REPORT TO CONGRESS

Process by which International Medical Graduates are Licensed to Practice in the United States

A Report of the Council on Graduate Medical Education (COGME) Medical Licensure Workgroup

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Public Health Service
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September 1995

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Professions
Division of Medicine

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Contents

Foreword

This report, mandated by Section 307 of P.L. 102-408, studies selected aspects of the process by which graduates of foreign medical schools ("international medical graduates", or "IMGs") are licensed to practice in the United States.

The report is the product of the COGME Medical Licensure Workgroup, a special workgroup of the Council on Graduate Medical Education (COGME). Members of the workgroup, selected for the depth and breadth of their experience and to match the organizational and educational diversity specified in the legislation, are as follows:

Name	*Affiliation*
Radheshyan Agrawal, MD	American Association of Physicians of Indian Origin (AAPI)
Busharat Ahmad, MD	IMG Advisory Committee, AMA
Regina Benjamin, MD, MBA	Alabama State Board of Medical Examiners
L. Thompson Bowles, MD, PhD	President, National Board of Medical Examiners
Paul Brucker, MD	President, Thomas Jefferson University
Sergio Bustamante, MD *(Vice chair)*	Louisiana State University School of Medicine
Mark Friedlander, MD	IMG Advisory Committee, AMA
Nancy Gary, MD	President, Educational Commission for Foreign Medical Graduates
Jagan Kakarala, MD *(Chair)*	International Association of American Physicians
Aliza Lifshitz, MD	Chair, IMG Advisory Committee, AMA
Marc L. Rivo, MD, MPH	Director, Division of Medicine, Bureau of Health Professions, Health Resources and Services Administration
Hanson P. Sachs, MD	Family Medicine, Marietta, GA
Stela Tudoran, MD	Treasurer and Board Member, South Florida Chapter, American College of International Physicians
Marjorie Wilson, MD*	President Emeritus, Educational Commission for Foreign Medical Graduates (ECFMG)
James Winn, MD	Executive Vice President, Federation of State Medical Boards

Consultant to COGME Medical Licensure Workgroup

Annette Van Veen Gippe	Director, Department of Physician Licensure and Career Resources, AMA

COGME Staff Liaison

Stanford Bastacky, DMD, MSHA	Associate Director for Policy and Planning, Division of Medicine, Bureau of Health Professions, Health Resources and Services Administration

* Dr. Wilson served as a Workgroup member from September 1994 through May 1995. On June 1, 1995, Dr. Gary became the President of ECFMG and replaced Dr. Wilson on the Workgroup.

Executive Summary

OVERVIEW

This report to Congress was mandated by Section 307 of Public Law 102-408, the Health Professions Education Extension Amendments of 1992. Congress, concerned that the medical licensure policies and practices of state medical boards might be discriminatory with respect to graduates of foreign medical schools ("international medical graduates"), mandated that three sets of issues be addressed:

1. Credentials verification - The statute called for a review of a private credentials verification system then being operated by the American Medical Association. Recommendations were to be developed for the establishment of nondiscriminatory policies and practices for the operation of the system and for the establishment and operation of any similar system.

2. Licensure policies and practices of State medical boards - The policies and practices of the individual states, including any relevant laws, with respect to the licensing of international medical graduates (IMGs) and domestic medical graduates (USMGs) were to be examined.

3. Medical licensure application processing times and percentage of applications approved - The statute called for an empirical study of the average length of time required for states to process the licensure applications of IMGs and USMGs respectively, and the respective percentages of applications approved. Any significant differences between the two groups of applicants with respect to these variables were to be highlighted and the reasons for the differences identified.

Three reports were called for

- Reports 1 and 2: The credentials verification and policies and practices of State medical board issues were to be addressed first in an interim report and then in a final report to be submitted no later than September 30, 1995. The interim report has since been submitted[1] and is attached as an appendix to this document (Appendix A). The present document constitutes the final report.

- Report 3: The study of IMG-USMG differences in licensure application processing times and approval rates was to be addressed in a report to be submitted no later than September 30, 1994. Because of a delay in implementing the statute, that deadline could not be met. The Department, in consultation with the Council on Graduate Medical Education Medical Licensure Workgroup, decided to incorporate its findings with respect to these issues in the present report.

BACKGROUND

In response to Public Law 102-408, the Department of Health and Human Services, convened a working group including selected members of the existing Council on Graduate Medical Education (COGME) to oversee the development of the mandated reports. The composition of the appointed COGME Medical Licensure Workgroup ("Workgroup") matched the balance and diversity specified in the legislation. The chairman of the Workgroup is a physician who was the consensus choice of several IMG groups; the vice chairman is the IMG representative of COGME. The Workgroup met in September 1994, December 1994, and June 1995 in Washington, DC, to consider the issues mandated in Public Law 102-408.

In a parallel effort, the Department awarded a contract to a private contractor to perform the empirical study called for in the legislation, including a review of state medical board experience with, and interest in, a uniform national credentials verification system. The contract was awarded to Macro International, Inc., and resulted in a study report[2] (subsequently referred to as the Macro Report), submitted as an appendix to this document (Appendix B). The study, which involved a comprehensive literature review followed by a survey of nine State medical boards, was monitored throughout its development by the COGME Medical Licensure Workgroup and reviewed upon its completion by the Workgroup meeting as a whole. The Interim Report to Congress[1] includes additional background material.

LIMITATIONS OF THIS REPORT

Credentials Verification

In 1992, at the time Public Law 102-408 was enacted, the American Medical Association had been operating a service — the American Medical Association's National Physician Credentials Verification Service® (AMA/NCVS®) — designed to minimize the burden faced by State medical boards in

[1] U.S. Department of Health and Human Services, *Interim Report to Congress of Council on Graduate Medical Education (COGME) Medical Licensure Workgroup*, December 1994.

[2] Macro International, Inc. *State Licensing of Medical Practitioners: Case Studies of U.S. and International Medical Graduates*, September 1995.

verifying the credentials of prospective medical licensees as well as the burden faced by applicants in producing the documentation required. Congress, in Section 307 of the law, mandated that the operation of this system be monitored and reviewed, and that recommendations be generated regarding (a) methods by which the system could be improved, and (b) the establishment of nondiscriminatory policies and practices for its operation. In 1994, however, the AMA discontinued the service, reporting that it was too costly to operate, given the number of physicians who subscribed to it and the number of States that were willing to accept the data verified by the service.

The AMA's decision to discontinue the system made it necessary to redesign the study approach. To meet the legislative intent, the background and operations of the AMA/NCVS® were reviewed in detail by the Workgroup. Other relevant aspects of the AMA/NCVS® were studied as part of the survey of nine State medical boards.

Licensure Policies and Practices of State Medical Boards

Time and resource constraints precluded conducting an in-depth study of the licensure policies and practices of all States. Instead, reference materials that deal with the issue were used to conduct the review. The materials reviewed included the AMA's 1995 Edition of U.S. Medical Licensure Statistics and Current Licensure Requirements[3] and the Federation of State Medical Board's (FSMB) 1994 Edition of The Exchange[4]. A fuller examination of the licensure policies and practices of selected States was conducted as part of the survey of nine State medical boards.

Medical Licensure Application Processing Times and Percentage of Applications Approved

Time and resource constraints limited to nine the number of State medical boards for whom licensure application processing times and approval rates were obtained; the States included in the sample were selected by the Workgroup. The small sample size reduced the analytic power of the data collected and was insufficient to generalize the results to the entire population of medical licensing jurisdictions. Because of this limitation, the Workgroup decided to "receive" the report of the nine-state study without further action.

[3] American Medical Association. *U.S. Medical Licensure Statistics and Current Licensure Requirements,* 1995 edition.

[4] Federation of State Medical Boards. *The Exchange*, 1994.

FINDINGS AND WORKGROUP RECOMMENDATIONS

Credentials Verification

1. The time required to verify the credentials of physicians applying for licenses remains a critical element in creating differences in the application process between international and domestic medical graduates.

2. AMA's decision to phase out the AMA/NCVS® was based on its determination that the resources needed to maintain a high-quality service that met subscriber needs and State medical board requirements necessitated either a larger subscription base or higher fees. Of the nine States included in the survey of medical boards, three (Arizona, Louisiana, and Ohio) utilized the service; one State (Texas) would have negotiated a contract for the service had it not been discontinued. Reasons offered by the other States for not using the service fell into three broad categories:

- cost,
- perceived system limitations, and
- statutory or regulatory constraints.

3. Asked to identify the organization they felt would be "most appropriate" to operate a successor system to the AMA/NCVS®, every State that replied chose the Federation of State Medical Boards (FSMB). Two States chose the Educational Commission for Foreign Medical Graduates (ECFMG) as well, and one State chose the AIM (Administrators in Medicine).

4. The FSMB recently completed a feasibility study, approved by its Board of Directors, which concluded that a substantial majority of State boards had an interest in the Federation's establishing and operating such a service. Many boards stated that they would seek to make the service mandatory within their jurisdiction.

RECOMMENDATIONS:

1. A national credentials verification system is urgently needed to assist State medical boards in verifying the credentials of IMGs and USMGs applying for initial licensure (the process by which physicians apply for the first time to practice in the United States) as well as licensure by endorsement (the process by which physicians licensed in one State apply to practice in another). The documentation requirements of the system should be uniform and nondiscriminatory as between IMGs and USMGs.

2. The Federation of State Medical Boards (FSMB) is encouraged to proceed with its efforts to develop a national credentials verification system to be used for both initial and endorsement licensure. In addition:

(i) FSMB is encouraged to pursue these efforts in cooperation with ECFMG, and IMG organizations and other entities.

(ii) Federal and private sector technical and financial assistance should be explored during the development and implementation of the system.

Licensure Policies and Practices of State Medical Boards

1. Policy differences regarding the IMG and USMG licensure application process continue to exist. The survey of nine State medical boards and a review of the literature revealed some of those differences. While the survey of medical boards was insufficient in scope to reach conclusions regarding the entire population of licensing jurisdictions, the literature review produced a number of substantive findings, briefly summarized below:

- **Documentation** - It is more difficult for IMGs to obtain, and for State medical boards to verify, the credentials documentation required for licensure than it is for USMGs, which may account for some of the delay in processing applications. The difficulty arises from the absence of a formal accreditation process that would certify the quality of medical education in medical schools outside the United States and Canada.

- **Examination requirements** - Following years of different examination requirements for IMGs as opposed to USMGs, a single medical examination — the United States Medical Licensure Examination, or USMLE — is now accepted by all 54 licensing jurisdictions. This advance, implemented incrementally between 1992 and 1994, levels the playing field for IMGs who have not yet taken an examination. It does not, however, address the problem faced by an IMG licensed in one state based on an examination taken prior to the availability of the USMLE, who then seeks an endorsement license in another state which does not recognize the earlier examination.

- **Graduate medical education**[5] - As of 1995, 34 licensing jurisdictions require more years of graduate medical education for IMGs than for USMGs. Of the 28 jurisdictions that require three years of graduate training for the initial licensure of IMGs, only one requires three years of such training for USMGs, two require two years, while the remaining twenty-five require only one year of graduate training for USMGs.

2. Despite advances in some respects, considerable diversity exists among State medical boards with respect to both the primary and additional requirements for licensure imposed on IMGs. Many boards insist on documenting the authenticity of medical school diplomas and other credentials. In some instances, the State law authorizing the medical board mandates such documentation.

3. A major step toward uniform requirements was taken with the adoption of the USMLE as the examination required for licensure in all States. The Workgroup anticipates additional progress toward the achievement of uniform licensure requirements.

RECOMMENDATIONS:

1. Maximum uniformity among States in licensure requirements is a recommended goal. While the Workgroup acknowledges the need for State medical boards to address the licensure issues mandated by their respective legislative bodies, it is recommended that the Federal government work with the FSMB to encourage States to seek greater uniformity of requirements.

2. An effective, expedient licensure process is needed for both IMGs and USMGs. In the interest of facilitating licensure processing and portability, States should be encouraged to share and retain information concerning the credentials of foreign medical schools. Applicants should not be asked to produce original documentation on aspects of their medical education that have already been documented in other States or in recent years within the same State.

Medical Licensure Application Processing Times and Percentage of Applications Approved

The limited number of States surveyed (nine) precluded reaching definitive conclusions regarding the nation as a whole. The data nonetheless yielded several important insights:

Processing times

If "processing time" is defined as the number of days between the date on which an application for licensure is received by the State medical board and the date on which a licensure decision is reached, differences in the application policies and/or practices of several States (California, Louisiana, and Texas) tended to mask the true IMG-USMG differences in those States. Additional information on these differences, which ranged in both directions, may be found in the body of the report (section 2.3).

In five of the other six States surveyed, IMG-USMG comparisons could reasonably be made. In each of those States, forty case histories, divided evenly between IMGs and USMGs, were studied, with the following results: average processing times tended to be longer for IMGs, compared to USMGs, with respect to initial licensure but not with respect to endorsement

[5] The numbers in this paragraph have been updated, where relevant, to reflect the 1995 edition of the AMA publication *U.S. Medical Licensure Statistics and Current Licensure Requirements.*

licensure. In four of the States, the average time required to process initial licensure applications from IMGs exceeded that for USMGs by amounts ranging from 24 to 35 days; in the fifth State, there was no difference. In States where there was a difference, the average processing time for IMGs ranged from 27 to 75 percent greater than that for USMGs. These differences, however, do not necessarily convey differential treatment; some of the difference may result from the greater mailing times required to solicit and receive original documentation from foreign medical schools. The differences in processing time for endorsement applications showed no pattern in one direction or the other.

The Workgroup emphasizes that these findings be interpreted with caution because of the relatively small number of States for which comparisons could be made (five) and the small sample size within each State (twenty IMGs and twenty USMGs).

Approval rates

Very few applications resulted in denial. According to the States surveyed, the majority of applicants know the State requirements and therefore apply, in most cases, only if they know they can meet those requirements. IMGs, aware of the generally stricter requirements applicable in certain States, may be reluctant to apply in those States, tending to narrow the observed difference between IMG and USMG denial rates.

Not all States were able to disaggregate the data on approvals and denials by country of medical school training. Of the seven States able to provide such data, differences of some magnitude were noted in three. In three of those States, the denial rate was significantly greater for IMGs than it was for USMGs with respect to endorsement licensure but not with respect to initial licensure. Because of resource limitations, it was impossible to judge whether these differences resulted from discriminatory practice. To reach such a judgment, a broader study, entailing resources beyond those available to support the present effort, would be required. The Workgroup does not recommend such an effort.

The Workgroup again emphasizes that these findings be interpreted with caution. While the sample in each State used to calculate approval rates was substantially larger than that used to calculate processing times, the number of States for whom such data were available (seven) was insufficient to permit broad conclusions to be reached concerning the nation as a whole.

General

This study, mandated by Congress, has brought to light a number of issues in need of attention such as the continued lack of uniformity among States on licensure qualification and documentation requirements. Some States, during the course of the study, adopted changes that can be expected to expedite the processing of applications for USMGs and IMGs alike. An example of such a change was Louisiana's decision to grant temporary licenses to IMGs permitting them to engage in graduate medical education on the same basis as USMGs.

RECOMMENDATION:

Consideration should be given to reconvening a medical licensure workgroup or similar group at an appropriate time in the future (e.g., in three years) to assess continued progress in the area of uniform credentials requirements and "nondiscriminatory" treatment of international medical graduates.

ACKNOWLEDGMENTS

This report was commissioned by the Division of Medicine, Bureau of Health Professions, of the Health Resources and Services Administration, a component of the U.S. Public Health Service. Howard Davis, Ph.D., of the Special Projects and Data Analysis Branch within the Division of Medicine, served as Project Officer. Additional guidance and support was provided by Stanford Bastacky, D.M.D., M.H.S.A., Associate Director for Policy and Planning of the Division of Medicine and Council on Graduate Medical Education Staff Liaison, and John Rodak, Jr., M.S. (Hyg.), M.S. (HSA), another key member of the Special Projects and Data Analysis Branch.

The COGME Medical Licensure Workgroup that guided the development of this report and produced the conclusions and recommendations reported therein was chaired by Jagan Kakarala, M.D., with the assistance of the workgroup vice-chairman, Sergio Bustamante, M.D. The full list of workgroup members appears in the Foreword.

Much of this report is based on the findings of a nine-State survey and associated literature review conducted by an independent contractor, Macro International, Inc. The Macro study report, authored by Richard Schmidt and Michelle Morey, is presented in Appendix B. An earlier report to Congress, produced by the COGME Medical Licensure Workgroup, is presented in Appendix A.

Assistance in the preparation of this report was provided by Leonard Greenberg, president of LBD Associates, Sterling, Virginia.

Overview

PURPOSE AND SCOPE

This report is submitted in response to Section 307 of Public Law 102-408, the Health Professions Education Extension Amendments of 1992. In paragraph (a) of that section, Congress mandated that the Secretary of Health and Human Services establish an advisory council on medical licensure, charged to:

(a) Monitor and review the operation of the private credentials verification system then being operated by the American Medical Association and develop recommendations regarding methods by which the system can be improved and for the establishment of nondiscriminatory policies and practices for the operation of the system;

(b) Determine to what extent the system has expedited and otherwise improved the efficiency and equitable operation of the process in the States for licensing individuals to practice medicine who previously have been licensed by another State (commonly known as licensure by endorsement); and

(c) Review the policies and practices of the States (including any relevant laws) in licensing international medical graduates and in licensing domestic medical graduates, and determine the effect of the policies.

The system cited in the legislation is the American Medical Association's National Physician Credentials Verification Service (AMA/NCVS®). The law mandated that two reports covering the council's activities with respect to this system and the States' licensure policies and practices — one interim and one final — be developed and submitted to Congress. The final report was to be submitted not later than September 30, 1995.

Section 307 also mandated that the Secretary conduct an investigation of possible differences in the process by which applications for medical licensure received from graduates of foreign medical schools ("international medical graduates") and those received from graduates of U.S. medical schools ("domestic medical graduates") are acted upon and approved. In particular, the law mandated that the Secretary study a sample of not less than 10 states for the purpose of determining:

(1) the average length of time required to process the licensure applications of domestic and international medical graduates respectively, and the reasons underlying any significant differences in such times.

(2) the percentage of licensure applications from domestic and international medical graduates that are approved, and the reasons underlying any significant differences in such percentages.

This report constitutes the Council on Medical Graduate Education Medical Licensure Workgroup's report to Congress on the several activities mandated in the legislation: those relating to the verification of medical credentials, those relating to differences in licensure policies and practices, and those relating to differences in licensure application processing times and approval rates between domestic and international medical graduates. The report of a nine-State survey of medical boards conducted by Macro International, Inc. (appended to the Council's Report) constitutes the Secretary's Report to Congress on these issues.

BACKGROUND

As emphasized by the Federation of State Medical Boards (FSMB), the purpose of medical licensure is the "protection of the public health and safety" (FSMB, *Final Report: Project to Develop a State Medical Board Model*, April 1990). Over the years, each of the States (and related jurisdictions) has proceeded independently to develop medical licensure policies and practices in keeping with its sense of public need. Therefore, there are some differences among States in medical licensure policies and procedures. Further, it is perceived that there is some inequality within states as to the licensure of international medical graduates (IMGs) and domestic medical graduates (USMGs).

