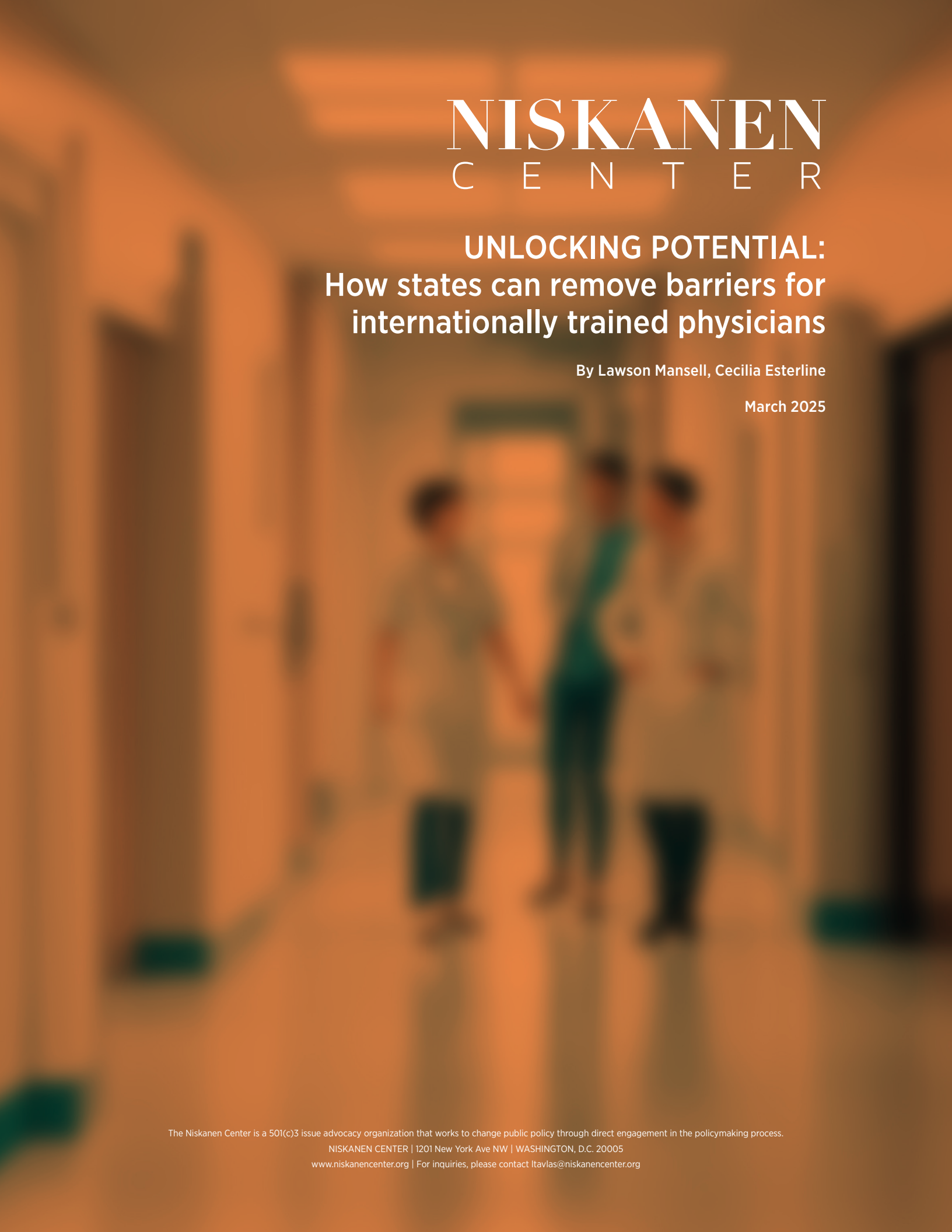

NISKANEN CENTER

UNLOCKING POTENTIAL: How states can remove barriers for internationally trained physicians

By Lawson Mansell, Cecilia Esterline

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Introduction

The United States is facing a critical physician shortage that is already undermining the quality and accessibility of healthcare for millions. With projections indicating a deficit of up to 86,000 doctors by 2036, including substantial shortfalls in primary care, policymakers must urgently address this growing crisis. While significant medical school and residency bottlenecks are the dominant factors limiting the supply of more doctors, the U.S. is also holding back a group of qualified, trained doctors that are currently barred from gaining licensure to practice medicine: international medical graduates (IMGs). Many IMGs have already completed years of post-graduate training and clinical experience yet still are forced to the sidelines due to cumbersome and redundant credentialing requirements.

In the last few years, state lawmakers have begun to address these issues by creating additional pathways for IMGs to receive licensure and begin practice. Thirty states have considered or passed legislation and among them, nine states have created alternative licensure pathways. But the design of these pathways and how regulators address the remaining barriers will be key to unlocking the potential of internationally trained physicians. As state policymakers and regulators consider how to leverage these sidelined doctors, they should prioritize policies that create a permanent pathway to licensure and remove duplicative U.S.- or Canada-based residency requirements. This paper will explore the causes of our current shortage, the barriers facing IMGs, and how to better integrate qualified internationally trained physicians into the American workforce.

The need: an urgent physician shortage

The Association of American Medical Colleges projects a deficit of up to 86,000 doctors in the U.S. by 2036, including a shortfall of 10,100 to 19,900 surgeons and 20,200 to 40,400 primary care physicians.[1] The situation is exacerbated by an aging population, which also means a significant portion of the current physician workforce is nearing retirement. As Americans age, their demand for healthcare grows in both quantity and complexity, requiring our healthcare system to invest more resources and allocate them better. 42 percent of our physician workforce is over 55 years of age, meaning in the next 10 years, many will begin transitioning into retirement.[2] Due to bottlenecks in the education and training of new doctors, the U.S. faces an uphill battle to replace retiring doctors, let alone exceed our current supply to keep up with rising healthcare demand.

