervision of a licensed physician and, after a designated period, may independently practice in underserved areas. A similar program exists for specialists who receive postgraduate training in countries other than the 29 approved jurisdictions. There is no reason we cannot do the same in the U.S., and some states are at least taking a step in the right direction.

For example, one year ago Arizona, followed by Montana and Pennsylvania, reformed their licensing laws to grant reciprocity to health care practitioners licensed in any of the 50 states and the District of Columbia. Missouri is poised to do the same. Lawmakers in the remaining states should follow their lead. But they can take reform even further.

Enlisting private certification organizations to help develop criteria, states should give reciprocity to health care practitioners licensed in certain countries with reputations for quality medical education. As some Canadian provinces have done, states should develop programs to facilitate integrating experienced doctors from less advanced countries into the pool of health care providers.

States should not be caught unprepared for the next public health crisis. As the physician shortage worsens, they should remove regulatory barriers obstructing eager and able doctors from other states and countries who want to help their patients.

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