The impetus for studying the issues defined in the legislation lies in a series of General Accounting Office reports as well as in concerns expressed by members of the IMG community and others concerning differential treatment. The General Accounting Office, in 1985, reported that:

> "State medical licensing boards continue to have difficulty obtaining reliable information about the quality of the education provided to some foreign medical graduates and thus are hampered in making proper licensure decisions." (U.S. General Accounting Office, *Federal, State, and Private Activities Pertaining to U.S. Graduates of Foreign Medical Schools*, Report No. GAO/HRD-85-112, September 27, 1985)

A more recent GAO study, dealing with the issue of endorsement licensure (the process by which physicians licensed in one state apply to practice in another), concluded that:

"Most states have differences between endorsement requirements for graduates of foreign medical schools and for graduates of U.S. medical schools. These differences are evident in examination and experience requirements: most states require that foreign medical school graduates pass a different licensure examination and complete more years of post-graduate (residency) medical training than their U.S. counterparts. ... Also, differences exist between U.S. and foreign graduates in the effort necessary to obtain education-related documents." (U.S. General Accounting Office, *Medical Licensing by Endorsement: Requirements Differ for Graduates of Foreign and U.S. Medical Schools,* Report No. GAO/HRD-90-120, May 1990)

In 1991, in an effort to minimize the burden faced by State medical boards in verifying the credentials of applicants for medical licenses, as well as the burden faced by applicants in acquiring the documentation required, the American Medical Association (AMA) initiated its National Physician Credentials Verification Service® (AMA/NCVS®). Before the Congressional mandate to study the system could be carried out, however, the service was discontinued. According to the AMA, the service was too costly to operate given the number of physicians who subscribed to it and the number of States that were willing to accept the data verified by the service. AMA's withdrawal left a void that remains to be filled, although the FSMB has expressed an interest in designing and implementing a replacement process. At one point, the Educational Commission for Foreign Medical Graduates (ECFMG) expressed a similar interest as well.

IMPLEMENTATION OF THE MANDATE

Actions taken

The Department of Health and Human Services' implementation of the Congressional mandate followed the outline specified in the legislation. Several changes were found to be necessary, however:

(1) Following discussions with the Department, Senators Kennedy and Simon agreed that the responsibilities of the designated advisory council on medical licensure could be carried out by a working group of the existing Council on Graduate Medical Education (COGME). COGME was established in 1986 by Congress to provide an ongoing assessment of physician workforce trends and to recommend appropriate Federal and private sector efforts to address identified needs. The composition of the COGME Medical Licensure Workgroup formed for this purpose matched the membership specified in the legislation. The chairman of the Workgroup was a physician who was the consensus choice of several IMG groups; the vice chairman was the IMG representative of COGME. Members of the Workgroup are identified in the Foreword.

(2) Because of the AMA's decision to discontinue operation of the AMA/NCVS®, the study design was changed from monitoring and reviewing a system which was no longer operational to soliciting the opinions of State medical boards with respect to (a) the perceived merits and drawbacks of the system, (b) desirable features of a similar system in the future, and (c) the most appropriate organization(s) for operating such a system.

(3) Although the legislation called for a study sample of not less than ten States, it was agreed that because of resource constraints and the timeframe mandated for submission of the report to Congress, the study sample would be reduced to nine. The States selected by the Workgroup for inclusion in the sample were:

• Arizona	• Illinois	• New York
• California	• Louisiana	• Tennessee
• Florida	• New Jersey	• Texas

Because of computer system-related difficulties encountered in meeting the detailed data requirements of the survey instrument, New York was later replaced by Ohio.

Survey design

The nine-State survey was conducted by an independent contractor, Macro International, Inc., with the guidance, oversight, and support of the COGME Workgroup. The survey, addressed to the medical board responsible for licensure in each State, requested information on the following:

(1)Medical board perception concerning the credentialing issues identified in the legislation (merits/drawbacks of the AMA/NCVS®, proposed improvements to the system, desired characteristics of similar systems, etc.).

(2)Medical board policies concerning licensure.

(3)The caseload of the board over the past year with respect to:

- the number of initial and endorsement licensure applications received from IMG and USMG candidates respectively

- the number of applications of each type that resulted in board action and the nature of the action taken (approved or denied)

- the number of applications withdrawn at applicant request.

(4) Reasons for withdrawals or denials.

(5) Description of the follow-up processes used by the State during the application process.

(6) Case studies, in each State, of twenty IMG and twenty USMG applications. These studies focused on determining the average licensure processing times for each group of applicants. "Processing time" was defined as the number of days between the date on which an application was received by the State medical board and the date on which it was either approved or denied.

Pilot test

The survey design was reviewed by the Department and by the COGME Medical Licensure Workgroup, and a number of changes were incorporated. The design was then pilot tested in New Jersey to determine whether the time and effort required by State medical board staff to provide the information requested was reasonable, and whether the information provided properly addressed the issues raised by Congress.

The pilot test proved successful in both respects although there was some concern by the Workgroup that the instructions for drawing a random sample of forty case studies needed to be more fully spelled out. Following this and other modifications requested by the Workgroup, the survey was administered to the remaining eight States.

Review of State licensure policies and practices

Prior to developing the survey design, a comprehensive literature review covering State licensure policies and practices was conducted by Macro International. The review is summarized in the Macro study report,[6] submitted as an appendix to this document. Some of the findings reported in the literature review have since been updated. Other issues relevant to State licensure policies and practices were addressed in the nine-State survey of medical boards.

STRUCTURE AND CONTENT OF THIS REPORT CONCLUSIONS

The section on findings highlights the findings associated with each of the three sets of study activities: credentials verification, differences in State licensure policies and practices, and differences in processing times and approval rates between IMGs and USMGs. The conclusions and recommendations developed by the COGME Medical Licensure Workgroup with respect to each of these sets of activities are summarized on page 11.

Two appendices are included. Appendix A is the previously submitted interim progress report to Congress. Appendix B is the Macro study report covering the nine-State survey of medical boards and associated literature review.

[6] Macro International, Inc. State Licensing of Medical Practitioners: Case Studies of U.S. and International Medical Graduates, June 1995.

Findings

The conclusions presented in this section are based on the survey of nine State medical boards reported in Appendix B. The nine States originally selected for this purpose were:

- Arizona
- California
- Florida
- Illinois
- Louisiana
- New Jersey
- New York
- Tennessee
- Texas

One substitution was later made, Ohio replaced New York. After reviewing the data collection instruments, the New York State Education Department, which serves as the medical licensing board for the State of New York, reported that computer system limitations made it impossible to provide data in the form required. Among other limitations, actions taken by New York with respect to initial applications could not be separated from those taken with respect to endorsement applications — an important distinction.

The survey instrument used to gather the information described in this section, and the accompanying instructions for the selection of case histories, are found in the Macro study report. The results of this data collection effort are summarized, by topic, below.

RESULTS APPLICABLE TO THE VERIFICATION OF CREDENTIALS

Three States (Arizona, Louisiana, and Ohio) had used the AMA/NCVS®. The replies of these States with respect to their experience with the system were as follows:

- **Did the NCVS facilitate the verification of credentials?**

Two states said "Yes". One (Arizona) did not respond.

- **What problems, if any, were experienced with the system?**

Two states said "None". The third (Arizona) said "Information was outdated."

- **What do you consider to be the main strengths of the system?**

The following replies were received:

- Less paperwork for the doctor (Arizona)
- Entire package arrives at the same time, reducing the effort required of licensure clerks (Louisiana)
- Good documentation (Ohio)

- **What do you consider to be the main weaknesses of the system?**

Arizona cited two weaknesses; Louisiana cited none. The replies received were as follows:

- Outdated information (Arizona)
- Duplication of effort (Arizona)
- Lack of participation in the system (Ohio)

Of the States that had not participated in the system, several cited statutory or regulatory constraints. Others perceived certain system limitations with respect to their own needs and/or statutory responsibility. One State mentioned cost as an inhibiting factor. Reasons given for not participating in the AMA/NCVS® included the following:

- Information collected would not verify an applicant's medical education and training to the extent required by law (California).
- Process currently being used in this State is at least equal to that used by the AMA/NCVS® (Illinois).
- Would need statutory authority (Florida).
- Information collected is not sufficiently detailed to obviate the need for contacting the original source. Also, board cannot delegate one of its primary statutory functions to an organization composed entirely of individuals whose profession the board is designated to regulate (New Jersey).
- State has a legislative mandate to obtain credentials directly from the original source (Tennessee).

A sixth State (Texas) was in the process of negotiating a contract with the AMA when the service was discontinued.

Asked to identify the organization they felt would be most appropriate to operate a system to replace the AMA/NCVS®, every State but one mentioned the Federation of State Medical Boards (FSMB); Arizona made no recommendation. Three States named a second organization as well: California and New Jersey mentioned the Educational Commission for Foreign Medical Graduates (ECFMG); Ohio mentioned the AIM (Administrators in Medicine).

Reasons given by the States for recommending the FSMB included the following:

- FSMB understands state licensure application requirements.

- FSMB maintains files, accessible by the states, on disciplinary actions taken with respect to licensed physicians.

- FSMB has the largest existing data bank on physician credentialing issues.

The reason given by New Jersey for recommending the ECFMG (in addition to the FSMB) was "ECFMG has an understanding of the foreign credentialing system and should be able to utilize that in preparing a credentialing system."

Asked if their State would require a legislative or regulatory change to permit the use of an NCVS-like system, every State that had not participated in the AMA/NCVS® replied in the affirmative. There was general agreement that a system of this nature would reduce the overall workload of the board and facilitate the issuance of licenses. Several respondents noted, however, that in order for such a system to be acceptable, the following are necessary:

a. the States would need to be assured that the data maintained were both accurate and current,

b. the system should focus on credentials associated with medical education and postgraduate training, and

c. there should be wide participation by the States in the system design.[7]

STATE LICENSURE POLICIES AND PRACTICES

Two sets of findings are presented in this section. The first set is based on the literature review reported in Appendix B, updated to reflect the latest information available from the American Medical Association[8] and Federation of State Medical Boards[9] on the subject of State-specific differences in licensure policies and practices. The second set of findings is based on the nine-State survey of medical boards conducted by Macro.

Highlights of the literature review reported in Appendix B, updated as appropriate (see footnote 5 on page ix), are as follows:

- **Documentation.** - It is more difficult for IMGs to obtain the credentials documentation needed for licensure than it is for USMGs. The difficulty arises from the absence of a formal accreditation process that would certify the quality of medical education in medical schools outside the United States and Canada. The additional documentation required of IMGs includes the curriculum vitae of faculty and clinical supervisors, descriptions of the school and its library, and certifications by the dean, all of which must be sent as original documents by the primary source.

- **Examination requirements.** - Following years of different examination requirements for IMGs as opposed to USMGs, a single medical examination — the United States Medical Licensure Examination, or USMLE — is now accepted by all 54 licensing jurisdictions. This advance, implemented incrementally between 1992 and 1994, levels the playing field for IMGs who have not yet taken an examination. It does not, however, address the problem faced by an IMG licensed in one State based on an examination taken prior to the availability of the USMLE, who then seeks an endorsement license in another State which does not recognize the earlier examination. Some States, for example, do not recognize the FLEX exam taken by most IMGs if it was taken more than a designated number of years ago or in more than one sitting.

- **Graduate medical education.** - Exhibit 1 displays, by State, the number of years of accredited graduate medical education required for the initial licensure of USMGs and IMGs respectively. The information, which is current as of 1995, shows that:

  - 34 jurisdictions require more years of graduate medical education for IMGs than for USMGs.

  - 28 jurisdictions require three years of graduate medical education for IMGs. Of those 28 jurisdictions, only one (Nevada) applies a similar requirement to USMGs. The remaining 27 jurisdictions with three-year training requirements for IMGs were divided as follows: two (Maine and Pennsylvania) require two years of graduate training for USMGs, the rest (25) require only one year.

The extra years of graduate medical education required for IMGs, compared to USMGs, are displayed geographically in Exhibit 2.

Other issues pertaining to State licensure policies and practices were raised in the nine-State survey of medical boards. Relevant findings resulting from the survey were as follows:

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[7] The American Medical Association reports that all 54 licensing jurisdictions were involved in the design process for the AMA/NCVS®.

[8] American Medical Association. U.S. Medical Licensure Statistics and Current Licensure Requirements, 1995 edition.

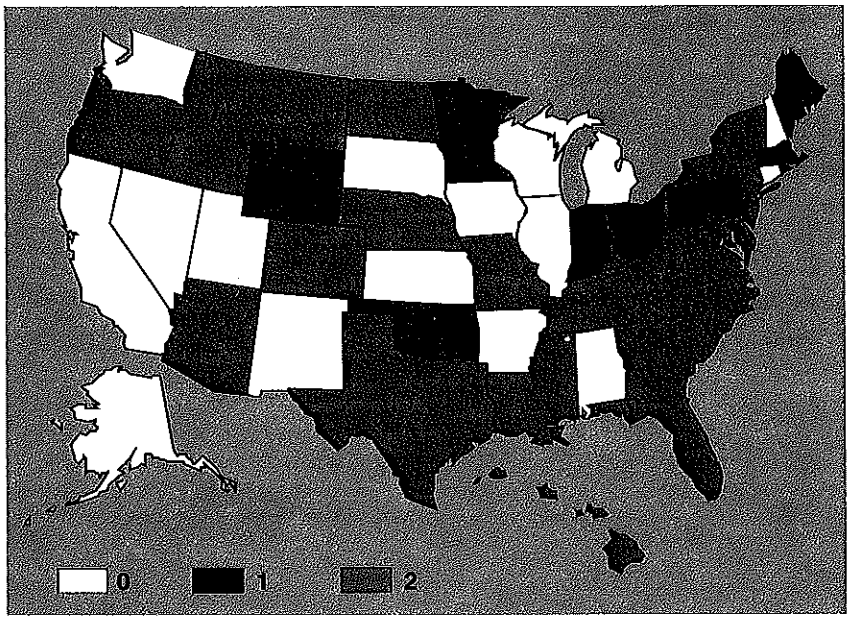
[9] Federation of State Medical Boards. The Exchange, 1994.

Exhibit 1. Years of Accredited Graduate Medical Education Required for Licensure, by State (1995)

State	*USMGs (yrs.)*	*IMGs (yrs.)*	*Difference*
Alabama	1	1	0
Alaska	1	1	0
Arizona	1	3	2
Arkansas	1	1	0
California	1	1	0
Colorado	1	3	2
Connecticut	2	2	0
Delaware	1	3	2
District of Columbia	1	3	2
Florida	1	3	2
Georgia	1	3	2
Guam	2	2	0
Hawaii	1	2	1
Idaho	1	3	2
Illinois	2	2	0
Indiana	1	2	1
Iowa	1	1	0
Kansas	1	1	0
Kentucky	1	1	0
Louisiana	1	3	2
Maine	2	3	1
Maryland	1	1	0
Massachusetts	1	2	1
Michigan	2	2	0
Minnesota	1	2	1
Mississippi	1	3	2
Missouri	1	3	2
Montana	1	3	2
Nebraska	1	3	2
Nevada	3	3	0
New Hampshire	2	2	0
New Jersey	1	3	2
New Mexico	2	2	0
New York	1	3	2
North Carolina	1	3	2
North Dakota	1	3	2
Ohio	1	2	1
Oklahoma	1	2	1
Oregon	1	3	2
Pennsylvania	2	3	1
Puerto Rico	1	1	0
Rhode Island	1	3	2
South Carolina	1	3	2
South Dakota	2	2	0
Tennessee	1	3	2
Texas	1	3	2
Utah	1	1	0
Vermont	1	3	2
Virgin Islands	1	1	0
Virginia	1	3	2
Washington	2	2	0
West Virginia	1	3	2
Wisconsin	1	1	0
Wyoming	1	2	1

Source: AMA, *U. S. Medical Licensure Statistics and Current Licensure Requirements*, 1995 edition, Tables 14 and 16.

Exhibit 2 - Extra Years of Accredited Graduate Medical Education Required for International vs. U.S. Medical School Graduates for Licensure by State (1995)



Source: American Medical Association. U.S. Medical Licensure Statistics & Current Licensure Requirements, 1995 edition.

Follow-up - All States followed the practice of sending letters to applicants notifying them of deficiencies in their applications. In one State, the letter was sent "upon receipt of application"; in others, it was usually sent within 30 to 45 days. The practice did not vary between IMG and USMG applicants nor was there any difference between IMGs and USMGs in the actions taken on applications that were incomplete. Some States archive incomplete applications after a prescribed period of time; others destroy them. California permits applicants — IMGs and USMGs alike — to maintain their files in inactive status by updating the file annually, so long as they are making a reasonable effort to meet state licensure requirements.

Needed legislative or regulatory changes - On the issue of changes needed to improve the licensure application process, the States replied as follows:

Endorsement licenses

To reduce duplicative effort with respect to endorsement licenses, several States reported the need for a national standardized license verification system similar to the AMA/NCVS®. The ability to conduct on-line verification of test scores, ECFMG certificates, and licenses in other States was mentioned as an important element of any system designed to eliminate duplication. Uniform licensure laws in the United States and Canada were also mentioned as a desirable change.

Initial licenses

To reduce processing time with respect to initial licenses, and to reduce any differences in processing times between IMG and USMG applicants, one State (California) noted that recent implementation of the USMLE uniform examination system had eliminated some of the latter differential but that a permit system in which both groups obtain training permits prior to entering postgraduate training would effect a further reduction.[10]

Other States reiterated the need for a centralized databank through which a physician's premedical, medical, and postgraduate record (including ECFMG certification, if applicable) could be checked. Such a system, however, "would have to be reliable and such information would have to be very detailed."

IMG-USMG COMPARISONS

Processing times

Based on the forty case histories selected in each State, divided evenly between IMGs and USMGs, average processing times were calculated for both groups of applicants. The findings are shown in Table 3 of the Macro Report and briefly summarized below:

Initial licenses

If one defines processing time as the elapsed time between the date on which an application was received by the medical board and the date on which it was approved or denied, two States (Louisiana and Texas) presented extremely long processing times for USMGs, while one State (California) presented extremely long processing times for IMGs. No conclusions should be drawn, however, from these differences. The numbers for these States are misleading for the following reasons:

- In California, in the year the survey was conducted, IMGs were required to apply for licensure prior to entering postgraduate training — a requirement that has since been changed — whereas USMGs normally apply later on in the training process. As a consequence, the processing time for IMGs, defined as the elapsed time between the date on which an application was received by the medical board and the date on which it was approved or denied, was misleadingly "long" compared to that for USMGs.
- In Louisiana, the reverse situation held in the year the survey was conducted: USMGs applied early, IMGs applied late. USMGs typically apply for licensure immediately upon graduation from medi-

[10] The issuance of temporary permits does not appear to be a major problem. At the time of the survey, eight of the nine States surveyed allowed both IMGs and USMGs to obtain temporary permits (or special temporary licenses) which would permit them to engage in postgraduate medical training. The sole exception (Louisiana) has since changed its policy; IMGs may now obtain temporary permits to participate in postgraduate training in that State.

cal school in order to receive the temporary permit needed to enter postgraduate training. Until recently, IMGs were precluded from obtaining temporary permits and thus had no reason to submit early applications.[11] The total processing time for IMGs, as herein defined, therefore appears short compared to that for USMGs.

- Graduates of Texas medical schools, comprising over half of the USMG applicants in that State, are encouraged to apply for licensure early in the postgraduate training process, again lengthening the elapsed time between application and licensure decision for USMGs.

No useful comparisons were possible for these States including Ohio.[12] In the remaining five States, a fairly consistent pattern was noted: in four of the States, the average processing time for IMGs exceeded that for USMGs by amounts ranging from 24 to 35 days; in the fifth State, there was no difference. In States where there was a difference, the average processing time for IMGs ranged from 27 to 75 percent greater than that for USMGs.

Endorsement licenses

No comparison regarding endorsement licenses was possible in California, where the twenty case histories selected all involved initial applications. In the remaining eight States, the results were evenly divided: in four, the average processing time was greater for USMGs than it was for IMGs; in the other four, the reverse situation held.

Approval rates

Of the nine States surveyed, seven were able to provide disaggregated data on approvals and denials by country of medical school training. An analysis of the caseload experienced in those States, reported in Tables 8 and 9 of the Macro Report, showed that the denial rate in three States (Louisiana, New Jersey, and Ohio) was significantly higher for IMGs than it was for USMGs with respect to endorsement licensure but not with respect to initial licensure.

The observed differences in endorsement licensure approval rates, although significant, do not in and of themselves denote discriminatory or other differential treatment. To reach such a determination, one would need to investigate not only the specific applications denied but a reasonable sample of others involving similar circumstances that were approved. Time and resource constraints precluded such an effort. Resource limitations also precluded any possibility of identifying IMGs who did not apply for licensure in a given State because the licensure policies or practices of that State were deemed to be prohibitive.