Internationally trained physicians are uniquely positioned to address this shortage because they have already completed residency training, a requirement that serves as the primary bottleneck to increasing the supply of domestically trained doctors.

Why is there a shortage?

Our supply of doctors is determined by our capacity for educating and training them, for which we rely on medical schools and teaching hospitals. Yet each year, substantially more people apply to medical school and residency programs than get accepted. For medical school, the first step in a prospective doctor's journey, over 30,000 failed to matriculate in 2023 — more than half of all applicants.[3] While having a highly competitive application process is laudable, available data suggests that the lack of acceptances has more to do with a scarcity of slots than with the quality of applicants. Over the last 10 years, applications to medical schools have increased while matriculations have stayed relatively steady.[4] In response to the shortage, medical schools have been increasing class sizes to accommodate more students.[5] However, neither medical school slots or post-graduate residency slots have managed to keep up with demand for medical education and training.

Even when doctors receive their medical degree, bottlenecks in residency and clinical training mean that nearly 9,000 seniors and graduates failed to match to a residency program in 2024.[6] Without residency training, medical graduates are unable to obtain full licensure to practice medicine. While it's important that medical schools and residency programs continue to screen applicants judiciously, qualified and motivated students and medical school graduates are being left on the sidelines in the midst of a supply crisis.

Some of these issues can be traced back to policy choices dating back to the 1980s that purposely restricted the production of more doctors, both at the medical school and residency levels. Following a report from the Graduate Medical Education National Advisory Committee in 1981 that recommended a slowdown of physician production due to fears of oversupply, medical schools instituted a moratorium on new enrollees.[7] The annual influx of MD (Medical Doctor) graduates entering residency programs declined, and it was only

1. "The Complexities of Physician Supply and Demand: Projections From 2021 to 2036," Association of American Medical Colleges, 2024.

2. Ibid.

3. "U.S. Medical School Applications and Matriculants by School, State of Legal Residence, and Gender, 2023-2024," Association of American Medical Colleges, accessed March 7, 2025.

4. Monica Correa, "Universities push ceilings on medical school enrollments," *Miami Today News*, July 5, 2022.

5. Patrick Boyle, "At medical schools, fewer apply but class sizes grow," The Association of American Medical Colleges, December 12, 2023.

6. "Results and Data: 2024 Main Residency Match," (National Resident Matching Program, June 28, 2024).

7. Robert Orr, "Unmatched: Repairing the U.S. Medical Residency Pipeline," (Niskanen Center, September 2021).

after the moratorium was revoked in 2005 that the number came to surpass the 1980 levels.[8] To make things worse, the Balanced Budget Act of 1997 capped Medicare-funded residency slots at 1996 levels, limiting a funding stream used to create new residency slots.[9] Medical schools can exceed this cap (and many do), but when they do, Medicare does not subsidize slots for the new trainees. The funding cap serves as a disincentive for hospitals to produce much-needed residency slots.

Funding fuels regional gaps

The structure of Medicare funding also inadvertently creates disparities among hospitals and regions. The volume of patients served and the cost charged for services help determine how much residency funding a hospital receives. As a result, wealthier areas and established institutions tend to not only train more residents, but also receive disproportionately more money per resident, while less affluent and more competitive markets are at a disadvantage. This imbalance is evident in the stark contrast between states like New York and Georgia. Despite New York training only three-and-a-half times more medical residents than Georgia, it receives six times more Medicare funding per resident for training programs.[10] Such discrepancies contribute to a mismatch between where doctors are trained and where patient demand is highest, exacerbating regional healthcare shortages.

Perverse incentives drive specialty imbalance

While the U.S. has significantly fewer primary care doctors than peer countries, we have a similar amount of specialists. This is in large part because the U.S. medical education pipeline, characterized by lengthy education requirements and high student debt, incentivizes students to choose more lucrative specialties that offer higher salaries and more prestige.

Additionally, Medicare provides more funding to teaching hospitals partially based on the cost of services their residents provide.[11] Because residents pursuing more lucrative sub-specialties perform more expensive procedures and thus increase reimbursements, the funding structure serves as a disincentive for residency programs to open up more primary care slots.

The consequences: worse outcomes and strained resources

Doctor shortages, particularly in primary care specialities, pose significant risk to patients. Without reliable and routine primary care, dangerous and life-threatening conditions are often missed or treated too late. This is partially due to long wait times for a primary care appointment. Americans have to wait over 20 days on average, and in some cities over 70 days, for an appointment with a general practitioner – much longer than the industry benchmark of 14 days.[12] These wait times are much higher than among European peers, where patients usually have to wait 10 days or less for a primary care appointment.[13]

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8. Ibid.

9. Lawson Mansell, "Healthcare abundance: An agenda to strengthen healthcare supply," (Niskanen Center, October 2024).

10. Robert Orr, "Federal policy misallocates American doctors," Niskanen Center, February 1, 2023.

11. Ibid.

12. Mary Chris Jaklevic, "In the U.S., wait times to see a doctor can be agonizingly long," Association of Health Care Journalists, August 7, 2024.

13. Anna Fleck, "Healthcare: How Long Do Patients Have To Wait?" Statista, September 17, 2024.

There is also evidence to suggest that a lack of primary care is resulting in worse outcomes for Americans than in those countries. On a metric of "treatable deaths," mortality from conditions that could be alleviated if treated early enough or appropriately, the U.S. performs worse than all other top-spending countries.[14]

In addition to making it harder to see a doctor in the first place, shortages strain healthcare resources and require doctors to spend less time with patients. Experts call time the currency of primary care because more time with patients likely means better diagnoses and an increased likelihood of identifying chronic and life-threatening conditions. But over the last 15 years, time with a primary care doctor has decreased while time with specialists has increased in the United States – corresponding with the primary care shortage.[15] As Adam Gaffney, a researcher at Harvard University noted, "It's not that primary care doctors are working any less, it's just that the total number of minutes is fixed."[16] Without an increase in the supply of primary care doctors, the U.S. will continue to fail patients on the basics of medicine – reliable, routine primary care.