As for the causes of licensure denial, States were asked to report the major reasons over the past five years for the denial of licenses to IMGs and USMGs respectively. In two States (Florida and Illinois), the reasons cited for denying licenses to IMGs were identical to those cited for USMGs. In the other States, some differences were noted, but those differences seemed to result from differences in the specific applications received in each State rather than constituting a matter of State policy or practice.[13] Of the reasons for denial over the past five years that were cited in the Macro Report, the only ones which, by their nature, are uniquely applicable to IMGs are as follows:

- Failure to complete 3 years of approved residency training in U.S. or Canada (Louisiana).

- No ECFMG certification (Ohio and Tennessee).

- Applied with only J-1 visa (Tennessee).

All of the other reasons cited could apply to either group, in theory if not in practice. "Falsifying information on application" and "Discipline in another state," although cited in some States for IMGs only, were cited in other States only for USMGs. "Did not receive appropriate original transcripts from original school" was cited only for IMGs in Tennessee, but clearly could apply to USMGs as well.

Withdrawals

Not all States were able to provide data on withdrawals but those that did reported a total of 36 applications withdrawn by USMGs and 11 by IMGs. This ratio is consistent with the ratio of USMGs to IMGs in the overall applicant population (80%:20% in 1992). Reasons cited for the generally low rate of withdrawals were as follows:

(1) Applications are complex and expensive to prepare. Applicants do not wish to waste their time on futile effort.

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[11] Effective May 20, 1995, this policy was changed. Louisiana now allows IMGs to obtain the same type of temporary license as USMGs, permitting them to participate in postgraduate training programs on the same basis as USMGs. There still remains, however, one essential difference: IMGs require three years of postgraduate training for licensure in Louisiana as opposed to one year for USMGs.

[12] In Ohio, of the twenty IMG case histories selected for inclusion in the sample, only one involved initial licensure. The rest were all endorsement applications.

[13] In California, for example, USMGs were denied licenses in the past five years because of discipline in another state for reasons related to "alcohol abuse" or "mental illness" whereas IMGs were denied licenses for discipline in another state related to "incompetence" or "sexual misconduct." These differences, however, reflect differences in the respective applicant pools over the past five years; they should not be taken to imply differences in policy or practice.

(2) The application fee is non-refundable.

In the case of applications that were withdrawn, the reasons for withdrawal, as perceived by the States, typically fell into three categories:

- Avoidance of stigma - Applicant wishes to avoid the stigma associated with denial, since denials are reported to other organizations and state licensing boards.

- Unintended discovery - Applicant realizes that the State has uncovered information intentionally not revealed in the application.

- Change of plans - Applicant seeking an endorsement license later decides not to relocate to the State in question.

No essential differences were noted between the reasons reported for IMG withdrawals and those for USMGs. The only difference of any consequence was in Tennessee where "difficulties with immigration" was cited for IMG applicants and "malpractice histories" was cited for USMG applicants seeking endorsement licenses. In all other States, the reasons cited for both groups of applicants were virtually identical.

Conclusions and Recommendations

This section summarizes the conclusions and recommendations developed by the COGME Medical Licensure Workgroup with respect to the three major issues addressed in the legislation:

a. Credentials verification, including judgments concerning the AMA/NCVS® and possible successor systems

b. IMG-USMG differences in State licensure policies and practice

c. IMG-USMG differences in processing times and approval rates

Credentials Verification

1. The time required to verify the credentials of physicians applying for licenses remains a critical element in creating differences in the application process between IMGs and USMGs. A uniform national system for verifying credentials, nondiscriminatory in its treatment of IMGs, is a national need for both IMGs and USMGs.

2. Any such system must avoid the difficulties encountered by the AMA in operating its predecessor system, the AMA/NCVS®. Specifically:

- Cost to both the subscribing physicians and the States must be kept low.
- Perceived system limitations — e.g., concern that the data collected may not verify an applicant's medical education and training to the extent required by law, or that the information may not be sufficiently detailed to obviate the need for contacting the original source — must be overcome.
- Regulatory or statutory constraints need to be addressed.

Involvement of the States in the design of such a system is deemed to be essential.

3. Unanimity was clearly expressed by the States that were surveyed that the most appropriate organization for operating a successor system to the AMA/NCVS® was the FSMB. This position was bolstered by a presentation at the June 23, 1995 meeting of the COGME Medical Licensure Workgroup by James Winn, M.D., Executive Vice President of the FSMB. Dr. Winn reported that the organization had recently completed a preliminary feasibility study, approved by its Board of Directors, which concluded that a substantial majority of State boards had an interest in the Federation's establishing and operating such a service. Many boards indicated they would seek to make the service mandatory within their jurisdiction.

The COGME Medical Licensure Workgroup encourages the FSMB to:

(a) proceed with its efforts to develop a uniform, nondiscriminatory national credentials verification system, and

(b) pursue these efforts in cooperation with ECFMG, and IMG organizations and other entities.

The Workgroup also recommends that:

(c) the possibility of Federal assistance in this effort, including financial assistance, be explored, and

(d) State boards be encouraged to move toward greater uniformity in the documentation required for licensure.

IMG-USMG Differences in Licensure Policies and Practice

Substantial differences exist among the States in the licensure requirements applicable to USMGs and IMGs respectively. Those differences exist with respect to:

- Documentation - It is more difficult for IMGs to obtain, and for State boards to verify, the credentials documentation required for licensure than it is for USMGs, which may account for some of the delay in processing applications.
- Examination requirements - Despite acceptance of the USMLE by all 54 licensing jurisdictions, IMGs licensed in one State based on an examination taken prior to the availability of the USMLE encounter difficulties when seeking endorsement licensure in other States which do not recognize the earlier examination.
- Graduate medical education - The number of years of graduate medical education required of IMGs is greater in most States than it is for USMGs. In 1994, of the 28 jurisdictions that imposed a three-year requirement on IMGs, only one applied a similar requirement to USMGs. The vast majority of States require only one year of graduate training for USMGs.

The Workgroup noted that many State boards

insist on documenting the authenticity of medical school diplomas and other credentials. In some instances, the State law authorizing the State medical board mandates such documentation.

IMG-USMG Differences in Processing Times and Approval Rates

Although the nine States surveyed are not necessarily representative of the other forty-five licensing jurisdictions, several important insights were gathered from the information presented:

Processing times

Ignoring the three States whose practices precluded any reasonable comparison of processing times, there was substantial evidence in the other States that the average processing time for applicants tends to be longer for IMGs than it does for USMGs with respect to initial licenses but not for endorsement licenses.

For initial licenses, the difference in average processing time for IMGs, compared to that for USMGs, ranged from moderate (27%) to substantial (75%). The differences for endorsement applications showed no pattern in one direction or the other.

Because of the limited number of States surveyed and the small sample size within each State, these findings should be interpreted with caution. Moreover, because of other data limitations, the differences noted may not tell the full story. Application processing times based on data supplied by the States do not include the generally greater expenditure of effort required on the part of IMGs to solicit and obtain original documentation prior to submitting an application.

Mechanisms, such as a centralized credentials verification system, that would substantially reduce this time would be helpful to, and reduce the feeling of differential treatment experienced by, IMG applicants for medical licenses.

Approval rates

Very few applications are denied. The reason, according to the States, is that the majority of applicants know the State requirements and apply, in most cases, only if they know they can meet those requirements. IMGs, aware of the generally more stringent requirements in certain States, may be reluctant to apply in those States, tending to narrow the observed difference between IMG and USMG denial rates.

Despite the limited number of States involved, it is noteworthy that of the seven States that were able to provide disaggregated data on the number of approvals and denials by country of medical school training, the denial rate for endorsement licensure was significantly greater in three States for IMG applicants than it was for USMGs.

Again, the existence of significant differences in approval rates does not necessarily denote discriminatory or other differential treatment. One would need to study not only the specific cases that were denied but a reasonable sample of others, involving similar circumstances, that were approved. The Workgroup does not recommend further study of either approval rates or processing times for the following reasons:

a. "Processing time" is a potentially misleading measure. It includes a number of imponderables that can vary from applicant to applicant as well as between States.

b. "Approval rate" is similarly misleading. States with licensure provisions deemed prohibitive by IMGs may nonetheless show a high approval rate because of the reluctance of IMGs to apply in that State.

Despite these data limitations, the study described in this report has accomplished a worthwhile purpose by bringing to light a number of issues in need of attention. Several States, during the course of the study, adopted changes that will expedite the application process for IMGs and USMGs alike. For example:

- Louisiana now grants temporary permits to IMG physicians permitting them to enter postgraduate training in the state prior to licensure.

- California no longer requires that IMGs apply for licensure prior to entering postgraduate training.

At its final meeting on June 23, 1995, the COGME Medical Licensure Workgroup made the following recommendation:

Consideration should be given to reconvening a medical licensure workgroup or similar group at an appropriate time in the future (e.g., in three years) to assess continued progress in the area of uniform credentials requirements and "nondiscriminatory" treatment of international medical graduates.

Appendix A– Interim Report to Congress – December 1994

The purpose of this report is to provide the Labor and Human Resources Committee of the Senate, the Energy and Commerce Committee of the House of Representatives, and the Secretary of Health and Human Services, a progress report on the implementation of section 307 of Public Law 102-408, the Health Professions Education Extension Amendments of 1992.

BACKGROUND

Section 307 of Public Law 102-408 mandated that the Secretary of Health and Human Services (Secretary) establish the "National Advisory Council on Medical Licensure." Specifically, Congress directed that the Advisory Council:

- Monitor and review the operation of the private credentials verification system (National Credentials Verification System) established by the American Medical Association (AMA) and develop recommendations regarding methods by which the system can be improved, and make recommendations for the establishment of nondiscriminatory policies and practices for the operation of the system;
- Determine to what extent the system has expedited and otherwise improved the efficiency and equitable operation of the process in the States for licensing individuals to practice medicine who previously have been licensed by another State (commonly known as licensure by endorsement); and
- Review the policies and practices of the States in licensing international medical graduates (IMGs) and in licensing domestic medical graduates (USMGs), and determine the effects of the policies.

The Congress directed the Secretary to appoint an Advisory Council with members selected in accordance with criteria specified in the law and required an interim and final report regarding the findings and recommendations of the Council. The Congress also directed the Secretary to conduct, in consultation with the Council, a study of State medical boards and report to Congress regarding:

- the average length of time required for the States involved to process the licensure applications of USMGs and IMGs and the reasons underlying any significant differences in such times; and
- the percentage of licensure applications from USMGs and IMGs that are approved and the reasons underlying any significant differences in such percentages.

Following passage of Public Law 102-408 in October, 1992, discussions regarding implementation of section 307 commenced between officials of the Health Resources and Services Administration (HRSA) and staff from the offices of Senators Kennedy and Simon. A major barrier to implementation was resources, both financial and staffing. After much discussion about a possible alternative, in December, 1993, Senators Kennedy and Simon wrote to Secretary Shalala indicating that HRSA had recommended, in the interests of both expediting the intended work of the Advisory Council and carrying out the mandate in a cost-effective manner, that the Advisory Council responsibility be carried out through a working group of the extant Council on Graduate Medical Education (COGME). They also indicated that the responsibilities of the workgroup must be consistent with the mandated responsibilities under Public Law 102-408.

Senators Kennedy and Simon expressed their reluctance to accept a substitute for the Advisory Council, but felt they could accept the workgroup alternative particularly if it could accomplish quickly, fairly, and comprehensively the work that had been envisioned for the Advisory Council. Other conditions which they specified were that the workgroup's report to Congress and the Secretary must comprise the findings and views of the Workgroup, not of COGME, and that the report be provided to Congress no later than September 30, 1995.

Secretary Shalala wrote to Senators Kennedy and Simon in February, 1994, indicating that the Department of Health and Human Services (HHS) was in agreement with the following:

- A COGME workgroup will be established to oversee the development of the report required in Public Law 102-408. The workgroup will be co-chaired by a physician who is the consensus choice of the IMG community and the IMG member of COGME.
- The members of the workgroup will include the balance of membership mandated in Public Law 102-408. HHS will consider congressional recommendations in choosing members of the workgroup.

- The responsibilities of the workgroup will be identical to those mandated of the Advisory Council.
- COGME's full membership will review the workgroup report at the time it is completed. If substantial disagreement exists between COGME and the workgroup, the recommendations of both groups will be reported.

COGME MEDICAL LICENSURE WORKGROUP

Following acceptance of the agreement by Senators Kennedy and Simon, HRSA began the tasks of: (1) constituting the COGME Medical Licensure Workgroup (Workgroup), (2) formulating an Action Plan and Workgroup Charge, and (3) developing a request for proposals for a contract to study the policies and practices of State medical boards in licensing IMGs and USMGs.

Membership

- The recommendations and input from a number of sources involved with IMG issues and interests, including recommendations from Congress, and health professional and international medical graduate organizations, were considered in appointing the Workgroup's membership. The Workgroup membership is set forth on page 16.
- Dr. Jagan Kakarala was appointed as Chairperson of the Workgroup and Dr. Sergio Bustamante (a COGME member) was appointed Vice Chairperson of the Workgroup.

Action Plan

- The 1994-1995 Workgroup Action Plan was prepared and included several conferences calls, two face-to-face meetings, and a timetable for completion of the contract to study the policies and practices of State medical boards. The plan was designed to complete all of the tasks in time to satisfy the requirement of transmitting the Workgroup's report to Congress by September 30, 1995. The Congress could then apply the report in its deliberations on the reauthorization of Title VII of the Public Health Service Act.

Workgroup Charge

- A statement of the Workgroup Charge was prepared, covering the Workgroup's duties and activities as specified in Public Law 102-408. The Workgroup Charge is set forth in Attachment II.

Study of State Medical Board Licensing Processes

- A request for proposals was developed to solicit proposals for a contract to study the policies and practices of State medical boards in licensing IMGs and USMGs as required by Public Law 102-408, and to assess the accomplishments of the National Credentials Verification System, or of a successor system, in expediting the licensure by endorsement process. In July, 1994, a 12-month, $134,000 contract was awarded to MACRO International of Calverton, Maryland, under a HRSA requirements order contract. A conference call was held on August 3, 1994, with the Medical Licensure Work Group Chairperson and Vice Chairperson, and representatives of the Division of Medicine, Bureau of Health Professions, HRSA, and of MACRO International. The purpose of the call was to review the contract scope of work with the Workgroup leadership and Contractor, and to respond to questions.

FIRST MEETING OF THE COGME MEDICAL LICENSURE WORKGROUP

The first meeting of the Workgroup was held on September 8, 1994, at the Holiday Inn Crowne Plaza in Rockville, Maryland. The purpose of the meeting was to introduce the Workgroup members, discuss the Workgroup Charge, review the scope of work of the contract to study State medical board licensing processes, obtain a briefing regarding the National Credentials Verification System (NCVS) and its status, and permit public comment on these issues. The meeting was productive and congenial and a positive tone was maintained throughout the morning and afternoon sessions.

A number of issues were raised by Workgroup members during the meeting:

- The role of the Workgroup in the study of State medical board licensing processes. Members believed strongly that the entire Workgroup should be advisory to the study;
- The specific States and number of States to be studied in the study of the State medical board licensing processes; and
- The continuation of a centralized credentials verification system given the demise of the NCVS on December 31, 1994. Members believed strongly that a credentials verification system is important to the IMG community and that some form of a centralized credentials verification system should be continued following closing of the NCVS.

Following are outcomes of the meeting:

Workgroup Charge

- The COGME Medical Licensure Workgroup Charge was approved by the Workgroup page 17.

Interim Report to Congress

- An interim report (this report) highlighting progress to date will be developed for review by the Workgroup and transmitted to Congress as soon as possible.

STUDY OF STATE MEDICAL BOARD LICENSING PROCESSES

- The study of State medical board licensing processes will include the following nine states approved by the Workgroup: Arizona, Louisiana, California, Tennessee, Florida, Texas, Illinois, New Jersey, and New York. Alternate States approved by the Workgroup include: Michigan, Ohio, and Missouri. States were chosen based on several criteria: number of IMG's applying for licensure in a particular State, number of concerns about the licensure process expressed by IMG's applying for licensure in a particular State, and whether a State has used the NCVS in its licensure process.
- The COGME Medical Licensure Workgroup will have an advisory role in the study of State medical board licensing processes.
- An additional face-to-face meeting of the Workgroup will be held following the pilot test of the State medical board survey questionnaire, so that the Workgroup may have input into and approve the final survey instrument.

Credentials Verification System

- Possible alternatives to the NCVS should continue to be explored. The Educational Commission for Foreign Medical Graduates (ECFMG) and Federation of State Medical Boards (FSMB) should be invited to the next meeting of the Workgroup to present their views on the NCVS in terms of the potential, if any, for the ECFMG or FSMB to assume NCVS functions.

NEXT STEPS

- Develop a draft interim report to Congress on the progress of the Workgroup. Following review by Workgroup members, forward the report to Congress.
- Proceed with the study of State medical board licensing processes; develop the survey questionnaire with Workgroup input; pilot test the questionnaire; and present pilot test findings to the Workgroup for review.
- Hold the next face-to-face meeting of the Workgroup following pilot testing of the survey questionnaire to study State medical boards licensing processes. ECFMG and FSMB will be asked to present at the meeting their views regarding an alternative to the AMA's NCVS.

COGME Medical Licensure Workgroup

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COGME Medical Licensure Workgroup Charge

1. Review the operations of the American Medical Association's National Credentials Verification System and recommend an alternative credentials verification system for physicians that assures nondiscriminatory policies and practices in the operation of the system. (Note: The National Credentials Verification System is being phased-out and will close on December 31, 1994.)

2. Review the policies and practices of State medical boards in licensing international medical graduates and in licensing U.S. medical graduates, and determine the effects of the policies and practices.

- Conduct a study of selected State medical boards to determine the:

  - average length of time required for medical boards to process the licensure applications of U.S. medical graduates vs licensure applications of international medical graduates and the reasons underlying any significant differences in such times;

  - percentage of U.S. medical graduates licensure applications approved by medical boards vs the percentage of international medical graduates licensure applications approved by medical boards and the reasons underlying any significant difference in such percentages; and

  - extent to which the National Credentials Verification System has expedited and otherwise improved the efficiency and equitable operation of the State medical board licensure by endorsement process.

3. Report and make recommendations to the Congress, the Secretary of Health and Human Services and the Council on Graduate Medical Education regarding:

- the operations of the National Credentials Verification System and an alternative credentials verification system for physicians that assures nondiscriminatory policies and practices in the operation of the system; and

- policies and practices of the State medical boards in licensing international medical graduates and in licensing U.S. medical graduates, and the effects of the policies and practices.

Appendix B–
State Licensing of Medical Practitioners: Case Studies of United States and International Medical Graduates

Submitted to:
U.S. Public Health Service
Health Resources & Services Administration
Bureau of Health Professions
Division of Medicine

by:
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The COGME Medical Licensure Workgroup that guided the development of this report was chaired by Jagan Kakarala, M.D., with the assistance of the workgroup vice chairperson, Sergio Bustamante, M.D. The full list of workgroup members appears in Appendix H of this report.

Executive Summary

Background

This report, State Licensing of Medical Practitioners: Case Studies of United States and International Medical Graduates, describes the results of a study of (1) the licensing policies and processes of nine State medical boards, (2) the medical boards' perceptions of the American Medical Association's National Physician Credentials Verification Service® (AMA/NCVS®),[1] and (3) the desired characteristics of a system to replace the AMA/NCVS®.

The report responds to Section 307 of Public Law 102-408, the Health Professions Education Extension Amendments of 1992, which requires the Secretary of Health and Human Services (the Secretary), in consultation with an advisory council (Council on Graduate Medical Education Medical Licensure Workgroup), to conduct a study of State medical boards' licensure processes for the purpose of determining:

(A) The average length of time required for the States involved to process the licensure applications of domestic medical graduates[2] and the average length of time required for the States to process the licensure applications of international medical graduates, and the reasons underlying any significant differences in such times.

(B) The percentage of licensure applications from domestic medical graduates that are approved and the percentage of licensure applications from graduates of international medical schools that are approved, and the reasons underlying any significant differences in such percentages.

In addition, Section 307 charges the advisory council with providing the Secretary with advice regarding the "operation of the system established by the American Medical Association for the purpose of verifying and maintaining information regarding the qualifications of individuals to practice medicine, and advice regarding the establishment and operation of any similar system." The system referenced in the statute is the AMA/NCVS®, which was established in 1991. In 1994, the American Medical Association (AMA) ceased operation of the AMA/NCVS®. The AMA reported that the system was costly to operate given the high standards it had to meet and the small number of physicians who chose to subscribe. The cessation of the service occurred just prior to launching this study; therefore, the study surveyed State medical boards' perceptions of the AMA/NCVS® and desired characteristics of a replacement system.

This report will be part of a final document to be submitted to the Secretary, the Committee on Labor and Human Resources of the Senate, and the Committee on Energy and Commerce of the House of Representatives by the COGME Medical Licensure Workgroup (the Workgroup). The final document will contain the Workgroup's recommendations regarding a national credential verification system and the policies and processes of State medical boards in licensing IMGs and USMGs.

Study Design

In order to keep within Federal and State resources and to complete the study schedule,[3] the design of the study was limited to case studies of 20 IMG and 20 USMG applicants in each of nine States. The nine States, selected by the Workgroup, surveyed were Arizona, California, Florida, Illinois, Louisiana, New Jersey, Ohio, Tennessee, and Texas. While the results of the study point to issues in need of further examination, the study design reduces the analytic power of the data collected and precludes generalization of the results to the entire population of licensing jurisdictions. In addition to these design limitations, the State of New York, which in 1994 had a caseload of 2,864 licenses[4] (35 percent were IMG licenses), withdrew from the study and was replaced by Ohio, which issued 1,461 licenses in 1994 (6 percent were IMG licenses).

Findings

1. To what extent has the AMA/NCVS® expedited and otherwise improved the efficiency and equitable operation of the State medical board licensure by endorsement process? Is there utility in continuing such a national credentials verification system?

Analysis of the data provided by all nine State medical boards suggests that there is potential utility in a national credentials verification system. If implemented, the benefits would accrue to both USMG and IMG applicants for licensure by endorsement. Of the nine States surveyed, three—Arizona, Louisiana, and Ohio—used the AMA/NCVS®. Texas was in the

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1 The AMA/NCVS® ceased operation in 1994.

2 The term "domestic medical graduates" includes graduates of both United States and Canadian medical schools. Within the body of this report, domestic medical graduates will be referred to as United States medical graduates or USMGs.

3 The final report is scheduled to delivered to the Secretary and the Congress by September 30, 1995.

4 Bidese, C.M. 1994. U.S. medical licensure statistics and current licensure requirements. American Medical Association.

process of negotiating a contract with the AMA when the AMA/NCVS® ceased operation. Due to the limited enrollment in the service by the States surveyed, it was not possible to demonstrate whether the AMA/NCVS® expedited or improved the efficiency and equitable operation of the endorsement licensure process. Additional information on these data is presented on page 37.

One insight gained from this study is the variation that exists among the States in carrying out essentially the same credentialing function. Although the limited database can only be considered suggestive, it shows nonetheless that there is at least as much variation among the States in the documentation requirements and the processing times for a common group (IMG or USMG applicants) as there is variation between the groups (comparing IMGs and USMGs). Further, in four of the nine States, endorsement processing times are either the same or greater than processing times for initial licenses. Both findings suggest that a national credentials verification system to obtain and verify a core set of credentials may help to standardize the process and perhaps reduce the processing times for both IMG and USMG endorsement applicants.

To assure the usefulness of a national credentials verification system to State medical boards, the boards surveyed indicated that they need to be included in the decision-making process regarding the documentation that would be necessary for such a system to collect.[5] They also need to be convinced that the processes used in any replacement national credentials verification system are as effective as the systems they currently use. Several State medical boards indicated that they would need a change in their legislative authority to permit reliance on a national credentials verification system. State medical boards suggested that the Federation of State Medical Boards (FSMB) is the preferred organization for operating such a system. The FSMB recently completed a feasibility study to determine interest in and commitment to a credentials verification system among member boards. The results of the feasibility study were favorable and the FSMB is contemplating the implementation of a replacement system.

A central system for verification of the credentials required for medical licensure could ease many of the difficulties facing physicians applying for endorsement licenses, especially those applicants whose medical training was obtained outside the United States or Canada. The full set of documentation requirements that applicants must fulfill is listed in Appendix E.

2. Are there differences in the average length of time required for the State medical boards involved in this study to process licensure applications of USMGs and the average length of time required to process licensure applications of IMGs? What are the reasons underlying any significant differences in such times?

The study revealed that there are differences in the average length of time required to process USMG and IMG licensure applications.[6] In six of the nine States participating in the survey, the average processing time was greater for initial applications from IMGs than for the comparable USMG group. When four States for which data problems exist were excluded, one State showed no difference in average processing times for IMG and USMG applicants and the four remaining States showed longer average processing times for IMG applicants. In these four States, it took, on average, 31.5 days longer for an IMG application to be processed.

Average processing times for endorsement applications reveal a mixed pattern. Four of the eight States for which data exist exhibited higher processing times for IMG applications and four exhibited higher processing times for USMG applications. A possible explanation for some delay in the processing of an IMG application is the complexity of international communication, including language barriers and the use of overseas mail. Detailed analyses of processing times of both initial and endorsement applications begin on page 33.

3. Are there differences between the rates of licensure applications approved/denied for USMGs and the rate of licensure applications approved/denied for IMGs in the State medical boards involved in this study? What are the reasons for any significant differences in such rates?

The study revealed modest differences in the rates of approval/denial for endorsement licensure applications. In three States—Ohio, Louisiana, and New Jersey—denial rates on IMG endorsement applications were significantly higher than the denial rates on USMG endorsement applications. See page 40 of this report for further explanation of these denial rates.

Overall, the study revealed that most applicants, both IMGs and USMGs, were ultimately approved for licensure. As illustrated in Table 8 on page 41, in the nine States combined, 1,428 initial license applications were approved (99.4%) and 8 were denied for IMGs, while 6,391 initial license applications were approved and (99.4%) 2 applications were denied for USMGs.

[5] It is noted by the AMA that all 54 United States licensing jurisdictions were involved in the initial design of the AMA/NCVS®.

[6] Average processing times within each State were calculated for both IMG and USMG licensure applicants. Average processing times were not compared across States because State board staffing, application case load, and procedures for licensing were found to be so heterogeneous that the calculation of an average processing time for USMG applicants and IMG applicants across States was inappropriate. Instead, this study compares within State differences between IMG and USMG application processing times.

Table 9 illustrates that endorsement applications for IMGs were approved at slightly lower rates. Of 1,757 IMG endorsement applications that reached a final decision, 1,735 were approved (98.7%) and 22 denied. For USMGs, the comparable numbers were 6,382 approved (99.8%) and 8 denied.

States generally report that their denial rates are low. The chief reasons for denial of IMG and USMG applications are misrepresentation of information on an application and falsification of credentials—situations that occur relatively rarely. Most applicants who apply do so knowing the State requirements and believing that they can satisfy those requirements. As a result, assert the State officials, very few cases are denied. The same logic applies to withdrawals. The application process is expensive and relatively complex. Applicants are reluctant to withdraw once they have committed themselves to obtaining licensure in a particular State. The low denial rates reported for IMGs, however, may be misleading since many IMGs, aware of the more restrictive requirements applicable in certain States (see Question 4 below), may choose not to apply in those States.

4. Do licensure policies differ for USMGs and IMGs in the State medical boards involved in this study?

The study revealed that State licensure policies continue to differ for USMGs and IMGs. The full set of requirements that the applicant must fulfill is listed in AppendixE. Seven States require more years of postgraduate training for IMGs than for USMGs. Tennessee provided an explanation for the differences in the training requirement. This explanation can be found in AppendixG.

There are also cases in which State medical boards ask USMGs and IMGs to produce different documentation to validate the fulfillment of a licensure requirement. For example, to validate an applicant's medical school education, a medical board could ask the applicant to produce a diploma, a transcript, a letter from the dean, and/or have the medical school complete a verification form. In three States surveyed—Louisiana, New Jersey, and Illinois—IMGs are required to produce two or three of the above-mentioned documents, while USMGs are only required to produce one or two of these documents. More examples of such policy variation are provided on page 35.

Until recently, Louisiana had a policy that excluded IMGs from participating in the second year of postgraduate training programs in the State. The State required a physician to have a license in order to enter the second year of postgraduate training. That requirement could not be met by IMGs because they needed 3 years of training to acquire a license. Effective May 20, 1995, this policy was changed by the State and temporary licenses will now be granted to IMGs on the same basis as USMGs.

Most of the processing time differences revealed in this study are caused by State medical board policy differences, some of which are being changed or have been changed. In three States—Texas, California, and Louisiana—the time differences for USMG and IMG applicants are substantial, but the differences are a result of policies that define when an applicant must apply. In Texas, it appears that the process is longer for USMGs than for IMGs because USMGs apply before they enter postgraduate training: IMGs apply at a later stage. In California, IMGs have to apply prior to entering graduate training and prior to taking their licensing examination, leading to a longer time to complete the process than is experienced by USMGs. California officials indicate that the implementation of the USMLE will reduce some of the time differences. More details on the policies in Texas, California, and Louisiana appear on pages 32 to 33.

It is important to note that, as previously stated, when discussing licensure approval rates, most applicants research the requirements of a State and assess whether or not they meet these requirements prior to applying. Therefore, it is impossible, given the design of this study, to determine the number of physicians who did not apply for licensure in a State because of differences in policies regarding IMGs and USMGs or as a result of policies that were perceived as prohibitive.

State Licensing of Medical Practitioners:

Case Studies of United States & International Medical Graduates

STUDY BACKGROUND

The United States has relied heavily on medical graduates from schools outside the United States. These medical graduates often come to the United States after their initial training, obtaining their graduate medical training in United States residency training programs. Many of these medical practitioners have come to believe that State licensing boards are often biased against graduates from schools outside the United States and Canada. They assert that long delays and requirements that go beyond those imposed on graduates from United States and Canadian medical schools force international graduates to jump over hurdles that are unreasonable and unnecessary for the purpose of deciding on their competence to practice medicine.

In 1990, the General Accounting Office (GAO) completed a study of endorsement[7] licensing practices and generally agreed that there are differences in processing licensing applications from international and U.S. graduates.[8] Although the GAO study did not go so far as to assert prejudicial treatment, they found differences in treatment of United States and international graduates and suggested that the differences might not be warranted. They acknowledged that many of the differences are related to the inherently more complex task facing State medical boards in assessing the quality and competence of medical graduates from schools outside the United States and Canada.

Congress requested that the Department of Health and Human Services (DHHS) study the issue and report back to Congress. Section 307 of Public Law 102-408, the Health Professions Education Extension Amendments of 1992, mandates that the Secretary of Health and Human Services establish an advisory council on medical licensure. Following discussions with the offices of Senator Kennedy and Senator Simon, it was agreed that the responsibilities of this advisory council would be carried out through a working group of the Council on Graduate Medical Education (COGME). COGME was established in 1986 by Congress to provide an ongoing assessment of physician workforce trends and to recommend appropriate Federal and private sector efforts to address identified needs. The COGME Medical Licensure Workgroup serves in an advisory capacity to the study. The members of the Workgroup are listed in Appendix H.

Congressional Mandate

The Congressional language that authorizes the study states that,

> *". . . the Secretary (of DHHS), in consultation with the Council, shall conduct a study of not less than 10 States for the purpose of determining—*
>
> *(A) The average length of time required for the States involved to process the licensure applications of domestic medical graduates and the average length of time required for the States to process the licensure applications of international medical graduates, and the reasons underlying any significant differences in such times; and*
>
> *(B) The percentage of licensure applications from domestic medical graduates that are approved and the percentage of licensure applications from graduates of international medical schools that are approved, and the reasons underlying any significant differences in such percentages."*

The law also required a review of the operation of the American Medical Association's National Physician Credentials Verification Service® (AMA/NCVS®) being operated at the time by the American Medical Association (AMA). That system was intended to minimize some of the burden facing medical license applicants and State medical boards by centralizing the major task of verifying essential credentials required by all States to assess the competence of prospective medical practitioners—both United States and international graduates.

The AMA decided during 1994 to cease operating its AMA/NCVS®. The AMA reported that the system was costly to operate given the high standards it had to meet and the small number of physicians who chose to subscribe. The cessation of the service occurred just prior to launching this study; therefore, the study sur-

[7] The term "endorsement" is used throughout the report to mean the process by which a State medical board in one State issues a license to a physician who has been licensed previously in another United States jurisdiction. State medical boards often use the term "reciprocity" to denote the same type of licensing process.

[8] Throughout the report, graduates from medical schools outside the United States or Canada are referred to as international medical graduates, or IMGs. Graduates from medical schools in Canada or the United States are referred to as United States medical graduates, domestic medical graduates, or USMGs.

veyed State medical boards' perceptions of the AMA/NCVS® and the desired characteristics of possible alternative systems.

Prior Studies of the Issue

Several prior studies of this issue had been completed and were available to Congress during its deliberations. The literature review, found in Appendix F, summarizes these studies, along with other relevant articles on the subject. The 1990 GAO study[9] stands out among the recent literature on the subject because it is one of the few studies of recent origin to examine possible bias against graduates of medical schools outside the United States or Canada.

The GAO's report on this subject found that

> *"Most states have differences between endorsement requirements for graduates of foreign medical schools and for graduates of U.S. medical schools. These differences are evident in examination and experience requirements: most states require that foreign medical school graduates pass a different licensure examination and complete more years of post-graduate (residency) medical training than their U.S. counterparts. In contrast, in the six states[10] for which we had data, education standards and documentation requirements are generally similar for foreign and U.S. medical school graduates. Exceptions exist in five of these States in their requirements for documenting clerkships, patient care experiences that are basic to U.S. medical school programs. Also, differences exist between U.S. and foreign graduates in the effort necessary to obtain education-related documents."*

The GAO study examined licensing by "endorsement," the practice whereby a physician licensed to practice in one State applies to practice in another United States State or United States territory. Endorsement licensing procedures differ slightly from the initial license application. For example, endorsement applicants need not repeat the initial examination process required for initial licensing. However, no State simply accepts another State's license as an adequate basis for granting a license to practice in that State.

Study Design

The original study design was developed by the Health Resources and Services Administration's (HRSA) Bureau of Health Professions (BHPr) in response to the specific language in the congressional study mandate. BHPr is assigned responsibility within the Department for issues relating to, among other things, healthcare workforce development.

The study design required the following components:

- Design and implementation of a survey of nine States[11]
- Collection of information about the AMA/NCVS®, a service offered by the AMA
- Formation of a working group composed of representation of the Department, international medical graduates, United States medical graduates, and other organizations
- Meetings of the COGME Medical Licensure Workgroup to examine the data flowing from the study and to deliberate on possible actions to be suggested to Congress
- Consultation from the Federation of State Medical Boards (FSMB) in the design and implementation of the study
- Analysis of the data and a report to the HRSA and the COGME Medical Licensure Workgroup.

The final study design, developed after discussions with the HRSA, included the following study stages:

1. Literature Review—A review of the literature surrounding the issue of medical licensure was completed. The literature review is presented in Appendix F.

2. Survey Design—The survey was designed to collect data from nine State medical licensing boards on the following subjects:

- Statistical history of each medical board's caseload over the past year regarding the processing of medical license applications, including the number of applications received and processed during the year and the number of application approvals, denials, and withdrawals
- Reasons for withdrawals or denials
- Follow-up processes used by States during the application process
- Medical board views on the AMA/NCVS® or other like systems
- Medical board policies regarding licensing
- Case studies of 20 domestic and 20 international

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[9] United States General Accounting Office. 1990. Medical licensing by endorsement: Requirements differ for graduates of foreign and United States medical schools.

[10] GAO visited and collected data from California, Florida, New York, Ohio, Texas, and Virginia.

[11] BHPr, in consultation with the COGME Medical Licensure Workgroup and congressional staff, decided to survey nine States. The decision was based on resource issues and the mandated timeframe for completion of this study and the report to Congress.

medical graduate licensure applications.

3. Pilot Test of the Survey—The survey was reviewed by HRSA and by the COGME Medical Licensure Workgroup and changes were incorporated. The survey was then tested in New Jersey to establish whether or not the data could be gathered within a reasonable amount of time and effort by New Jersey board staff and whether or not the survey would provide the data needed to respond to the congressional questions.

The test proved to be successful relative to the ability of State board staff to collect and report on the data requested. Copies of the still-draft survey instrument were distributed to the remaining eight States for their review and comment. States were asked to comment on the basic design, including the feasibility of collecting specific data elements within their State. Follow-up calls were placed to each State to ensure that all States had an adequate opportunity to comment. The data collected from New Jersey was reported to the COGME Medical Licensure Workgroup in a meeting held in December 1994.

Key findings from the New Jersey pilot test included

- New Jersey had never approved use of the AMA/NCVS®, thus it had no experience with the system. One reason given by New Jersey officials for their decision not to participate in the AMA/NCVS® was that the system was operated by the AMA, the organization representing the community of medical practitioners being regulated by the State board.
- When asked about alternative organizations to operate a national credentials verification system (NCVS®), board officials indicated a preference for an organization such as the FSMB because this organization is well aware of State licensing requirements. The ECFMG also was considered a potentially effective system operator because of its expertise in dealing with applications from international graduates.
- In New Jersey, processing times for international applicants were similar to or less than those for domestic applicants. New Jersey's system had been altered radically during the period covered by the test data, which might have affected the data. The State had almost completely closed its processing of applications for a period of 4 months because of a legal challenge filed by the State Medical Society. The State Board had to revise its procedures for processing domestic applications.[12]
- New Jersey licenses a substantial number of graduates from medical schools outside the United States or Canada—approximately 35 percent of the total number licensed in any one year.
- Relatively few applications are denied each year. The State board asserts that most applicants are aware of the State's requirements and that the $325 nonrefundable application fee makes potential applicants cautious. Most applicants qualify and are approved because they know in advance what the State requires and because they would not be willing to pay the fee unless they believed their application would be approved.

4. Implementation of Full Survey—The pilot test data were viewed with concern by the COGME Medical Licensure Workgroup because of the central finding that processing of applications from international graduates required less time than applications from United States graduates. Although the State had used a random sampling plan to draw the sample of 40 cases, the board suggested that the final survey instructions define the specific method for drawing the sample. Other changes were suggested and incorporated into the final instrument design. The changes included the following:

- Specific questions were added regarding the number and reasons for license withdrawals and denials;
- A question was added regarding the extent to which State boards issued temporary licenses that would permit applicants to become licensed for the purpose of receiving postgraduate training; and
- A question was added to obtain information about board processes for obtaining missing information, how long incomplete applications were held, and the reasons for withdrawals by applicants.

[12] In New Jersey, the State medical board had been asking its applicants for information concerning possible misuse of controlled substances. The State's legislative investigation arm wrote a report criticizing the board for failing to review adequately physicians who had experienced problems with drug abuse. The criticism asserted that behavior known to the State medical society was not communicated to the licensing board, in part because the board had never asked. The board then began to ask new and renewal applicants a series of questions regarding their physical and mental health status, especially in relation to substance abuse and other behavioral problems that might interfere with their ability to practice medicine. The State medical society filed a law suit challenging the State board's authority to obtain such information on the grounds that it violated the Americans with Disabilities Act (ADA). The medical society claimed that programs for substance abuse treatment for practicing physicians would be jeopardized by the medical board's inquiries. In reviewing the case, the U.S. Department of Justice agreed that the specific wording being used by New Jersey was probably in violation of the ADA. Working with Justice, the State medical board developed a new set of questions aimed at obtaining information about the performance of physicians, rather than about specific use of drugs or other potential abuse substances. This process of developing a new solution to the issue led to a virtual closure of the State process for a period of several months during 1993, backing up the applications. The State board staff believe that this system interruption led directly to the seemingly anomalous data reported in the survey, in which U.S. graduates' applications required longer times to process than international graduates.