But there are doctors willing to contribute that face a wall of unnecessary licensure and training requirements: internationally trained physicians.

The workforce: underutilized trained physicians

Immigration context: pathways to entry

The path to practice in the United States is linear for most aspiring doctors – a bachelor's degree, U.S. medical school, residency, some exams along the way, and finally the right to practice as a physician. However, approximately 25 percent of active U.S. physicians attended medical school outside the United States or Canada.[17] For these physicians, the path to practice looked very different as they were forced to overcome visa restrictions and credentialing barriers in order to participate fully in the American labor force.

Internationally trained physicians can generally be separated into two categories: those who came to the United States via a visa pathway specifically designed to facilitate their employment or continued medical education and those who came through other pathways unrelated to their training and expertise as a doctor. Each of these groups face their own unique challenges when integrating into the U.S. labor market.

Most physicians who come through training and employment pathways use either the J-1 or H-1B visas. The J-1 is a cultural exchange visa that is used by a wide variety of visitors, including au pairs, summer camp counselors, and physicians, among others.[18] Through the J-1 visa program, internationally trained physicians can come to the United States to complete graduate medical training, such as residency.[19] In fiscal year 2022, 3,302 physicians participated in the J-1 alien physician program.[20] These physicians, like other J-1 recipients, are typically required to exit the United States for at least two years at the conclusion of their

14. Mansell, *Healthcare Abundance*.

15. Adam Gaffney and David Himmelstein et al., "Trends and Disparities in the Distribution of Outpatient Physicians' Annual Face Time with Patients, 1979–2018," *Journal of General Internal Medicine* 38 (2023): 434–441.

16. Richard Payerchin, "Physician-patient face time increases over 40 years, but not necessarily for primary care," *Medical Economics*, September 8, 2022.

17. "U.S. Physician Workforce Data Dashboard," (The Association of American Medical Colleges, 2024).

18. "7.4.1 Exchange Visitors (J-1)," Handbook for Employers M-274, U.S. Citizenship and Immigration Services, October 17, 2023.

19. "Physicians Program," BridgeUSA, U.S. Department of State, n.d.

20. "Participant and Sponsor Totals 2022," BridgeUSA, U.S. Department of State, n.d.

program, meaning that they are largely ineligible for changes of status to H-1B or other employment visas that would allow them to join the American workforce.[21] When these physicians leave, they take expertise garnered from top American medical institutions, often putting it to use in competitor nations, even as the U.S. struggles to provide basic, adequate care for its citizens.

Fortunately, there are some exceptions to this requirement. For instance, under the Conrad 30 program, each state may waive the two-year foreign residency requirement for up to 30 physicians each year, in exchange for three years of service in a medically underserved area.[22] Government agencies, such as the Department of Health and Human Services or the Department of Veterans' Affairs, may also request that the requirement be waived if it is in the public interest that the physician remain in the United States.[23] When these exemptions are issued, most physicians will change to H-1B status.

The H-1B is a temporary employment visa for specialty occupations, used by software developers, architects, and teachers alike.[24] In FY 2023, U.S. Citizenship and Immigration Services approved 3,676 initial H-1B petitions for physicians and surgeons, in addition to 4,845 petitions for extensions or amendments of H-1B employment.[25] In the same year, states requested 1,105 waivers under the Conrad 30 program, meaning that around 30 percent of initial H-1B issuances for physicians likely went to those working in underserved areas who recently completed their J-1 training period.[26] Latest data from FY 2021 indicates that government agencies requested another 453 waivers for physicians in the public interest.[27]

Though the H-1B allows these physicians to work in the U.S., often in the most understaffed hospitals nationwide, it has significant limitations. First, the H-1B is generally a capped visa, offering 85,000 slots per year across all industries, and registrants are selected at random in an annual lottery.[28] Individuals offered positions at a nonprofit hospital associated with a university and beneficiaries of the aforementioned waiver programs are exempt from this annual cap.[29] However, the visa can only be extended for up to six years unless an employer is willing to sponsor the physician for a green card, a process that could take up to 134 years, depending on the physician's nationality and employment category.[30] While some nationalities and categories benefit from shorter wait times, the high costs and lengthy delays still make the employment-based green card process unattractive or even inaccessible to many employers and physicians.

Therefore, even participants in the visa programs designed to train and employ qualified foreign physicians face significant barriers to long-term practice in the United States.

On the other hand, there are other internationally educated physicians present in the U.S. who did not arrive

21. "Exchange Visitor Visa," U.S. Department of State, n.d.

22. Matthew La Corte and Gil Guerra, "The bipartisan immigration policy that helps rural Americans get access to local physicians," Niskanen Center, May 4, 2023.

23. "Request by an Interested U.S. Federal Government Agency," U.S. Department of State, n.d.

24. Cecilia Esterline, "The H-1B Visa, Explained," *The Dispatch*, January 7, 2025.

25. "Characteristics of H-1B Specialty Occupation Workers FY2023," U.S. Citizenship and Immigration Services, March 6, 2024.

26. "Conrad 30 Slots Filled FFY 2023 10/22 to 9/23," 3RNET, n.d.

27. "INA 212(e) Waiver Recommendations - Fiscal Year 2021," U.S. Department of State, n.d.

28. "H-1B Cap Season," U.S. Citizenship and Immigration Services, February 5, 2025.

29. "H-1B Specialty Occupations," U.S. Citizenship and Immigration Services, February 5, 2025.

30. David Bier, "1.8 Million in Employment-Based Green Card Backlog," Cato Institute, August 29, 2023.

through employment or educational pathways. These individuals include both native-born U.S. citizens who completed their medical education abroad and foreign-born individuals who arrived in the U.S. through any number of pathways unrelated to their occupation. Perhaps they moved here as the spouse or relative of a U.S. citizen, as a refugee, as a beneficiary of the diversity visa (the "green card lottery"), or as an asylum seeker. Although these individuals generally have more stability in their long-term immigration statuses than those on the temporary visas mentioned previously, they are particularly vulnerable to underutilization and face their own barriers to entry in the U.S. medical system.

Long-term demographic trends will soon necessitate the improvement or expansion of immigration pathways for medical providers, but in the interim, states must take action to maximize the productivity potential of the talent that already resides within our borders.

Underutilized healthcare workforce in the U.S.

Whether native- or foreign-born, physicians trained outside the United States face significant hurdles to integration in the U.S. labor market. One study found that just one-third of physicians who immigrated to the U.S. between 2004 and 2022 were on track to practice medicine in the U.S. by early 2024.[31] These barriers come about because regardless of a physician's expertise or years of experience abroad, if they did not complete a U.S.- or Canada-based residency, they may not be recognized as a qualified physician in the United States. While there are ways for these physicians to gain U.S. licensure, they are often costly, time-consuming, and prohibitive, particularly for immigrants who are eager to begin working and support themselves financially as quickly as possible after arrival. This is because unlike some other countries that automatically recognize U.S. medical training, the U.S. does not have broad international parity or mutual recognition of foreign medical training. Regardless of how many degrees or years of experience IMGs have, they must compete against U.S. medical school seniors for the same limited number of residency slots in the vast majority of states.

While nationally representative data quantifying the underutilization of foreign-trained physicians is not yet available, we do have information about the number of international medical graduates who apply to U.S. residencies.[32] This data is illuminating because regardless of the outcome of their applications, these applicants have already met the requirements for certification from the Educational Commission for Foreign Medical Graduates (ECFMG) including passage of the medical science, clinical skills, and communication skills examinations.[33]

In 2024, 44,853 applicants, including 30,066 domestic and 14,772 foreign graduates, competed for just 38,494 first-year residency slots (see Figure 1).[34] Although they all passed the same exams, the matching rates for U.S. graduates and international medical graduates vary widely. In 2024, U.S. MD seniors and U.S. DO (Doctor of Osteopathic Medicine) seniors had match rates of 93.5 and 92.3 percent respectively.[35] By contrast, just 67 percent of U.S. citizen IMGs and 58.5 percent of non-citizen IMGs successfully matched to first-year residency programs.[36]

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31. Tyler Boesch and Ryan Nunn, "Occupational licensing can detour immigrant physicians' career paths," Federal Reserve Bank of Minneapolis, January 19, 2024.

32. Gizem Korkmaz et al., "Bridging the Gap for New Americans," (Westat Insight for the U.S. Department of Labor, March 15, 2024).

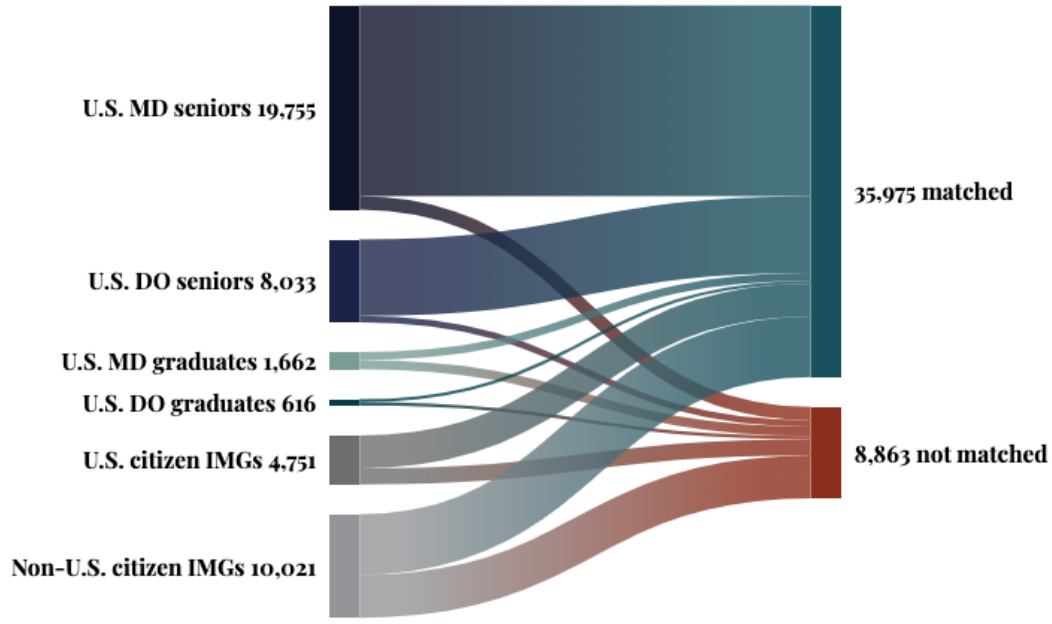
33. "Are You Eligible?," National Resident Matching Program, n.d.

34. "Results and Data: 2024 Main Residency Match," (National Resident Matching Program, June 28, 2024).

35. Ibid.

36. Ibid.

Figure 1. 2024 Main residency match outcomes by applicant type



Source: National Resident Matching Program, Results and Data: 2024 Main Residency Match
MD seniors and graduates are in their final year of or have completed Medical Doctor programs in the U.S.
DO seniors and graduates are in their final year of or have completed Doctor of Osteopathic Medicine programs in the U.S.
IMGs (international medical graduates) completed medical school outside the United States.