One change was made in the selection of participating States. In the earlier design, the New York State Medical Board had been selected as one of the state boards to participate. After reviewing the data collection requirements, the New York State Education Department, which serves as the medical licensing board for the State of New York, decided that it could not participate in the survey. The board indicated that the type of historical data required by the study design are not available in New York because of computer system limitations. Apparently, only two dates are maintained in their record system: 1) the date on which the application is received and 2) the date on which the license is granted. In addition, applications are not separated into "initial" and "endorsement," making it impossible to supply the information retrospectively.

The board indicated that few applications are disapproved. Generally, applications are approved pending receipt of any remaining necessary qualifications. The New York Department of Education also stated that the AMA/NCVS® was not used in New York. The State of Ohio was invited and agreed to participate as the ninth State in the study.

The final survey instrument and instructions were reviewed by HRSA and the COGME Medical Licensure Workgroup and approved for final distribution. The final survey instrument and instructions are presented in Appendices A and B.

Design Issues

This study attempts to provide evidence by which one can judge the extent to which State policies and processes produce differences in the outcomes of applications from both United States and international medical graduates. Outcomes of specific interest include the length of time required to obtain a decision by a State board, the nature of the decisions—approval or denial of the medical license—and differences in State policy in regards to the licensure of IMGs and USMGs.

The study design was limited in its reach by virtue of sample size and by the fact that States, which administer the medical licensing system in the United States, operate their systems based on State laws and regulations, rather than any central or national criteria. Generally, State systems follow common principles, but each State has its own process and these processes may well lead to differences in outcomes, as will be discussed in later sections of the report.

In order to keep within Federal and State resources and to complete the study and transmit a report to the Secretary and Congress by September 30, 1995, the design of the study was limited to case studies of 20 IMG and 20 USMG applicants in each of nine States. While the results of the study point to issues in need of further examination, the limitations of this scope of the study reduce the analytic power of the data collected and preclude generalization of the results to the entire population of licensing jurisdictions. In addition to these design limitations, the State of New York, which in 1994 had a caseload of 2,864 licenses[13] (35 percent are IMG licenses), withdrew from the study and was replaced by Ohio, which, in 1994, had issued 1,461 licenses[14] (6 percent are IMG licenses).

As documented in the enclosed literature review, differences in the length of graduate medical education and requisite supporting documentation for IMGs and USMGs exist. This study is not designed to address the necessity of such differences.

STUDY FINDINGS

Over the years, States have begun to employ more uniform requirements and regulations regarding the licensure of physicians. What continues to vary are the processes that each board uses to obtain the required elements. Each board has its own process which has evolved in response to State needs and concerns. These differing processes show up in the statistics reported by State boards in the survey. The case studies captured the date an application was received by the board and the date on which a license was issued. The difference between these dates was computed to reveal the number of days it took for the application to be processed. But, as is explained later, the data often measure procedural differences more than actual "processing" times, if by "process" one implies the flow of papers through some series of review stages.

Take for example the results in Louisiana. In Louisiana, other factors artificially inflate the processing times of initial USMG applicants. Within Louisiana, graduate training programs appear to recruit heavily from the in-State medical schools. Medical graduates typically submit their applications for licensure directly after graduation from medical school, to get a temporary permit to do their postgraduate training. Once they have completed their initial year of postgraduate training, the supervising hospital sends a confirmation notice to the board and a full license is issued. Thus, the "processing" times recorded for USMGs in Louisiana include the year of postgraduate training. The processing times for IMGs do not include their training time because, until 1995, IMGs were not allowed to obtain these temporary permits.

Having made the above caveat, the data derived through the survey of nine States nonetheless reveal significant differences in processing times among States and between international and domestic graduates. It is

[13] Bidese, op. cit.

[14] Ibid.

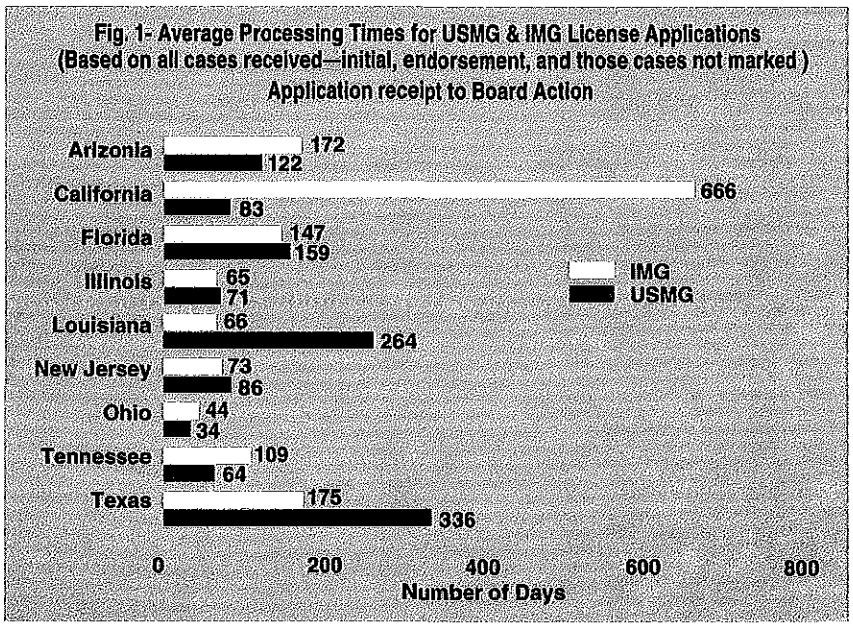

Table1: Average Processing Times for Texas Applicants

	Initial	*Endorsement*	*Combined*
USMG	515 (n=9)	190 (n=11)	336 (n=20)
IMG	180 (n=1)	175 (n=19)	175 n=20)

important to note, however, that, with some exceptions, the between-State variation is generally greater than the differences between IMG and USMG applications within a State.

Figure1 illustrates the average values respectively for the combined data of all initial and endorsement applications in each State. The elapsed time illustrated in the figure represents the time from receipt of the application by a State board until a board took action to approve or deny the license. Average processing times for initial and endorsement cases combined are substantially greater for IMG graduates in three of the States—Arizona, California, and Tennessee. In two of the States—Louisiana and Texas—average processing times are greater for USMGs.

In most of the States, processing times appear to reflect the relative differences in processing applications from United States or international graduates. In three States—California, Louisiana, and Texas—the differences are so large that State officials were asked for explanations.

In Louisiana, average processing times are affected greatly by the substantial initial license application processing times experienced by many USMGs. If the combined data shown in Figure1 are desegregated into initial and endorsement applications, USMG average "processing" time for initial license applications is 396 days against 65 days for IMGs, with the difference attributable to the 1-year temporary license granted to United States graduates. Virtually all USMG applications require at least 1 year and generally take longer, because they apply at the beginning of their postgraduate training. International graduates are not eligible to apply until they complete 3 years of graduate training. In addition, until recently, IMGs were not granted temporary licenses that would permit them to enter the 2nd year of their training programs in Louisiana.[15]

In contrast, in California, State regulations require an IMG to submit a license application and meet minimum curricular and testing requirements prior to entering an ACGME-accredited postgraduate training program and prior to taking the USMLE in the State. Thus, the processing time for IMGs reported by California includes the entire postgraduate training year plus the time it takes to schedule and sit for the licensing exam. Since USMGs are not required to submit an application that early, their processing times appear substantially lower than those encountered by IMGs. California explains their process on page C-12 of AppendixC and in a letter in AppendixD. California officials indicate that the implementation of the USMLE will reduce some of the time differences measured. Comparisons of these two systems is more a comparison of the procedural variation than of any efficiency differences, or even of any difference in relative paperwork burden.

In Texas, over half of the USMG applicants are from Texas medical schools. Applications for licensure are sent directly to the schools for dissemination to graduating medical students. State officials believe that Texas medical graduates may be applying early—prior to completion of their first year of postgraduate training. The following table suggests that the Texas medical graduates may be skewing the data, creating the impression that USMG processes are longer on average than IMG applications.

State Licensing Workload

Overall workload in each State varies substantially. During 1994, the number of cases reaching the final decision stage ranged from a high of 3,567 (endorsement plus initial) applications in California to a low of 608 in Arizona. In California, 816 international graduates applied for licensure, compared with 22 in Arizona. Tables 8 and 9 illustrate the number of cases reaching a final decision during 1994 and the decision outcomes.

[15] Louisiana has changed its requirements effective May 20, 1995, to allow international graduates to obtain the same type of temporary license as United States graduates, thereby allowing them to participate in graduate training programs on the same basis as United States graduates.

Table 2: Median Processing Times From Receipt of Application to Board Action

	Median Initial Processing Time (Days)		*Median Endorsement Processing Time (Days)*	
	IMGs	*USMGs*	*IMGs*	*USMGs*
Arizona	146	127	144	128
California	749	57	174	no cases
Florida	155	118	155	158
Illinois	29	33	80	57
Louisiana	63	452	41	40
New Jersey	68	80	73	95
Ohio	171	29	39	32
Tennessee	75	43	90	65
Texas	180	626	179	186

Table 3: Average Processing Times from Receipt of Application to Board Action

	Average Initial Processing Time (Days)		*Average Endorsement Processing Time (Days)*	
	IMGs	*USMGs*	*IMGs*	*USMGs*
Arizona	161	126	175	122
California	692	83	174	no cases
Florida	151	119	150	164
Illinois	56	32	72	85
Louisiana	65	396	143	41
New Jersey	85	85	66	87
Ohio	171	37	39	34
Tennessee	89	54	114	71
Texas	180	515	175	190

Processing Time

One of the questions raised by Congress concerns the amount of time required to process applications from USMGs and IMGs. The survey requested data on a sample of 20 cases from IMG applications and 20 cases from USMG applications. The survey included questions on the dates of request for an application, the date on which an application was received, and the final date of approval or denial. In theory, the survey data should reveal both total elapsed time and the actual time to process the applications. Because several States do not record the actual date an application is requested or mailed, the total elapsed time is not available uniformly.

Overall, then, what do the survey data reveal about the differences in processing times of IMG and USMG applications?

- Average and median processing time for all States reveal differences between IMG and USMG applications. Tables 2 and 3 provide the data from the survey. There are significant differences between the two groups of applicants. Overall, the average processing times for initial IMG applicants are greater than for USMGs in six of the nine States.
- States that stand out are California, Louisiana, and Texas, two of which show longer periods for USMGs than for IMGs. As noted earlier, how-

ever, these differences appear to be explained by the different processes used in these States.

- Using Table 3, when four States for which data problems exist[16] are excluded, five States—Arizona, Florida, Illinois, New Jersey, and Tennessee—remain. One State showed no difference in average processing times for IMG and USMG applicants. The four remaining States showed longer average initial application processing times for the IMG applicants. In these four States, it took, on average, 31.5 days longer for an IMG initial application to be processed than a USMG initial application.
- Average processing times for endorsement applications reveal a mixed pattern. Four of the eight States for which data exist exhibited higher processing times for IMG applications and four exhibited higher processing times for USMG applications.
- A possible explanation for some delay in the processing of an IMG application is the complexity of international communication, including language barriers and the use of overseas mail.
- Many States did not log the date of request for all applications. Therefore, computing the total elapsed time, i.e., the time period between the request for an application and board action, is not always possible. In examining the data that do exist, the total elapsed time appears to be between three and six times the processing period discussed above.
- Interstate differences in processing times appear to be greater than intrastate time differences between IMG and USMG applications, with California, Louisiana, and Texas standing out in this regard. All three States show far longer processing times than the other States.

Requirements for Licensure

The physician licensing process includes both testing and credentials verification. For the State boards, the tests represent a snapshot of a prospective physician's capabilities. In addition to the use of standard examinations, State boards rely on review of documents that record the type of didactic and clinical training received during a physician's training. AppendixE summarizes State licensing requirements.

This study revealed that State licensure policies differ for USMGs and IMGs in four ways. First, seven States require more years of postgraduate training for IMGs than for USMGs. Tennessee provided an explanation for the differences in the training requirement, which can be found in AppendixG.

Second, there are cases in which State medical boards ask USMGs and IMGs to produce different documentation in order to validate a licensure requirement. Three examples are provided here. Others can be found by comparing the exhibits in AppendixE.

- In order to validate an applicant's medical school education, a medical board could ask the applicant to produce a diploma, a transcript, a letter from the dean, and/or have the medical school complete a verification form. In three States surveyed—Louisiana, New Jersey, and Illinois—IMGs are required to produce two or three of the above documents while USMGs are only required to produce one or two of these documents.
- In order to validate an applicant's postgraduate training, a medical board could ask the applicant to produce either a letter from the director or a certificate of completion. In two States—Florida and Louisiana—IMGs are asked to produce both of these documents while USMGs are only required to produce one.
- To validate an applicant's clinical rotations, a board may ask for certificates of affiliation and evaluation reports. Four States—California, Illinois, New Jersey, and Texas—require IMG applicants to produce one of these items while not asking USMGs to provide either.

Third, until recently, Louisiana had a policy that excluded IMGs from participating in the second year of postgraduate training programs in the State. The State required a physician to have a license to enter the second year of postgraduate training. That requirement could not be met by IMGs, because they needed 3 years of training to acquire a license. Effective May 20, 1995, this policy has been changed by the State, and temporary licenses will now be granted to IMGs on the same basis as that of USMGs.

And finally, as previously explained, the processing time differences revealed in California, Louisiana, and Texas are caused by State medical board policy differences.

As stated by the State licensing authorities, most applicants research the requirements of a State and assess whether or not they meet these requirements prior to applying for licensure. Therefore, it is impossible, given the design of this study, to determine the number of physicians who did not apply for licensure in a State due to differences in policies regarding IMGs and USMGs or due to policies that were prohibitive.

[16] California, Louisiana, and Texas data were not used in this analysis because of the policy issues that confounded the study's measurement of processing times for the two pools of applicants. Ohio's data were not included in this analysis because the State's random selection of case histories only contained one IMG initial application case.

Table 4: Examination Combinations Recommended by the FSMB as Acceptable for Medical Licensure if Completed Prior to Year 2000

Accepted Examination Sequence	*Recommended as Acceptable*
NBME Part I plus NBME Part II plus NBME Part III	NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus NBME Part III or USMLE Step 3
FLEX Component 1 plus FLEX Component 2	FLEX Component 1 plus USMLE Step 3 OR NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus FLEX Component 2
USMLE Step 1 plus USMLE Step 2 plus USMLE Step 3	

Within the United States and Canada, State boards rely on outside, independent accreditation bodies to set the standards for the teaching institutions and the hospitals in which physicians-in-training acquire their medical education. Although differences are thought to exist within and between the educational settings in the United States and Canada, the accrediting bodies ensure that minimum quality standards are satisfied by all institutions. The central concern of State boards regarding graduates from outside the United States or Canada arises from the absence of any equivalent accrediting body that might certify that the quality of training satisfies United States/Canadian minimum standards. The World Health Organization maintains a directory of medical training institutions, but it does not "accredit" those institutions; rather, it accepts the listing of any institution that is credited by its national government with issuing medical degrees.

Graduates of medical schools outside the United States and Canada, in addition to satisfying the normal United States standards, must pass tests of their English language competence and their medical knowledge, both administered by the Educational Commission for Foreign Medical Graduates (ECFMG). The ECFMG now accepts Step 1 and Step 2 of the USMLE as its examination. Table4 summarizes the acceptable combinations of examinations recommended by the FSMB.[17]

The ECFMG was established in 1956 by the Association of American Medical Colleges, the American Hospital Association, the AMA, and the Federation of State Medical Boards to assess the readiness of IMGs to enter accredited American residency programs (ECFMG, 1993). The ECFMG certification process is composed of medical education requirements, including a credentials verification component, and exam requirements in the medical sciences and English proficiency. ECFMG certification is a requirement of the Accreditation Council for Graduate Medical Education (ACGME) to enter accredited residency programs and is a prerequisite to licensure for IMGs in 52 of the 54 United States licensing jurisdictions. Meeting the ECFMG exam requirements for certification is also a prerequisite for participation in the National Resident Matching Program.

In the survey completed in this study, a number of questions were asked about possible changes in State policies or processes that might improve the processing of applications. Survey questions 23 through 26 specifically inquired about the overall licensing process in the State. Full responses to the questions have been transcribed and can be found beginning on page C-11 of AppendixC in this report.

State board responses indicated that the following changes in the current system could reduce workload and duplicative processes:

- Establishment of a national credentials verification system

[17] United States Medical Licensing Examination (USMLE) 1995 Bulletin of Information. The Federation of State Medical Boards of the United States, Inc. and the National Board of Medical Examiners.

- Uniform licensure laws in the United States and Canada
- Establishment of a central depository for a defined minimum standard of educational documents, specifically detailed premedical, medical, and postgraduate documentation
- Creation of a single, national, standardized license verification form
- Creation of a computer system that would allow online, original source verification of test scores, ECFMG certificates, and other State licenses.

Of some concern to international medical graduates is the issue of special or temporary licenses, by which an applicant is granted permission to engage in postgraduate medical training. The survey asked whether State boards issued such licenses. The survey responses are illustrated in Table 5. In two of the nine States—California and Florida—although special temporary licenses cannot be obtained by either IMG or USMG applicants, they can both enter postgraduate training in those States. California issues a special training permit and Florida registers the physicians as "unlicensed physicians." Louisiana had not issued such licenses for IMGs until a recent change was approved by the State board[18].

Credentials Verification

In its 1990 study, GAO found agreement, during their round-table discussion,[19] that a central clearinghouse that would verify and maintain information on educational backgrounds and credentials of licensure applicants would be beneficial. In response to this need and in recognition of the AMA's research and field testing of a credentials verification service, Section 307 of Public Law 102-408 mandated the Department of Health and Human Services to obtain advice regarding the operation of the AMA/NCVS® and determine whether or not the system has expedited and improved the efficiency and equity of endorsement licensure.

Table 5: Special Training Licenses or Permits for IMGs

State	*Training Permits*
Arizona	YES
California	YES
Florida	YES
Illinois	YES
Louisiana	NO[18]
New Jersey	YES
Ohio	YES
Tennessee	YES
Texas	YES

In 1991, the AMA opened the AMA/NCVS®, which served as a national repository for medical credentials for both IMGs and USMGs. One of the main purposes of the service was to assist the State boards to obtain and verify documents required by the boards in their licensing process. Individual medical license applicants asked the AMA to obtain documents from primary sources that were then verified by the AMA. It was thought that this service would allow States to accelerate their review process by relying on a central system of document validation.

The AMA/NCVS® collected and verified information on a number of documents. Table6 summarizes the types of documents verified by the NCVS® service. During the 3 years of its operation, the NCVS® acquired 1,500 physician subscribers. Proportionately, IMGs took greater advantage of the service than did USMGs.

The AMA decided in 1994 to cease operation of the AMA/NCVS®. The decision to phase out the service was based on an independent AMA evaluation of the system which concluded that the system was not cost-effective. They determined that the resources needed to maintain a high-quality service that met subscriber needs and State medical board requirements were sufficiently high that the organization would need either a much larger subscription base, or higher fees. They decided finally that they could not continue to operate the system in its current form. With the phase out of the AMA/NCVS®, the need identified by the GAO continues to exist. Data from this study also strongly support the need for a system that would facilitate credentials verification and expedite endorsement licensure.

When applying for a license to practice medicine, applicants would expect logically that the process to obtain an initial medical license would take longer than subsequent endorsement license processes. Applicants and State medical boards need to obtain and validate a substantial number of documents demonstrating that the applicant is who he or she purports to be and that his or her training is acceptable to the State board. Yet, in four of the nine States surveyed, IMG endorsement applications took longer on average to be processed than IMG initial applications. In a different four States, USMG endorsement applications required longer times

[18] Louisiana has changed its policy effective May 20, 1995 and will now permit IMGs to obtain temporary licenses.

[19] The following organizations were represented at the GAO round-table discussion: Administrators in Medicine, American Medical Association, Association of American Medical Colleges, Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, International Association of American Physicians, National Board of Medical Examiners, New York State Board of Medicine, and U.S. Department of Health and Human Services.

on average to be processed than for USMG initial applications. Although hardly conclusive, this type of evidence is at least strongly suggestive of the need to reexamine State endorsement processes from the perspective of a national credentials verification system. It would seem that such a system, were it to be accepted by State medical boards broadly, could lead to reductions in the complexity and time needed to obtain licenses by endorsement.