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Even though IMGs, on average, apply to nearly twice as many residency programs as MD graduates, in 2024, around 40 percent, or over 5,700, qualified, ECFMG-certified IMGs went unmatched.[37] Because few states provide alternative pathways to practice, even for IMGs who already completed residencies abroad, these graduates were likely pushed into other jobs that require far less education, such as medical coding, either in the short-term until they are able to reapply or for longer given the high cost of repeating the process. While residency may require more comprehensive changes in the future, states can do more to recognize the existing qualifications of IMGs in the interim.

The payoffs could be especially high because international medical graduates are five to nine times more likely to enter primary care than U.S. graduates, which is imperative given the importance of primary care in meeting our long-term healthcare needs.[38] IMGs also have similar or even better patient outcomes than U.S. graduates and are more likely than U.S. graduates to serve rural or underserved communities.[39] Improving the pathway to practice for these foreign-trained physicians would allow the U.S. to capitalize on these benefits and improve the medical landscape for all Americans.

37. Brendan Murphy, "Here's how many residency programs med students really apply to," American Medical Association, September 16, 2024; "Results and Data: 2024 Main Residency Match," (National Resident Matching Program, June 28, 2024).

38. Tarun Ramesh et al., "Effects of Citizenship Status on International Medical Graduate Specialty Choice and Practice Location," *Journal of General Internal Medicine*, October 14, 2024.

39. Yusuke Tsugawa et al., "Quality of care delivered by general internists in US hospitals who graduated from foreign versus US medical schools: observational study," *British Medical Journal*, February 3, 2017; Yusuke Tsugawa, et al., "Comparison of Patient Outcomes of Surgeons Who Are US Versus International Medical Graduates," *Annals of Surgery*, December 2021; Leonard Baer, Thomas Ricketts, and Thomas Konrad, "International Medical Graduates in Rural, Underserved Areas," North Carolina Rural Health Research and Policy Analysis Program, May 1998.

The barriers: unnecessary requirements

Internationally trained doctors face a litany of obstacles to practice medicine in the United States, both before and after licensure. Figure 2 illustrates the steps they must take to be in compliance with federal, state, and industry requirements. At each step, international graduates face a new gatekeeper. Although state laws stipulate some of the basic requirements, it is primarily self-regulation by industry actors such as medical boards, licensing boards, accreditation councils, and schools themselves that determine who can and cannot practice.[40] While some of these requirements are necessary to ensure prospective doctors are competent, others simply serve to create scarcity with no corresponding benefits to patients.

Current path to practice

Before a foreign graduate can apply to a residency program, they must pass the first two tests of the United States Medical Licensing Exam, which assesses their basic science education and clinical knowledge. They can then obtain approval from the Educational Commission for Foreign Medical Graduates, a nonprofit entity authorized to screen foreign graduates to determine their readiness for residency. The commission will determine whether they graduated from an approved international medical school and validate their diploma.

Figure 2. Path to U.S.-based practice for international medical graduates[41]

	Steps	Authorizing Entity
1.	US Medical Licensing Exam (USMLE) Steps 1 & 2	The Federation of State Medical Boards (FSMB) + The National Board of Medical Examiners (NBME)
2.	ECFMG Certification	Educational Commission for Foreign Medical Graduates (ECFMG), but required by The Accreditation Council for Graduate Medical Education (ACGME)
3.	Residency Application	Universities and teaching hospitals, then matched by the National Resident Matching Program (NRMP)
4.	US Residency	Universities and teaching hospitals, funded primarily by the Center for Medicare and Medicaid Services (CMS)
5.	USMLE Step 3	The Federation of State Medical Boards (FSMB) + The National Board of Medical Examiners (NBME)
6.	State Medical License	State Medical Boards, with statutory guidance from state legislatures
7.	Specialty Board Certification	Private, independent national specialty boards, governed primarily by the American Board of Medical Specialties (ABMS)
8.	Employment credentialing	Individual hospitals and clinics

40. Jeffrey Flier and Jared Rhoads, "The U.S. Health Provider Workforce: Determinants and Potential Paths to Enhancement," (Mercatus Center, February 2018).

41. This path is limited to the 41 states that require a U.S. or Canada-based residency program. For the nine states that offer IMGs an alternative pathway, steps 3 and 4 related to residency would be replaced with their alternative pathway. That pathway often requires two to four years of supervised practice in lieu of U.S.- or Canada-based residency training. The process for applying to Canadian residency programs is different than for U.S.-based programs and requires a different matching process. This paper only deals with IMGs who choose the U.S. residency pathway. IMG applicants are more likely (50-60%) to match to U.S. residency programs than Canadian ones (23%). Source: Inge Schabort and Pascal WM Van Gerven, "Selection of international medical graduates into postgraduate training positions in Canada. Who applies? Who is selected?" *Canadian Medical Education Journal* 15, no. 2 (2024): 49-53.

Residency

Once steps 1 and 2 are completed, an IMG can apply to U.S. residency programs. But many programs have rigid application rules, such as requiring that applicants are no more than a few years removed from their original medical school graduation date.[42] Other programs simply note that they prefer more recent graduates.[43] For older international physicians who have been practicing medicine in their home country for decades before moving to the U.S., this requirement is disqualifying. Although they have extensive and recent experience, the restriction forces them to either apply to residency programs far away from home or to work below their training. Some programs also require applicants to be permanent residents of the United States.

In addition to having narrower application options, IMGs are less likely to match once they find a program they qualify for. Based on data from the Match program, 5,727 IMGs failed to match to a residency program in 2024.[44] IMGs were approximately 32-35 percent less likely to match compared to U.S.-trained doctors in 2024.[45] A major reason is that American-trained medical students already have some U.S. clinical experience, which many residency programs prefer to ensure a frictionless transition.

The thousands of IMGs who run this gauntlet and complete a U.S.-based residency training must also pass the United States Medical Licensing Exam's third test, which is usually taken during or after residency training. All graduates, foreign and domestic, must complete all 3 steps of the USMLE to obtain licensure. This exam is a prerequisite for most state licensing boards and covers everything related to generalist medical practice.

Licensing

Achieving full and unrestricted licensure is the next step in a prospective IMG's path to independent practice authority. State medical boards are responsible for evaluating licensure applications as well as investigating complaints and taking disciplinary actions, including license suspension, revocation, or reinstatement, for physicians under their jurisdiction. However, state governments set the regulatory and legislative foundation on which state licensing boards operate.

In 41 of 50 states, state licensing boards require that all licensed physicians complete a U.S.- or Canada-based residency program. This requirement has served as the primary barrier to licensure for internationally trained physicians. Nine state legislatures have already created alternative pathways for IMGs to earn licensure by practicing under supervision – an arrangement similar to an apprenticeship, a licensure pathway found in over 1,000 different occupations, including healthcare.[46]

Specialty board certification and employment credentialing

An under-discussed barrier facing IMGs is difficulty securing specialty board certification. After residency, medical specialty boards require aspiring doctors to sit for another exam to certify their expertise in the specialty. Many hospitals require this board certification as a condition for employment and hospital privileges. To sit for the exam to receive certification in one of the 38 specialties or 89 subspecialties (family medicine,

42. "Residency match for Older IMGs," IMGPrep, December 18, 2023

43. "How to Apply - Internal Medicine Residency," University of Maryland School of Medicine, accessed March 7, 2025.

44. "Results and Data: 2024 Main Residency Match," (The National Resident Matching Program, June 2024).

45. Authors' calculations. Source: "Results and Data: 2024 Main Residency Match," (The National Resident Matching Program, June 2024).

46. "Apprenticeships: An Alternative Pathway to Licensure," The Council of State Governments, March 12, 2021.

surgery, anesthesiology, etc.) supervised by the 24 member boards of the American Board of Medical Specialties (ABMS), a doctor has to meet certain requirements beyond just state licensure. Similar to state licensing boards, all specialty boards in the United States require a U.S. or Canada-based residency to sit for the certification exam.[47] This barrier applies even in the nine states that have done away with the residency requirement. In fact, as of 2018, nearly 50,000 licensed IMGs lack board certification – 22 percent of total IMGs in the United States.[48]

Lacking board certification can be a major roadblock to employment.[49] Health systems, hospitals, and physician groups, who will serve as the sponsoring entities for IMGs, form credentialing committees (also called hiring boards) to examine the validity of applicants' credentials. This is perhaps the most thorough credentialing review doctors receive during their path to practice.[50] Among the most important credentials reviewed by employers is board certification, on which they rely as a marker of physician competency.

Additionally, doctors have to spend more on malpractice insurance when they lack specialty board certification as malpractice insurers believe they carry a higher risk.[51] Malpractice premiums are often covered by employers — another disincentive to hire internationally trained doctors who aren't able to become specialty board-certified despite having a full license.

This step becomes increasingly important as states begin to implement laws that allow providers to sponsor international graduates and internationally trained doctors to work under their supervision in lieu of residency training. Without sufficient reason to sponsor these doctors, laws providing this alternative pathway will see little take-up and qualified doctors will continue to be left on the sidelines.

Policy recommendations

State lawmakers, along with regulating entities like medical and specialty boards, should prioritize reforms allowing qualified IMGs to practice medicine as efficiently as possible without compromising quality. Research shows that practicing IMGs have equal or better patient outcomes than U.S.-trained doctors and even perform better on in-training internal medicine exams.[52]

U.S.-based residency training has long been the norm for ensuring sufficient clinical experience prior to allowing doctors full and independent practice authority. Research shows that there is significant overlap in residency training between the U.S. and international programs in Europe, Asia, and Africa.[53] Additionally, some training variation is common — significant variations in residency training can be found between states for the same specialty in the U.S.[54]

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47. Jonathan Wolfson, "Cutting the American Physician Shortage With International Doctors," (Cicero Institute, January 2025).

48. Author's calculations based on: Aaron Young, PhD and Humayun J. Chaudhry, DO, MACP, et al., "FSMB Census of Licensed Physicians in the United States, 2018," *Journal of Medical Regulation* 105, no. 2 (2019).

49. Gary L. Freed and Kelly M. Dunham, et al., "Changes in hospitals' credentialing requirements for board certification from 2005 to 2010," *Journal of Hospital Medicine* 8, no. 6 (2013): 298-303.

50. Flier and Rhoads, *The U.S. Health Provider Workforce*.

51. "Who Pays the Most for Malpractice Insurance?" Nexus Insurance, n.d.

52. Yusuke Tsugawa and Anupam B. Jena, et al., "Quality of care delivered by general internists in US hospitals who graduated from foreign versus US medical schools: observational study," *British Medical Journal* 356 (2017): j273; Richard A Garibaldi and Raja Subhiyah et al., "The In-Training Examination in Internal Medicine: an analysis of resident performance over time," *Annals of Internal Medicine* 137.6 (2002): 505-10,.

53. "Global Variations in Medical Residency Training," (Cicero Institute, 2024). Maya Hicks and Kenneth Chanda, et al., "Comparison of a U.S. and Zambian Ob/Gyn Residency Training Programme," *ecancermedicalscience* 16 (2022): 1468.