1. Utilization of the AMA's National Physician Credentials Verification Service (AMA/NCVS®)—Survey questions 21 and 22 asked about each State's perceptions of the AMA/NCVS®. Full responses from each State have been transcribed and can be found beginning on page C-6 of Appendix C in this report.

Analysis of the data provided by all nine State medical boards suggests that there is potential utility in a national credentials verification system. If implemented, the benefits would accrue to both USMG and IMG applicants for licensure by endorsement. Of the nine States surveyed, three—Arizona, Louisiana, and Ohio—used the AMA/NCVS®. Texas was in the process of negotiating a contract with the AMA when they decided to cease operation of the AMA/NCVS®. As a result of the limited enrollment in the service by the States surveyed, it was not possible to demonstrate whether the AMA/NCVS® expedited or improved the efficiency and equitable operation of the endorsement licensure process.

Both Louisiana and Ohio reported that the AMA/NCVS® did facilitate the verification of credentials. Arizona had a negative perception of the system and asserted that the AMA/NCVS® data were "outdated" and caused duplication of work. The State did not elaborate further.

California, Florida, Illinois, New Jersey, Tennessee, and Texas did not participate in the AMA/NCVS®. Three primary reasons were given for not participating in the AMA/NCVS®:

- The State has a legislative responsibility to verify credentials from the original source;
- The process that the AMA/NCVS® used to obtain and verify documents was not satisfactory; and
- The AMA/NCVS® did not include all of the documentation necessary to meet the State's requirements.

Overall, State officials thought that their own State processes for verifying credentials were more thorough than the system put in place by the AMA/NCVS®. Therefore, subscribing to the service was not an efficient option and could compromise quality. States assert that they have been assigned the responsibility to assure the overall competence of physicians practicing within their State borders. They feel strongly that they cannot delegate that basic responsibility to another agent unless they are assured that the processes employed to verify credentials are as rigorous as their own. Thus, any national system will need to: a) engage the States in the system design process, and b) satisfy the requirements of the most rigorous of the State processes.[20]

2. Appropriate Organizations to Administer a Credentials Verification System—Survey question [21] asked State boards to suggest the most appropriate organization to operate a credentials verification system to replace the AMA/NCVS®. The most prominent response was the Federation of State Medical Boards (FSMB). The reasons given for this recommendation are as follows:

- The States believe that the FSMB understands the State license application requirements;
- The FSMB is ultimately responsible to its member organizations, State medical boards, which results in a good fit;
- The FSMB maintains files on disciplinary actions taken by States on licensed medical practitioners, and the States have had success in accessing these files; and
- The FSMB is perceived by some to have the largest existing databank about physician credentialing issues.

Of the eight States that responded to this question, each one identified the FSMB as an appropriate organization to assume the NCVS® functions. Two States identified the ECFMG, and another State also identified the AIM (Administrators in Medicine). Table 7 shows the State responses.

It should be understood that, simply because a State has identified an organization as appropriate to operate a credentials verification system, it does not mean that the State would automatically participate in such a system, were one to be developed by that organization. In some States, legislative changes would be needed to permit the board to delegate part of its responsibility to an outside body to verify credentials. Also, States would want to be consulted on the design of the system and the system would have to meet the needs of the most rigorous State process. Even then, there is no guarantee of State participation.

3. Key Components of a Credentials Verification System—State Boards generally agreed that some type of credentialing verification system would reduce

[20] It is noted by the AMA that the State medical boards were involved in the initial design of their AMA/NCVS®.

Table 6: AMA/NCVS® Verification Process

American Medical Association
Physicians dedicated to the health of America

Verification Process

National Physician Credentials Verification Service

*The American Medical Association's National Physician Credentials Verification Service (AMA/NCVS®) process utilizes various cross-checks to verify and reinforce the verification of application information.

AMA/NCVS Application Information	*Primary Source Contacted by AMA/NCVS	Curriculum Vitae	AMA Masterfile Profile	Transcripts (sent directly from the school to AMA/NCVS.)	Notorized Documents: Diploma(s); Birth Certificate; Name Change Documents; Graduate Medical Education Certificates; ECFMG Certificate; ECFMG Interim Letter; Certificate of Insurance; Etc.	Other Documents: Social Security Card; Evaluation Sheets; Specialty Board Certificates; ACLS-ATLS Cards; Letters – Certificates of Completion; Etc.	Naturalization Certificate; Alien Registration Document; Visa, Passport	Military DD214 or Orders of Separation
Personal Information								
Name		•	•	○	◉	○	◉	•
Address		○	•	○	○			
Date and Place of Birth			•		◉		◉	•
Parents Names and Address					○			
Citizenship					◉		◉	•
Sex			•		•			•
Name Change			•		◉		◉	
Professional Information								
Undergraduate/ Non-Medical Graduate Education	Ⓟ	•		◉	•			
Medical Education	Ⓟ	•	•	◉	◉			
Clinical Clerkship	Ⓟ	•				•		
Fifth Pathway	Ⓟ	•			◉	•		
ECFMG	Ⓟ				◉			
Graduate Medical Education	Ⓟ	○	•		○			
Military Experience	◉	•						•
State Board Constructed Exam	◉							
Licensure	◉	•	◉					
Other Professional Licenses	◉	•			•			
Specialty Board Certification	◉	•	•			•		
Teaching Appointment	Ⓟ	•	•					
Hospital Affiliation	Ⓟ	•						
Experience/ Work History	Ⓟ	•			•	•		
Current Practice	Ⓟ	•	•		•			
National Association Membership (AMA, AOA)	◉	•						
ACLS	◉	•				•		
ATLS	◉	•				•		
Professional Liability Insurance	◉				◉			

* Primary Source = Medical School, Post Graduate Training Program, State Medical Board, Hospital, etc.
*Cross-check of information
P = Photo sent
○ = Required for verification

Table 7: State Views on Organizations to Operate an NCVS

State	*Organization Recommended*
Arizona	None recommended
California	FSMB or ECFMG
Florida	FSMB
Illinois	FSMB
Louisiana	FSMB
New Jersey	FSMB or ECFMG
Ohio	FSMB or AIM (Administrators in Medicine)
Tennessee	FSMB
Texas	FSMB

their overall workload and would likely facilitate the issuance of licenses.

States listed some characteristics of a strong system and characteristics that they would like to see in a future credentials verification system. The responses were varied and generally not very specific. Some of the characteristics are as follows:

- The system would need to maintain accurate and up-to-date data;
- The system would need to focus on credentials associated with medical education and postgraduate training; and
- The system would need to include wide State participation during the design stage.

Whether one takes a minimalist approach and designs a system that only verifies some minimum level of premedical, medical, and graduate education, or a larger system which attempts to verify the most stringent documentation levels of each State, a major issue remains. The States need to be confident that they can rely on the accuracy and authenticity of the documentation and the quality of the process by which it was obtained. Therefore, not only does the system need to be administered by an organization that the States trust, but, as New Jersey suggests, the organization should involve the States in the design of the system if they want the system to be utilized to its maximum potential.

All of the States that did not use the AMA/NCVS® system indicated that the State would require a change in legislation in order to permit the use of an NCVS®-like system. New Jersey indicated that such legislative changes could be made within the next 5 years if the State board found, through review of the proposed system, that it would meet all of the board's requirements. None of the other State boards thought that these legislative changes would occur within the next 5 years.

License Approvals, Denials, and Withdrawals

The rates of license approvals, denials, and withdrawals are viewed as potential evidence of the extent of bias that might exist in State systems. Either high denial rates or high withdrawal rates by IMG applications might signal system differences that, absent any other explanatory factors, would suggest biases against IMG applicants. The survey asked for the numbers of license approvals, denials, and withdrawals during the 12-month period of January 1994 through December 1994. States were also asked to provide reasons for such denials and withdrawals. Tables 8 and 9 summarize the data on overall approvals and denials during 1994 in the nine States. Appendix C, pages 61 through 69, provides the data on withdrawals.

The data from the survey suggest that most license applications are approved. Data from the State surveys indicate that State boards denied a total of 40 applications. Only 25 USMG applications and 11 IMG applications were withdrawn.

Although several States could not supply full data on approvals and denials, for IMG applications, State boards approved 1,428 initial applications and 1,735 endorsement applications. State boards denied 8 initial license applications and 22 endorsement applications.

For USMGs, State boards approved 6,391 initial license applications, while denying 2 applications. Of 6,390 USMG endorsement applications receiving a final decision, 6,382 were approved and 8 were denied.

In three States—Ohio, Louisiana, and New Jersey—denial rates on IMG endorsement applications are significantly higher than the denial rates on USMG endorsement applications. Ohio experienced nine denials of IMG endorsement applications, out of a total of 372 applications that reached a final decision, for a denial rate of 2.42 percent, compared with the USMG rate of less than 0.1 percent. In Louisiana, 10 IMG endorsement applications were denied out of 196 that reached a decision, for a denial rate of 5.1 percent, compared with the rate for USMGs of 0.9 percent. And, in New Jersey, 2 out of 66 IMG endorsement applications were denied (3.1 percent), compared with a zero percent denial rate for USMGs.

1. Reasons for Denial of Applications—Questions 17 through 20 solicited reasons for the denial of USMG initial, USMG endorsement, and IMG initial and IMG endorsement licenses. The complete responses have been transcribed and begin on page 61 of Appendix C in this report.

Table 8: Initial License Caseload Decisions

State	USMG Approved	IMG Approved	USMG Denied	IMG Denied	USMG Approval Rate	IMG Approval Rate
Arizona	51	12	0	0	100%	100%
California	2687	778	1	0	99.9%	100%
Florida	NA	NA	NA	NA	NA	NA
Illinois	728	222	0	0	100%	100%
Louisiana	157	95	NA	5	NA	95%
New Jersey	410	163	1	2	99.8%	98.8%
Ohio	1224	35	0	1	100%	97.2%
Tennessee	299	20	NA	NA	NA	NA
Texas	835	103	0	0	100%	100%
Total	6391	1428	2	8	99.9%	99.4%

Table 9: Endorsement License Caseload Decisions

State	USMG Approved	IMG Approved	USMG Denied	IMG Denied	USMG Approval Rate	IMG Approval Rate
Arizona	535	10	0	0	100%	100%
California	62	37	1	1	98.4%	97.4%
Florida	1970	551	NA	NA	NA	NA
Illinois	651	210	0	0	100%	100%
Louisiana	560	186	5	10	99.1%	94.9%
New Jersey	351	64	0	2	100%	96.9%
Ohio	1335	363	1	9	99.9%	97.6%
Tennessee	NA	NA	NA	NA	NA	NA
Texas	918	314	1	0	99.9%	100%
Total	6382	1735	8	22	99.8%	98.7%

Two factors are associated with the low denial rates: 1) applicants are aware of the State requirements prior to submission of their application and 2) most applicants will not submit an application and the non-refundable application fee if they believe they will not be able to meet these requirements.

The low denial rates reported for IMGs, however, may be misleading because many IMGs, aware of the more restrictive requirements applicable in certain States, referenced in Section C-Requirements for Licensure, may choose not to apply in those States.

In addition, boards indicated that they try to work with the applicant so that they will be able to fulfill any requirement that is not yet met. For example, when requirements are not met,

". . . the Board recommends deferral in most instances to allow for the individual to get additional education or training, etc., rather than denying licensure." (Reference, survey data from Illinois)

The survey found that USMG and IMG initial license applications are denied when applicants do the following:

- Fail to meet statutory requirements for licensure, i.e., exam requirements or training requirements
- Falsify an application
- Have been convicted of a crime substantially related to the practice of medicine

- Have unlawfully used or prescribed controlled substances, or have prescribed controlled substances without examination.

Some reasons for the denial of initial licenses are unique to IMGs. For example:

- No ECFMG certificate
- Clinical clerkship not accredited
- Unapproved training
- An applicant applies with a J-1 visa status. This type of visa is reserved for physicians in clinical graduate training programs and the visa requires physicians to return to their country of origin for a period of at least 2 years following the completion of their training.[21]

The States surveyed identified the following reasons for the denial of both USMG and IMG endorsement applications:

- No license to endorse
- Any action or discipline taken in another State, i.e., resulting from unlawful use or prescription of controlled substances; incompetence; substance abuse; or sexual misconduct
- Applicants do not meet statutory requirements for licensure, i.e., training and exam requirements.

Reasons which were unique to USMG endorsement applicants were:

- Discipline in another State because of mental illness
- Falsifying information on applications
- Unprofessional conduct
- Healthcare entity/peer group action.

Reasons identified that were unique to IMG endorsement applicants are:

- No ECFMG certification
- Clinical clerkship not accredited
- Unapproved training program.

2. Withdrawn Applications—Generally, very few applications were withdrawn from the licensure review process. Adding the numbers from the States that were able to provide data on this issue, a total of 25 USMG applications and 11 IMG applications were withdrawn (compared with over 16,000 approved applications). The withdrawal rates are fairly representative of the 1992 overall proportion of IMG license recipients—20 percent—to USMG license recipients—80 percent.

Questions 27 through 30 of the survey inquired about applications that are withdrawn from the review process prior to board action. The full responses to these questions have been transcribed and can be found on page 67 of Appendix C in this report. States cited the following two reasons for the low number of withdrawals:

- It is complex and expensive to prepare and submit an application in the first place and the applicant does not want to waste that effort; and
- The application fee is nonrefundable.

The primary reasons for withdrawals were the same for USMG and IMG applications and included the following:

- The physicians were trying to avoid a denial since denials are reported to other organizations and State licensing boards;
- The physicians realized that the State uncovered information that they intentionally did not reveal in their application; and
- The physicians had changed their plans and decided not to relocate.

3. Follow-Up Actions—Finally, questions 31 through 33 inquire into the process that States use to follow-up with applicants once an application is submitted. Full transcriptions of the responses can be found on page 68 of Appendix C in this report. Table 10 summarizes the State responses to the question about follow-up actions.

All States have a similar process of sending out letters notifying applicants of deficiencies in their applications. These letters are mailed anywhere from 30 to 60 days after the receipt of the application. In every State, the process is the same for IMG and USMG applicants.

4. Incomplete Applications—What do States do with applications that are never completed? Here again, States vary considerably in how they dispose of incomplete applications, but they show no variation between handling IMG and USMG incomplete applications. Their transcribed responses are included in Appendix C on page 69.

Incomplete applications are held anywhere between 4 months in Tennessee to 3 years in Illinois. Table11 summarizes the length of time applications are

[21] The H-1B Temporary Worker Provisions allow a foreign professional to enter the United States for temporary employment purposes and is the most commonly utilized classification. Tennessee indicated that it is not the norm to deny applicants because of inappropriate visa status. Typically, if the applicant applies for licensure prior to obtaining an H-1 visa from the Immigration and Naturalization Service (INS), the State will give the applicant extensions to keep his or her file open until his or her visa status is changed by the INS. Only if the INS does not grant the change in their status is the applicant denied.

Table10: State Follow-Up Process

State	*Follow-Up Process*
Arizona	Deficiency letter sent 30 days after receipt of application
California	Deficiency letter sent 30-45 days after receipt of application
Florida	Deficiency letter sent
Illinois	Deficiency letter sent upon receipt of application
Louisiana	Deficiency letter sent
New Jersey	NA
Ohio	Deficiency letter sent
Tennessee	Deficiency letter sent
Texas	Deficiency letter sent

Table 11: Length of Time Incomplete Applications Are Held

State	*Period Held*
Arizona	1 year
California	At least 1 year
Florida	1 year
Illinois	3 years
Louisiana	At least 6 months
New Jersey	NA
Ohio	6 months
Tennessee	Approximately 4 months
Texas	2 years

held by States. There are no differences in the treatment of IMG or USMG applications. Once this time period expires, States dispose of the applications in a variety of ways. California returns the application to the applicant. Arizona, Tennessee, and Florida archive the files. Ohio and Louisiana indicate that some applications are archived in "enforcement" or "not licensed" files, respectively, while the rest of their applications are destroyed. Texas and Illinois also destroy their files.

SUMMARY OF FINDINGS

This study examined the issue of potential State bias against international medical graduates. The study sought an answer to the question: Do State medical licensure processes cause different outcomes in the case of international and United States medical graduate applications, and what are the explanations for any such differences that are found to exist?

The study design collected data that were intended to provide answers to four questions that represent components of the question raised above. The four parts are as follows:

- Does State experience with or perception of a national system for credentials verification suggest that such a system would improve the performance of the current processes by which physicians become licensed?
- Do application processing times differ for the two groups? What are the reasons for any differences?
- Do the rates of license approvals, denials, or withdrawals differ for the two groups?
- Do the licensing policies employed by State boards differ systematically for IMG and USMG applicants?

We summarize our answers to these questions below.

Potential Utility of a National Credentials Verification System

The AMA/NCVS® was operational from 1991 to 1993. During that time, 23 State medical/osteopathic boards voted to accept the AMA/NCVS® as a part of their licensing processes. Data in this study do suggest that there is utility in the establishment of a national credentials verification system. However, this study was not able to demonstrate whether the AMA/NCVS® expedited or improved the efficiency and equitable operation of the endorsement application process.

Variation exists among States in carrying out essentially the same credentialing function. Although the limited database can only be considered suggestive, it shows nonetheless that there is at least as much variation among the States in the documentation requirements and the processing times for a common group (IMG or USMG applicants) as there is variation between the groups (comparing IMGs and USMGs). Further, in four of the nine States, endorsement processing times are either the same or greater than processing times for initial licenses. Both findings suggest that a national credentials verification system to obtain and verify a core set of credentials may help to standardize the process and perhaps reduce the processing times for both IMG and USMG endorsement applicants.

The keys to the success of such a system are cost of operation and credibility. States must believe in the validity of the process used to verify credentials and they need to be assured that their specific State requirements will be accommodated. States would also need

to be involved in the decision-making process regarding the collection of the documentation required by such a system.

Do Application Processing Times Differ for USMG and IMG Applicants?

The study revealed that there are differences in the average length of time required to process USMG and IMG licensure applications. In six of the nine States participating in the survey, the average processing time was greater for initial applications from IMGs than for the comparable USMG group. When four States with data problems were excluded, one State showed no difference in average processing times for IMG and USMG applicants and the four remaining States showed longer average processing times for the IMG applicants. In these four States, it took, on average, 31.5 days longer for an IMG application to be processed.

Average processing times for endorsement applications reveal a mixed pattern. Four of the eight States for which data exist exhibited higher processing times for IMG applications and four exhibited higher processing times for USMG applications. A possible explanation for some delay in the processing of an IMG application is the complexity of international communication, including language barriers and the use of overseas mail.

As we reported in earlier sections, the different processes used in the participating States produced different total times to obtain licenses by the two groups of physicians. The differences are attributable to the approaches taken to the licensing process by each State. Three States stand out—Texas, Louisiana, and California. In Texas and Louisiana, processing times are greater for United States than for international medical graduates. Much of the processing time in those States is attributable to the application timetable and on how one counts "processing time." In California, the reverse situation prevails. IMG applicants are required to apply before they enter postgraduate training and before they take their licensing examination. California's 2-year processing time is again mainly a waiting period.

Ohio and Tennessee stand out from the other States in the sample by the relatively modest numbers of international graduates who apply for and receive initial licenses. In Ohio, processing times are among the lowest of the sample, yet relatively few international graduates apply for their initial license in Ohio.

Processing times for seemingly equivalent processes (e.g., processing an IMG or USMG initial or endorsement application) are so varied among the States surveyed that greater uniformity in both procedures and documentation required would appear to be a goal worthy of pursuit by State medical boards. In addition, processing times for endorsement applications are not uniformly shorter than for initial applications, a result that is, at the least, counterintuitive. This also suggests the need for common procedures and documentation requirements and the potential utility for a national credentials verification system, such as the service being considered by the FSMB.

Do License Approval and Denial Rates Differ for USMG and IMG Applicants?

The study revealed modest differences in the rates of approval/denial for endorsement licensure applications. In Ohio, Louisiana, and New Jersey denial rates on IMG endorsement applications are significantly higher than the denial rates on USMG endorsement applications.