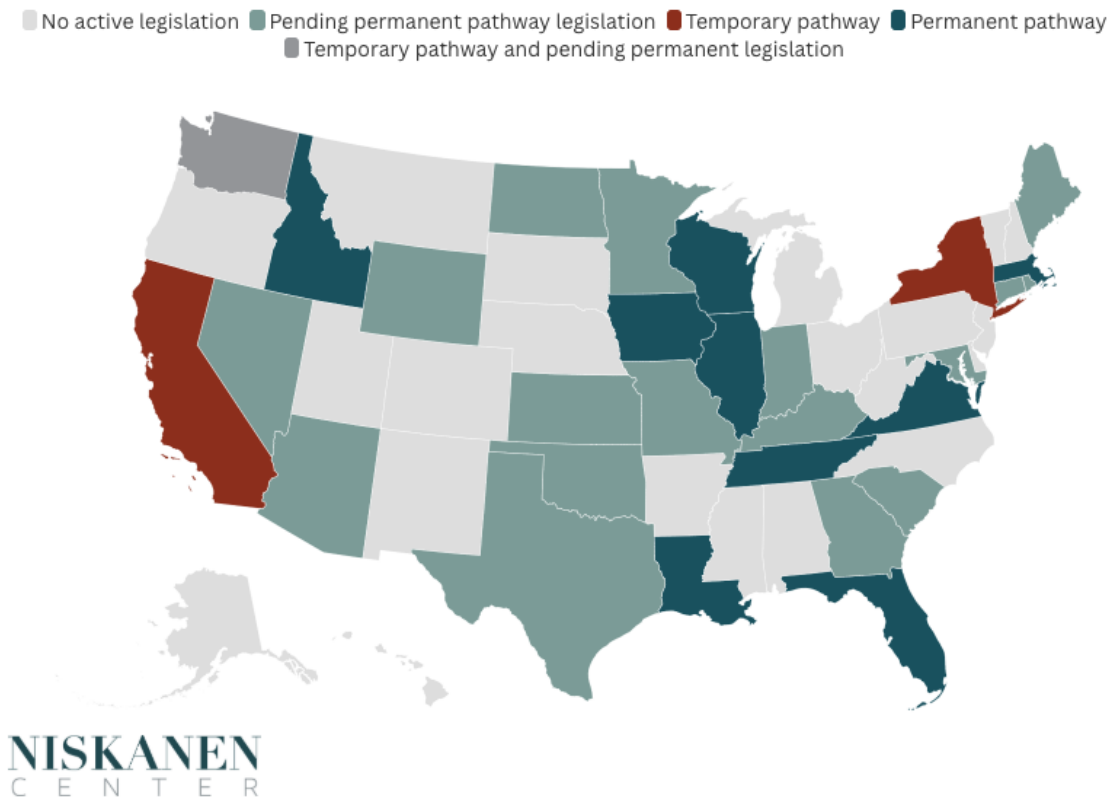
54. "Global Variations in Medical Residency Training," (Cicero Institute, 2024).

There are several trustworthy, proven safeguards to judge doctor competency and quality outside of a U.S. or Canada-based medical residency, including employer accountability and the several nationally standardized exams all licensed doctors must complete. Those exams, combined with scrutiny from the Educational Commission for Foreign Medical Graduates, provide a sufficient floor of credentialing for doctors with post-graduate training, including clinical knowledge and English language proficiency. Since it is employers who must sponsor and supervise IMGs, hiring processes also create safeguards that can filter for the most qualified applicants. These hiring processes are robust because it is ultimately the employers and doctors themselves, not medical boards or licensing boards, that are held liable if those doctors make a mistake.[55]

States should create alternative pathways to licensure

The most promising innovation is creating an alternative pathway for international doctors to prove their competency by practicing under the supervision of an already licensed provider. This avoids the inefficiency of making qualified, internationally trained doctors repeat their residency training and allows them to immediately enter the workforce and begin earning income. So far, nine states have passed a permanent pathway like this into law, with varying specifications and requirements (see Figure 3). Because the majority of these laws were passed in 2024, states are only now beginning to implement them. Other states have opted for shortening the residency requirements or creating temporary pathways for IMGs to practice, build experience, and improve their U.S. residency applications.

Figure 3. Legislative progress by state[56]



55. Russell G. Thornton, "Responsibility for the acts of others," *Proceedings (Baylor University Medical Center)* Volume 23 (2010): 313-5.

56. Authors' research, with sourcing from the Federation of State Medical Boards and Cicero Institute. Data collected and map created by Eric Lu.

There are a several key provisions state lawmakers should consider when crafting new pathways for international doctors:

1. All pathways should result in full and permanent licensure.

While temporary licenses are a helpful bridge to provide all qualified doctors a period to acclimate to the U.S. system, they will draw limited interest without a pathway to full licensure. Moreover, temporary pathways might be appropriate for IMGs with limited post-graduate training or clinical experience, but not for internationally trained doctors who have already completed post-graduate training. A temporary pathway would leave such trained doctors back where they started at the expiration of their allotted practice time, still needing duplicative residency training before they can practice with a full license. A permanent pathway would also provide employers certainty that a sponsored doctor could offer long-term patient care.

The state of Washington was the first to enact a temporary pathway for IMGs to gain clinical experience in 2021. The clinical experience license gives doctors a two-year provisional license with the opportunity to renew once for two more years.[57] While this mechanism successfully put 40 doctors into the workforce (the only state, as of this writing, to successfully license IMGs through an alternative pathway), four years later, many of these doctors treating patients will lose their license if the state does not either extend the renewal period or offer a permanent pathway.[58] New York has limited pathways in law that are renewable biennially with no limits but has not established a pathway for a full-practice, permanent license.[59] California has a temporary three-year pathway program exclusively for doctors trained in Mexico that is non-renewable.[60] Oregon is currently considering a bill to offer only a temporary licensure pathway for IMGs.[61] These temporary pathways do allow currently sidelined workers to begin treating patients but represent a missed opportunity to incentivize more doctors to participate in the program. States with temporary pathways should consider joining the nine states with a full licensure pathway.

2. All pathways should remove the U.S.- or Canada-based residency requirement.

Two states, Colorado and Alabama, have opted to shorten residency but maintain a U.S.- or Canada-based residency requirement.[62] Arizona has recently introduced similar legislation.[63] While these measures will allow IMGs to receive full licensure earlier, the primary barrier remains: matching to a residency program. Waiving residency requirements altogether for trained physicians is a more effective pathway and would open up more slots to medical graduates who actually need the residency training. Without U.S. or Canadian residency requirements, IMGs can prove their competency under supervision and by passing the several certifications and exams required without the need to duplicate their post-graduate training.

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57. "International Medical Graduates Clinical Experience License," Washington Medical Commission, n.d.

58. Lawson Mansell, "Testimony: Creating a full license pathway for international medical graduates," Niskanen Center, January 31, 2025.

59. New York State Law, see "§6528. Qualification of certain applicants for licensure."

60. "Licensed Physicians from Mexico Pilot Program (LPMPP), Assembly Bill 1045," UC Davis Health, n.d.

61. Oregon SB 476 (2025).

62. Colorado's bill shortened residency requirements to one year, but also stipulated that the state medical board open up a permanent pathway without North American residency. As of this writing, the board still requires "one year of clinically based postgraduate training in the United States or Canada." Alabama's legislation reduced the residency requirement from three years to two.

63. Nevada SB 204 (2023), Arizona SB 1249 (2023).

3. Qualification requirements should ensure adequate home-country training without excluding primary care physicians.

While all IMGs enter the U.S. with a medical degree, they have varying levels of postgraduate training. Those who already completed a residency program (or equivalent) overseas are often referred to as internationally trained physicians (ITPs). Those who both completed a residency program and have already practiced under a license in their home country are often referred to as internationally licensed physicians, but all these doctors are grouped under the term international medical graduates (IMGs).

State lawmakers, when designing and clarifying an alternative pathway for IMGs, should ensure that IMGs are treated according to their previous experience. Those with additional training and clinical experience should receive a more expedited path than those with limited practice experience. For example, a bill recently introduced in Washington state allows the state medical commission to offer "exceptionally qualified" IMGs an abbreviated assessment program.[64]

States that have created permanent pathways have different clinical experience and residency training requirements, with six of the nine requiring at least three years of clinical experience in the IMG's home country.[65] Clinical experience requirements ensure that IMGs going through a state's pathway already practiced under license in their home country without issues.

But these home-country training requirements should not be written so as to exclude international general practitioners (primary care doctors, as they are known in the U.S.). This can happen if states choose to recognize foreign residencies but impose American expectations for their duration. In Tennessee, permanent pathway legislation waived the U.S. residency requirement for IMGs provided they had completed a residency program of at least three years abroad.[66] Although U.S.-based primary care residencies are three years, in other countries, primary care residency programs can be as short as one year.[67] As a result, only physicians who completed residencies overseas in programs of longer length are eligible to apply. Because nationwide physician shortages are most drastic in the primary care specialties, state policymakers should ensure that requirements do not exclude IMGs who completed a shorter primary care residency. States should also clarify in statute or rulemaking that requirements for home-country residency training include all types of international primary care post-graduate training.

4. Sponsoring-entity requirements should not exclude rural or underserved areas.

Laws passed in Colorado and Tennessee provide for supervised sponsorship in lieu of residency, but they require that the IMG-sponsoring entity also run a residency program. This provision limits prospective sponsoring employers to larger teaching hospitals with the capacity for a residency program, most of which tend to be located in urban centers. In fact, only 2 percent of Medicare-funded residency training occurs in rural or underserved areas.[68] This requirement will likely limit the amount of time IMGs will spend in the

64. Washington SB 5185 (2025).

65. Jonathan Wolfson, "Cutting the American Physician Shortage With International Doctors," (Cicero Institute, January 2025).

66. Cheryl Clark, "Tennessee Medical Board Refuses to Enforce New IMG Law," *MedPage Today*, September 6, 2024.

67. Ibid.

68. Jacob Rains and George Mark Holmes, et al., "The Distribution of Additional Residency Slots to Rural and Underserved Areas," *JAMA*330, no. 10 (2023): 968-969.

areas of highest demand. To ensure IMGs treat patients in these areas, Idaho, Massachusetts, and Virginia even stipulate that IMGs practice in underserved or rural areas to receive their provisional license.[69]

Specialty boards should accommodate internationally trained physicians

All specialty boards in the U.S. require IMGs to complete a U.S. or Canadian residency as a prerequisite for taking the exam to become specialty-board certified. As state lawmakers begin to waive this requirement as a condition for licensure, specialty boards should follow suit and allow licensed IMGs who completed a residency overseas to sit for specialty exams. This policy would enhance employment opportunities for licensed IMGs, reduce barriers to practice, and incentivize healthcare providers to sponsor and employ internationally trained doctors, supporting the implementation of alternative licensure pathways enacted by various states.[70]

Conclusion

The physician shortage in the United States is a complex challenge that requires innovative solutions. By removing unnecessary barriers to practice for internationally trained physicians, we can tap into a valuable resource already present within our borders. State policymakers are currently creating alternative pathways to licensure to put international graduates to work, but there is much more to do. State policymakers and regulators have the power to bridge healthcare gaps and improve patient outcomes by simply removing unnecessary barriers and establishing common-sense safeguards. We can address the physician shortage quickly and efficiently by leveraging the skills and expertise of IMGs, creating a more resilient healthcare system for all Americans.

69. Legislation in Idaho, Massachusetts, and Virginia.

70. In December of 2023, the Federation of State Medical Boards, Intealth, and the Accreditation Council for Graduate Medical Education formed an Advisory Commission on Additional Licensing Models to guide policymakers pursuing alternative pathways for IMGs. In January 2025, they released their first set of recommendations. While they acknowledged that specialty board certification will serve as a barrier to IMGs licensed under these pathways, they did not recommend that specialty boards remove their U.S.- or Canada-based residency requirement or allow licensed IMGs to sit for specialty certification exams.