As indicated earlier, most applications are eventually approved by States. License denials and withdrawals are infrequent: collectively, they amount to less than 1 percent of the caseload. States assert that they work hard to avoid denials. When candidates cannot fulfill some requirement, the State board will work with that candidate to attempt to find a solution. States are rigid about such things as falsifying an application, as can be seen from their explanations of denials, although such events are extremely rare. Applicants may be driven away from some States by the realization that they cannot fulfill those States' requirements.

However, the low denial rates reported for IMGs may be misleading since many IMGs, aware of the more restrictive requirements applicable in certain States, referenced in Section C—Requirements for Licensure, may choose not to apply in those States.

Do State Policies Differ for USMG and IMG Applicants?

In 1990, the GAO found that there were differences in both examination and experience requirements for endorsement applicants. The implementation of the USMLE eliminates the examination differences, but the differences in experience requirements remain. Seven of the nine States surveyed in this study required more years of postgraduate training for IMGs than for USMGs.

There are also cases in which State medical boards ask USMGs and IMGs to produce different documentation to validate a licensure requirement. For example, to validate an applicant's medical school education, a medical board could ask the applicant to produce a diploma, a transcript, a letter from the dean, and/or have the medical school complete a verification form. In three States surveyed, IMGs are required to produce two or three of the above documents, while USMGs are

only required to produce one or two of these documents.

Until recently, Louisiana had a policy that excluded IMGs from participating in the second year of postgraduate training programs in the State. The State required a physician to have a license in order to enter the second year of postgraduate training. That requirement could not be met easily by IMGs, because they needed 3 years of training to acquire a license. Effective May 20, 1995, this policy has been changed by the State and temporary licenses will now be granted to IMGs on the same basis as USMGs.

Finally, the major differences between IMGs and USMGs in application processing times in California, Louisiana, and Texas appear to be caused by policy differences.

It is important to note that most applicants research the requirements of a State and assess whether or not they meet these requirements prior to applying for licensure. Therefore, it is impossible, given the design of this study, to determine the number of physicians who did not apply for licensure in a State as a result of differences in policies regarding IMGs and USMGs; or as a result of policies that were prohibitive.

States appear to be moving closer together in terms of what they require of medical graduates. States have settled on a common examination, an important move towards overall standardization. However, even if States adopt identical policies, differences will remain. It will still be relatively more difficult for graduates from medical schools outside the United States or Canada to obtain a license. Two issues will continue to contribute to the greater difficulty.

First, unless IMG applicants know where they will want to practice—or enter postgraduate training—before they leave the country where they received their medical school training, they may not know exactly what documents they will need to apply for a license. Thus, a long-distance communications process may continue to be required, during which the applicants attempt to obtain all of the required documents. This problem lends strength to the suggestions for increased commonality in application requirements and for a national credentials verification system.

Second, many of the States require international medical graduates to provide evidence of the quality of their training, including evaluation reports and clinical clerkships not required of United States graduates. In these processes, States are attempting to compensate for the absence of a global accreditation process that would be equivalent to the LCME process.

Appendices

APPENDIX A —SURVEY INSTRUMENT

Survey of Licensure Policies of State Medical Authorities

State Board:		Board Address:
Tele:	FAX:	

BOARD POLICIES

A. Please attach a copy of the most current state regulations covering the process by which physicians become licensed in your state.

B. Please attach a copy of the application kit that is given to applicants for licensure in your state.

STATISTICAL HISTORY OF MEDICAL LICENSE APPLICATIONS

Please provide the following data covering applications for medical license submitted to your state board between **1/1/94 and 12/31/94**. Place the answer in the box to the right of each question.

INITIAL LICENSE APPLICATION WORKLOAD: 1/1/94 -- 12/31/94	
1. Number of pending applications for initial medical license from graduates of medical schools **in the U.S. or Canada** (USMGs) as of January 1, 1994.	
2. Number of pending applications for initial medical license from **International Medical Graduates** (IMGs) -- graduates of medical schools **outside the U.S. or Canada** as of January 1, 1994.	
3. Number of applications received for initial medical license from USMGs during the period January 1, 1994 through December 31, 1994.	
4. Number of applications received for initial medical license from IMGs during the period January 1, 1994 through December 31, 1994.	

BOARD ACTIONS ON INITIAL LICENSE WORKLOAD 1/1/94 -- 12/31/94

5. Number of initial full & unrestricted medical licenses approved for USMG applicants during the period January 1, 1994 through December 31, 1994.	
6. Number of initial full & unrestricted medical licenses approved for IMG applicants during the period January 1, 1994 through December 31, 1994.	
7. Number of initial medical license applications denied to USMG applicants during the period January 1, 1994 through December 31, 1994.	
8. Number of initial medical license applications denied to IMG applicants during the period January 1, 1994 through December 31, 1994.	

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ENDORSEMENT APPLICATION WORKLOAD: 1/1/94 -- 12/31/94

9. Number of pending applications for endorsement medical license from USMG applicants as of January 1, 1994.	
10. Number of pending applications for endorsement medical license from IMG applicants as of January 1, 1994.	
11. Number of applications received for endorsement medical license from USMG applicants during the period January 1, 1994 through December 31, 1994.	
12. Number of applications received for endorsement medical license from IMG applicants during the period January 1, 1994 through December 31, 1994.	

BOARD ACTIONS ON ENDORSEMENT APPLICATIONS: 1/1/94 -- 12/31/94

13. Number of full & unresticted endorsement medical licenses approved for USMG applicants during the period January 1, 1994 through December 31, 1994.	
14. Number of full & unrestricted endorsement medical licenses approved for IMG applicants during the period January 1, 1994 through December 31, 1994.	
15. Number of endorsment medical license applications denied to USMG applicants during the period January 1, 1994 through December 31, 1994.	
16. Number of endorsement medical license applications denied to IMG applicants during the period January 1, 1994 through December 31, 1994.	

REASONS FOR DENIAL

17. Summarize in the spaces below the three most frequent reasons for denials of initial licenses to USMG applicants over the past five years.

a.

b.

c.

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18. Summarize in the spaces below the three most frequent reasons for denials of initial licenses to IMG applicants over the past five years.	
a.	
b.	
c.	
19. Summarize in the spaces below the three most frequent reasons for denials of endorsement licenses to USMG applicants over the past five years.	
a.	
b.	
c.	
20. Summarize in the spaces below the three most frequent reasons for denials of endorsement licenses to IMG applicants over the past past five years.	
a.	
b.	
c.	

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PERCEPTIONS OF NATIONAL CREDENTIALS VERIFICATION SYSTEM (NCVS)

21. For states that used the NCVS, please answer the following questions:

a. Did the NCVS facilitate the verification of credentials? (Cite reasons)

b. What problems, if any were experienced in using the NCVS?

c. What do you consider to be the main strengths of the NCVS?

d. What do you consider to be the main weaknesses of the NCVS?

e. In your opinion, what would be the most appropriate organization to operate such a system?

____The Educational Commission on Foreign Medical Graduates (ECFMG)

____The Federation of State Medical Boards (FSMB)

____Other (Specify) _____

(Cite reason for your choice)

f. What changes or additions to the NCVS would be necessary to make the system more useful for your state's purposes?

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PERCEPTIONS OF NCVS

22. For states that DID NOT use the NCVS, please answer the following questions:

a. List up to three reasons why NCVS was not used in your state:

b. What changes, if any, would make your state consider use of a centralized credentials verification system (Be as specific as possible, taking additiional pages if needed):

c. In your opinion, what would be the most appropriate organization to operate such a system?

_____ Educational Commission on Foreign Medical Graduates (ECFMG)
_____ Federation of State Medical Boards (FSMB)
_____ Other (Specify) _____

(Cite reasons for choice)

d. Would your state require a change in legislation or regulations to permit use of an NCVS-like system?

☐ YES ☐ NO If Yes, what changes would be required and what is the likelihood that such changes will be implemented within the next five years?

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LICENSE APPLICATION PROCESS

23. For physicians already licensed to practice in the U.S., what changes in your current system would serve to reduce duplicative verification processes?

24. For physicians applying for initial licenses (no other medical license in the U.S.) what changes would reduce processing time, or reduce the differences in processing application time between international and domestic medical graduates?

25. Are there any conditions under which your state board would consider accepting a license from another U.S. jurisdiction without further credentials verification (while still allowing for independent verification of competent performance within the licensing jurisdiction)?

26. Does your state allow special or regular medical licenses to be issued that would permit graduates of medical schools outside the U.S. or Canada to enter a graduate medical education residency training program?

YES ☐ NO ☐ If NO, explain the changes in state law or regulations that would be required to permit such licensing to occur.

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WITHDRAWN APPLICATIONS

27. a. In the past year, how many IMGs withdrew their applications before the Board could complete its processing and reach a decision? _____

b. If the previous year was unusual, how many IMG applications are withdrawn in your estimation each year? _____

28. In your judgment, what are the top three reasons for the withdrawal of an IMG application?

29. a. In the past year, how many USMGs withdrew their applications before the Board could complete its processing and reach a decision? _____

b. If the previous year was unusual, how many USMG applications are withdrawn in your estimation each year?_____

30. In your judgment, what are the top three reasons for the withdrawal of a USMG application?

FOLLOW-UP ACTIONS

31. What is the normal process for Board follow-up to obtain missing items for application submitted by USMGs and IMGs?

32. a. How long are incompleted applications held by the Board before being returned to the applicant or discarded?

b. To what extent, if at all, do the procedures differ for handling such incompleted applications for IMGs and for USMGs?

33. What does the Board do with applications that are never completed?

a. From IMGs?

b. From USMGs?

Survey of Licensure Policies	PAGE of

CASE HISTORIES

CASE NUMBER:	INITIAL LICENSE ☐	ENDORSEMENT LICENSE ☐

1. Date of request for license application received by the Board	
2. Date license application sent to applicant	
3. Date of initial receipt of application by the Board	
4. Date by which application was complete enough to review forapproval\disapproval	
5. Date of Board action	
6. Outcome of Board action	Approved ☐ Disapproved ☐
7. Date license was issued (if Board approved)	

8. Elements missing or incomplete in application submitted initially by applicant: (Check all that apply)

a. Application form		f. Pre-Med Education		k. Foreign Medical Diploma		p. ECFMG Verification	
b. Application fee		g. Medical Education Forms		l. Verif. of license in U.S.		q. Birth Certificate	
c.Sister State Endorsement		h. Medical Diploma		m. Medical School Transcript		r. Curriculum Vitae	
d. Nat'l Board Certification		i. Cert. of Post-Grad Training		n. Military Service Form		s. Physician Profile	
e. National Exam Score		j. Cert. of hospital employ.		o. Foreign Medical License		t. Other Document	

9. Reasons for denial if application was disapproved:

10. Was NCVS Used in Case? YES ☐ NO ☐

CASE NUMBER:	INITIAL LICENSE ☐	ENDORSEMENT LICENSE ☐

1. Date of request for license application received by the Board	
2. Date licensure application sent to applicant	
3. Date of initial receipt of application by the Board	
4. Date by which application was complete enough to review for approval\disapproval	
5. Date of Board action	
6. Outcome of Board action	Approved ☐ Disapproved ☐
7. Date license was issued (if Board approved)	

8. Elements missing or incomplete in application submitted initially by applicant: (Check all that apply)

a. Application form		f. Pre-Med Education		k. Foreign Medical Diploma		p. ECFMG Verification	
b. Application fee		g. Medical Education Forms		l. Verif. of license in U.S.		q. Birth Certificate	
c.Sister State Endorsement		h. Medical Diploma		m. Medical School Transcript		r. Curriculum Vitae	
d. Nat'l Board Certification		i. Cert. of Post-Grad Training		n. Military Service Form		s. Physician Profile	
e. National Exam Score		j. Cert. of hospital employ.		o. Foreign Medical License		t. Other Document	

9. Reasons for denial if application was disapproved:

10. Was NCVS Used in Case? YES ☐ NO ☐

Appendix B—

INSTRUCTIONS FOR COMPLETING SURVEY OF LICENSURE POLICIES OF STATE MEDICAL LICENSING AUTHORITIES

The survey of licensure policies is intended to provide information on state policies and processes concerning the issuance of medical licenses to graduates of domestic and international medical schools. The survey is divided into two main sections. The first section asks questions regarding the policies of the state, a statistical history for a 12-month period, reasons for denial of license applications, the perceptions of the National Credentials Verification System (NCVS®), the license application process, withdrawn applications, and follow-up action. The second section provides forms—two per page—that ask the State to summarize case histories of completed individual license applications. In all, twenty such case history sheets are provided, allowing for a total of 40 case histories.

The state medical licensing board (the Board) is asked to complete the first section of the survey using data from its cases in process or completed during the time period January 1, 1994 through December 31, 1994. For the second section, the case histories, the Board is asked to select randomly 40 cases that were completed during the period January 1, 1994 through December 31, 1994. Please select 20 cases for domestic medical graduates and 20 cases for graduates of international medical schools—medical schools outside the U.S. or Canada. A random selection methodology is provided for the Board in Attachment A of the instructions. A glossary of terms is supplied in Attachment B of these instructions.

DETAILED INSTRUCTIONS:

Board Policies

A. Provide a copy of the most recent state law and regulations covering the process by which the Board reviews and makes decisions regarding applications for a medical license.

B. Provide a copy of the full application kit sent by the Board to applicants for medical licenses. Please be certain that the kit covers all required information elements for domestic as well as international medical graduates. It is assumed that the kit will define the fees required of applicants. If not, please provide a separate statement that defines all fees required of applicants.

Statistical History of Medical License Applications

Initial License Applications

Initial license applications are applications for medical licenses from individuals who have never been licensed to practice medicine in a U.S. jurisdiction.

1. In the box to the right of the question, please indicate the number of pending—open—applications for initial medical licensure from USMGs—graduates of U.S. or Canadian medical schools as of 1/1/94.

2. Indicate the number of pending open applications for initial medical licensure from IMGs—graduates of medical schools outside the U.S. or Canada as of 1/1/94.

3. Indicate the number of applications received during the period 1/1/94—12/31/94 for initial medical licenses from USMG applicants.

4. Indicate the number of applications received during the period 1/1/94—12/31/94 for initial medical licenses from IMG applicants.

Board Action on Initial License Workload: 12/1/94 —12/31/94

5. Indicate the number of initial full and unrestricted medical licenses approved during the period 1/1/94—12/31/94 for USMG applicants —licenses to practice medicine to physicians who have never before been licensed to practice in a U.S. jurisdiction.

6. Indicate the number of initial full and unrestricted medical licenses approved during the period 1/1/94—12/31/94 for IMG applicants.

7. Indicate the number of initial medical license applications that were disapproved/denied during the period 1/1/94—12/31/94 to USMG applicants.

8. Indicate the number of initial medical license applications that were disapproved/denied during the period 1/1/94—12/31/94 to IMG applicants.

Endorsement License Application Workload

Endorsement license applications are applications for medical licenses from individuals who currently hold valid full and unrestricted medical licenses to practice medicine in a U.S. jurisdiction.

9. Indicate the number of pending—open—applications for endorsement medical licenses from USMG applicants as of 1/1/94.

10. Indicate the number of pending—open—applications for endorsement medical licenses from IMG applicants as of 1/1/94.

11. Indicate the number of applications received during the period 1/1/94 —12/31/94 for endorsement medical licenses from USMG applicants.

12. Indicate the number of applications received during the period 1/1//94—12/31/94 for endorsement medical licenses from IMG applicants.

Board Action on Endorsement Applications: 1/1/94-12/31/94

13. Indicate the number of endorsement full and unrestricted medical licenses approved during the period 1/1/94—12/31/94 for USMG applicants.

14. Indicate the number of endorsement full and unrestricted medical licenses approved during the period 1/1/94—12/31/94 for IMG applicants.

15. Indicate the number of endorsement medical license applications that were disapproved/denied during the period 1/1/94 —12/31/94 to USMG applicants.

16. Indicate the number of endorsement medical license applications that were disapproved/denied during the period 1/1/94 —12/31/94 to applicants who were IMG applicants.

Reasons for Denial of License Applications

In the next four questions, the Board is asked to summarize the three most common reasons for denial/disapproval of license applications over the past five years. These questions ask the Board to consider the total set of experiences of the Board over a five year period and define the most frequent reasons for denial.

17. Define the three most frequent reasons for denial of initial license applications from USMG applicants.

18. Define the three most frequent reasons for denial of initial license applications from IMG applicants.

19. Define the three most frequent reasons for denial of endorsement license applications from USMG applicants.

20. Define the three most frequent reasons for denial of endorsement license applications from IMG applicants.

Perceptions of National Credentials Verification System (NCVS®)

The National credentials Verification System (NCVS®) is the system that was operated by the American Medical Association to verify the medical credentials of U.S. or international medical graduates. The questions in this section ask for the perceptions of state boards that have experience with use of that specific, AMA-operated NCVS® system.

21. For states that used the NCVS®:

a. Explain whether the NCVS® improved the processing of applications—reducing time to obtain verified documents, or in some other way improving the process.

b. Explain any problems that were experienced in using the NCVS® system.

c. Explain the main strengths of the NCVS®.

d. Explain the main weaknesses or limitations of the NCVS®.

e. Indicate the organization that your state believes would be the most appropriate and effective to operate an NCVS®-like system. Please cite the reasons for your choice.

f. Explain any changes or additions to the NCVS® which would make it more useful to your state.

For states that did not use the NCVS®, the following questions attempt to clarify why the NCVS® was not used.

22. For states that did not use the NCVS®:

a. Cite up to three reasons the state board did not use the NCVS®.

b. Explain the changes that would be necessary to allow the state to use the NCVS®, or a replacement system. Please be as specific here as possible.

c. Identify the organization your state would select as the most appropriate and effective to operate an NCVS®-like system. Please cite the reasons for your choice.

d. Explain the state legislative or regulatory changes, if any, that would be required to permit use of such a credentials verification system. If such changes are required, speculate on the potential that such changes will be made within the next five years.

License Application Process

In this section, the Board is asked to define the need to make changes in the present state system to improve the processes by which physicians are licensed in your state.

23. Define what legislative or regulatory changes in the state system would be needed to improve the process by which license applications are considered for graduates who are already licensed to practice medicine in a U.S. jurisdiction. Improvement in this case means reduction of time to process the application, or reduction in the need to verify credentials that have already been verified by another U.S. jurisdiction.

24. Define the most useful legislative or regulatory changes that would improve the process by which initial license applications are considered by state boards.

25. With reference to state laws and regulations, explain whether there are any conditions under which other valid, full and unrestricted medical U.S. or Canadian medical licenses would be accepted by your state without the need to verify credentials—assuming that the state would still be permitted to verify the competence of licensed physicians by checking performance with existing employers—hospitals, residency programs, etc.

26. Explain whether your state allows licenses to be issued to graduates of medical schools outside the U.S. or Canada for purposes of entering a medical residency program. If not, what legislative or regulatory changes would be required to permit such licenses to be issued.

Withdrawn Applications

In the following four questions the Board is asked to consider the number of applications that are withdrawn from the application process prior to the Board approving or disapproving/denying a licensure application . Questions 28 and 30 ask the Board to consider the total set of experiences of the Board over a five year period and define the top three reasons for withdrawals.

27. During the period January 1, 1994 to December 31, 1994, how many IMG applicants withdrew their applications prior to the Board coming to an approval/disapproval decision? If the number of withdrawals is significantly larger or smaller than normal, estimate the typical number if IMG applications withdrawn each year.

28. Based on your experience, indicate the top three reasons that IMG applicants withdraw their applications.

29. During the period January 1, 1994 to December 31, 1994, how many USMG applicants withdrew their applications prior to the Board coming to an approval/disapproval decision? If the number of withdrawals is significantly larger or smaller than normal, estimate the typical number if USMG applications withdrawn each year.

30. Based on your experience, indicate the top three reasons that USMG applicants withdraw their applications.

Follow-Up Actions

The following three questions ask the Board to detail the normal procedure for follow-up on applications and the policy for handling applications which are never completed by an applicant.

31. Describe the process that the Board uses to follow-up with both an IMG and USMG physician who submits an application.

32. a. Indicate the length of time an incomplete application is considered open/active before it is classified as closed/inactive and returned to the applicant or discarded.

b. Indicate whether the same procedure for handling incomplete applications is used for IMGs and USMGs. Explain the differences, if any, in procedure.

33. a. Indicate what the Board does with applications from IMGs which are never completed.

b. Indicate what the Board does with applications from USMGs which are never completed.

Case Histories

The State is requested to answer the questions on case histories for 40 completed cases during the period January 1, 1994 to December 31, 1994. Twenty cases must be randomly selected from the file of completed cases of international medical graduates and 20 cases must be randomly selected from the file of completed cases of domestic medical graduates. See Attachment A for the random selection methodology to be used in identifying cases.

Identifying Information

Case Number—provide an identifying number, without identifying the applicant by name

Initial license/Endorsement license—check appropriate box to indicate whether the application is for an initial license or an endorsement license

1. Cite the date a request for license application was received by the state board.

2. Cite the date by which the application kit was mailed to the applicant.

3. Cite the date by which the Board received the application as submitted originally by the applicant.

4. Cite the date by which a complete application was available for full review. A complete application means that all information and documents needed to proceed with full review were available.

5. Cite the date by which the Board acted on the application.

6. Indicate whether the Board acted to approve or disapprove.

7. Assuming Board approval, indicate the date the license was issued.

8. Check the specific documents missing in the initial submission by the applicant.

9. If the application was denied/disapproved, explain the Board's reasons.

10. Check appropriate box to indicate whether the NCVS® was used in this case.

ATTACHMENT A

Random Selection Methodology

The State of Ohio was requested to use the following random selection methodology to identify the case histories for the Survey of Licensure Policies of State Medical Authorities:

Selection of case histories, for applications closed during the period of January 1, 1994 through December 31, 1994, for USMGs—graduates of medical schools in the U.S. or Canada:

1. From the file of closed applications, select the 2nd from last application closed on or before December 31, 1994 for USMG applicants.

2. Moving backwards in time, select every 100th closed application from USMG applicants, until you have reached 20 cases (even if you need to go further back in time than January 1, 1994).

Selection of case histories, from the period of January 1, 1994 through December 31, 1994, for IMGs—graduates of medical schools outside the U.S. or Canada:

1. From the file of closed applications, select the 4th from last application closed on or before December 31, 1994 for IMG applicants.

2. Moving backwards in time from December 31, 1994, select every 7th closed application from IMG applicants, until you have reached 20 cases (even if you need to go further back in time than January 1, 1994).

ATTACHMENT B

Glossary of Terms

For the sake of clarity, the U.S. Health Resources and Services Administration will use the following definitions within the Survey of Licensing Policies of state Medical Licensing Authorities.

U.S. medical graduate (USMG)—A physician who graduated from a medical school which lies within the U.S. or Canada.

International medical graduate (IMG)—A physician who graduated from a medical school which lies outside the U.S. or Canada.

Initial license application—An application for a medical license from an individual who has never been licensed to practice medicine in a U.S. jurisdiction.

Endorsement license application—An application for a medical license from an individual who currently holds a valid, full, and unrestricted medical license to practice medicine in a U.S. jurisdiction.

Complete Application—A license application in which all information and documents needed to proceed with full review is available.

Incomplete Application—A license application in which some of the information and/or documentation needed to proceed with a full review has not been submitted to the Board.

Pending Application—A license application which has not yet been acted on by the Board. This would include both incomplete applications which are waiting for missing items to be submitted and completed applications which are waiting for Board action.

Closed Application or Closed Case—A license application on which the Board has taken either an approval or disapproval/denial action.

Appendix C—

NARRATIVE RESPONSE TO SURVEY QUESTION

NARRATIVE TO SURVEY QUESTIONS

17. Summarize in the spaces below the three most frequent reasons for denials of initial licenses to USMG applicants over the past five years.

Arizona

a. Falsifying information on applications.

California

a. Discipline in another state due to unlawful use/prescribing of controlled substances or incompetence.

b. Unlawful use/prescribing of controlled substances.

c. Conviction of a crime substantially related to the practice of medicine.

Florida

a. Do not meet statutory requirements for licensure.

b. Unable to prove practice with reasonable skill and safety in order to protect the citizens of the state of Florida.

Illinois

The Board recommends deferral in most instances to allow for the individual to get additional education or training, etc., rather than denying licensure.

Louisiana

a. Failing a licensing examination (FLEX, National Board of Medical Examiners Examination) or any component thereof more than 3 times.

b. Failure to successfully complete a PGY-1 (internship)

c. Abuse of drugs and/or conviction of a felony.

New Jersey

a. Lack of good moral character.

b. Did not complete a thorough and comprehensive medical education.

c. Substance abuse.

Ohio

a. Did not have training.

Tennessee

a. Do not meet exam requirements

b. Have not completed their residency— they apply early and residencies end on June 30 typically.

Texas

a. Falsification of application.

b. Exam failure.

18. Summarize in the spaces below the three most frequent reasons for denials of initial licenses to IMG applicants over the past five years.

Arizona

a. Falsifying information on applications.

California

a. Conviction of a crime substantially related to the practice of medicine.

b. Making false statements on the application.

c. Prescribing controlled substances without examination.

Florida

a. Do not meet statutory requirements for licensure.

b. Unable to prove practice with reasonable skill and safety in order to protect the citizens of the state of Florida.

Illinois

The Board recommends deferral in most instances to allow for the individual to get additional education or training, etc., rather than denying licensure.

Louisiana

a. Failing FLEX more than three times.

b. Did not complete three years of approved residency training in the United States or Canada (three years of training with progressive responsibility).

c. Dismissal from a training program.

New Jersey

a. Lack of good moral character.

b. Did not complete a thorough and comprehensive medical education, fragmented and disjointed.

c. Lack of good moral character plus a fragmented and disjointed medical education.

Ohio

a. Did not meet training requirements.

b. No ECFMG certification.

Tennessee

a. They apply with only having a J-1 Visa. They cannot get a license until they have an H-1 B Visa or marry, etc to get out of the J-1 visa status.

b. Do not meet training requirements.

c. Did not receive appropriate original transcripts from the original school.

d. Do not have ECFMG certification.

e. Has not passed exams; do not meet exam requirements

Texas

a. Clinical clerkship not accredited.

b. Unapproved training.

c. Exam failure.

19. Summarize in the spaces below the three most frequent reasons for denials of endorsement licenses to USMG applicants over the past five years.

Arizona

a. Falsifying information on applications.

California

a. Discipline in another state due to unlawful use/prescribing of controlled substances.

b. Discipline in another state due to alcohol abuse.

c. Discipline in another state due to mental illness.

Florida

a. Do not meet statutory requirements for licensure.

b. Unable to prove practice with reasonable skill and safety in order to protect the citizens of the state of Florida.

Illinois

The Board recommends deferral in most instances to allow for the individual to get additional education or training, etc., rather than denying licensure.

Louisiana

a. Failing FLEX, National Board of Medical Examiners examination, or any component thereof more than 3 times.

b. Failure to successfully complete a PGY-1 (internship) or dismissal from other training programs.

c. Action taken by another state.

New Jersey —No response.

Ohio

a. No license to endorse.

Tennessee

a. Actions taken against them in another state.

b. Chemical abuse, substance abuse, sexual misconduct.

c. Do not meet requirements (the state in which they are licensed had lower requirements).

Texas

a. Incompetence.

b. Unprofessional conduct.

c. Health care entity (illegible)/peer group action.

20. Summarize in the spaces below the three most frequent reasons for denials of endorsement licenses to IMG applicants over the past five years.

Arizona

a. Falsifying information on applications.

California

a. Discipline in another state due to unlawful use/prescribing of controlled substances.

b. Discipline in another state due to incompetence.

c. Discipline in another state due to sexual misconduct.

Florida

a. Do not meet statutory requirements for licensure.

b. Unable to prove practice with reasonable skill and safety in order to protect the citizens of the state of Florida.

Illinois

The Board recommends deferral in most instances to allow for the individual to get additional education or training, etc., rather than denying licensure.

Louisiana

a. Failing FLEX, or any component thereof, more than three times.

b. Did not complete three years of approved residency training in the United States or Canada (three years of training with progressive responsibility).

c. Action by another state.

New Jersey—No response

Ohio

a. Did not meet training requirements.

b. No license to endorse.

c. No ECFMG certification.

Tennessee

a. Actions taken against them in another state.

b. Chemical abuse, substance abuse, sexual misconduct

c. Do not meet requirements (the state in which they are licensed had lower requirements).

Texas

a. Clinical clerkship not accredited.

b. Unapproved training program.

c. Exam failure.

21. For States that used the NCVS®, please answer the following questions:

a. Did the NCVS® facilitate the verification of credentials ? (Cite reasons)

Arizona—No. The processing time was the same because we still needed some of our own forms filled out (in addition to the NCVS® information).

Florida — No. Would need statutory authority.[1]

Louisiana—Yes. Entire NCVS® package arrived at the same time and it relieved licensure clerk of some work.

Ohio—Yes. We only had two.

b. What problems, if any were experienced in using the NCVS®?

Arizona—Outdated information.

Florida—N/A

Louisiana—None.

Ohio—None.

c. What do you consider to be the main strengths of the NCVS®?

Arizona—From the Doctor's perspective there is less paperwork. From our perspective there is none.

Florida—N/A

Louisiana—Entire NCVS® package arrived at the same time and it relieved licensure clerk of some work.

Ohio—Good documentation (only had two).

d. What do you consider to be the main weaknesses of the NCVS®?

Arizona—Outdated information; Duplication of work.

Florida—N/A

Louisiana—None.

Ohio—Lack of participation.

e. In your opinion, what would be the most appropriate organization to operate such a system? The ECFMG, the FSMB, or another (specify). (Cite reasons for choice)

Arizona—We do not recommend another organization because it is unlikely that another system would be able to reduce the duplication of work that we would need to do in order to ensure that the information is up-to-date (updated within the past 6 months).

Florida—FSMB; they currently possess the largest data bank.

Louisiana—FSMB; The FSMB maintains disciplinary files.

Ohio—FSMB; Administrators in Medicine.

f. What changes or additions to the NCVS® would be necessary to make the system more useful for your state's purposes?

Arizona—Adoption of our forms; Current documentation.

Florida — Would need statutory authority.

[1] Florida responded to items in Question 21 even though Florida did not use the NCVS®.

Louisiana—None.

Ohio—Concentrate on more medical education and post-doctoral training.

22. For states that DID NOT use the NCVS®, please answer the following questions:

a. List up to three reasons why the NCVS® was not used in your state:

California—The Board determined that the information collected by the NCVS® would not verify an applicant's medical education and training to the extent required by current California law. For example, the NCVS® could verify the authenticity of a physician's medical school diploma and transcripts, but would not be able to verify that physicians had completed the specific number of weeks of clinical training required in Section 2089.5 of the B&P Code. Staff would still need to continue collecting and verifying extensive information from various other primary sources. As a result, the NCVS® service would not be cost effective to the Board or to its applicants.

Florida — Need statutory authority.

Illinois— 1) The high cost to the physician with regard to the credentialing service fee, and the state licenses fee. 2) Retrieval of IMGs credentials from schools in countries that will not release documents. The Department has a specific policy by which such applications are handled and there was a concern as to what mechanism or policy NCVS® would follow. 3) The process currently in place in Illinois, met, if not exceeded, the process that was being utilized by NCVS®.

New Jersey—1) The Board did not feel it could delegate one of its prime statutorily mandated functions to an organization whose membership is composed exclusively of individuals in the profession that the Board is designated to regulate. 2) The information that was collected by NCVS® was not sufficiently detailed to eliminate the need for the Board to contact sources who had provided verifications to the NCVS®.

Tennessee—1) The rules and regulations mandate that we receive original documentation directly from the medical schools, residency programs, exam entities, etc. because we have had cases of applicants falsifying documents. 2) There is a time lag between an action occurring and recording at the databank. 3) There is not a lot of trust in the way they run their program.

Texas—The Board was in the process of negotiating a contract with NCVS® when NCVS® was canceled.

b. What changes, if any, would make your state consider use of a centralized credentials verification system (Be as specific as possible, taking additional pages if needed)?

California— If the credentials verification system verified physicians' medical education and training and credentials to the extent required by California law or could provide customized verifications.

Florida — Would need statutory authority.

Illinois—When this topic was discussed by the Board/Department, it was the general consensus, that should changes occur in the future, it would be reconsidered at that time.

New Jersey—1) If the information in the centralized verification system was sufficiently detailed, the system could be beneficial. 2) The Board would have to have assurances regarding the quality of the verification system. 3) The system would need to be flexible to address the needs of individual states.

Tennessee—It would take a change of our Board member attitudes to relinquish a bit of their control over the process.

Texas—There is no need to establish a central credentialing agency, as state boards are already credentialing physicians better than any other organization. But there is a need for a central depository for core documents.

c. In your opinion, what would be the most appropriate organization to operate such a system? The ECFMG, the FSMB, or another (specify). (Cite reasons for choice)

California—ECFMG; FSMB; The FSMB or the ECFMG may have the expertise to operate such a system.

Florida—FSMB; they currently possess the largest data bank.

Illinois—FSMB; Due to the fact that the Federation has maintained examination history as well as disciplinary history for a number of years on physicians, the FSMB would be the most appropriate organization to operate such a system.

New Jersey—1) The Federation of State Medical Boards—The FSMB is an organization that is ostensively responsible to its member organizations, State Medical Boards. The Federation should be responsive to the needs of its members organizations. The Federation would have access to

individuals with expertise in the areas of credentialing and should be able to put together a system that would be acceptable to Boards if it took direction from the Boards when designing the system. 2) The Educational Commission for Foreign Medical Graduates—ECFMG has an understanding of the foreign credentialing system and should be able to utilize that in preparing a credentialing system such as this contemplates.

Tennessee—FSMB; Due to our familiarity with their databank and their familiarity with State needs. We get quick response and are pleased with the way the system works.

Texas—FSMB.

d. Would your state require a change in legislation or regulations to permit use of an NCVS®-like system? Yes or No. If yes, what changes would be required and what is the likelihood that such changes will be implemented within the next five years?

California—Yes. The Board would need to amend Section 1323 of Title 16, California Code of Regulations to delegate to an outside agency the authority to verify the authenticity of applicants' medical education credentials.

Florida—Yes. 1. Removal of the Department's investigate authority to be placed with an NCVS®-like system. 2. Unlikely to be implemented within the next five years.

Illinois—Yes. The Rules and Regulations for the Administration of the Medical Practice Act of 1987 would need to be amended.

New Jersey—Yes. The Board most probably would want to implement a major change in its credentialing procedure by means of a regulation. Such a regulation would be proposed only if an NCVS®-like system which met the Board's requirements was created and could meet the Board's quality requirements.

Tennessee—Yes. It would require a change in the Board's attitude, and that is not likely.

Texas—Yes. Statutory changes would be necessary if a central credentials verification system were required. Such a change may be difficult to enact, as licensure is viewed as a state responsibility that cannot be delegated to others.

23. For physicians already licensed to practice in the US, what changes in your current system would serve to reduce duplicative processes?

Arizona—No status phone calls or limited status calls prior to 30 days of application.

California—The Board considers its application review process to be very efficient, considering the large volume of applications received and the extent of the credentials verification process required by California's licensing laws. The Board's well-trained staff processes applications within 30-45 days of their receipt date. In order for processing times to be reduced, the laws relating to specific educational requirements would need to be repealed.

Illinois—No response.

Florida—1. Uniform licensure laws in U.S./Canada. 2. Removal of Department's investigative powers.

Louisiana—None unless another system like the NCVS® was put into place.

New Jersey—If extensive documentation of a physician's pre-medical, medical, and post-graduate education and employment positions was contained in a system upon which the Board could rely and if the Board did not have to seek this information from various outside sources, this would serve to reduce duplicative verification processes. Such information would have to be reliable and such information would have to be very detailed. A simple indication that someone has graduated or has completed a program is useless.

Ohio—Verification of post-doctoral training, other state licenses, ECFMG certification, and independent background check required.

Tennessee—To have a national standardized license verification form would be a big help. So would on screen (from our desk computers) verification of test scores, ECFMG certificates, and other state licenses. This way we can be proactive in verifying pieces of information.

Texas—A minimum standard established for credentialing basic educational documents and a central depository for these documents would reduce duplication. By using this central depository for most, if not all, documents required by states, we could rely on the initial state's work and expedite processing time.

24. For physicians applying for initial licenses (no other medical license in the U.S.) what changes would reduce processing time, or reduce the differences in processing application time between international and domestic medical graduates?

Arizona—None.

California—The difference in application processing time between international and domestic graduates is somewhat artificial. Sections 2101(d) and 2102 of the B&P Code require IMGs to submit a licensing application and meet minimum curriculum and testing requirements prior to entering ACGME-accredited postgraduate training programs in this state. IMGs also were required to submit their applications to the Board prior to taking the FLEX exam in this state. DMGs need only to register with the Division of Licensing before entering the same program (see Section 2065 of the B&P Code), and they applied directly to the NBME to take all parts of the NBME examination. The recent implementation of the USMLE uniform examination system has eliminated some of this differential. The differential could be further eliminated by devising a training permit system in which both groups obtain training permits prior to entering postgraduate training.

Florida—1. IMG and USMG taking responsibility for their respective application. 2. Follow instructions.

Illinois—No response.

Louisiana—None unless another system like the NCVS® was put into place.

New Jersey—If extensive documentation of a physician's pre-medical, medical, and post-graduate education and employment positions was contained in a system upon which the Board could rely and if the Board did not have to seek this information from various outside sources, this would serve to reduce duplicative verification processes. Such information would have to be reliable and such information would have to be very detailed. A simple indication that someone has graduated or has completed a program is useless.

Ohio—Verification of post-doctoral training, other state licenses, ECFMG certification, and independent background check required.

Tennessee—Getting transcripts from the international schools more quickly would reduce the differences in processing times.

Texas—Since the majority of states require three years of training in the US for IMGs, it would be possible for these physicians to apply for licensure prior to their training completion date, in order to be issued a license when they complete their training. This has worked effectively in Texas for several years.

25. Are there any conditions under which your state board would consider accepting a license from another US jurisdiction without further credentials verification (while still allowing for independent verification of competent performance within the licensing jurisdiction)?

Arizona—None.

California—No.

Florida—Under current statute, no. The Medical Practice Act is created, amended, etc. by the legislative body of the state of Florida.This is not a function of the Board of Medicine.

Illinois—No response.

Louisiana—None unless another system like the NCVS® was put into place.

New Jersey—At this point in time, the licensure requirements and documentation standards are so varied from state to state and are so varied over the course of time, the Board would be derelict in its duty in simply accepting the license of another U.S. jurisdiction without further credentials verification.

Ohio—No.

Tennessee—The only condition is if they are applying for a Locum Tenens License to do temporary/intermittent work in the state but they must live outside the state. There are no other conditions under which this takes place.

Texas—If the verification standards were used by another state board and the statutes were changed. ADMINISTRATORS IN MEDICINE could establish a peer review panel to insure that the minimum standards are met by the state licensing board.

26. Does your state allow special or regular medical licenses to be issued that would permit graduates of medical schools outside the US or Canada to enter a graduate medical education residency training program? Yes or No. If no, explain the changes in state law or regulations that would be required to permit such licensing to occur.

Arizona—Yes.

California—No. California law does not authorize the issuance of special licenses to trainees in residency programs. Currently trainees are exempted from licensure for 12-24 months while they train in an ACGME-accredited residency program if they qualify for the training exemption in Section 2065 or 2066 of the B&P Code. If ineligible for a training exemption, the prospective resident trainee must hold a full and unrestricted California medical license. To implement a special training license system in California would require amendments to the statutes and regulations governing the Division's authority to issue, renew and verify the status of licenses, set fees and license eligibility requirements, etc.

Florida—No. We do not license; We register as unlicensed physicians provided they are in a program.

Illinois—Yes.

Louisiana—Yes and No. New rules allowing IMG residency training in Louisiana are expected to be formally promulgated on May 20, 1995.

New Jersey—Yes. Residency training permits are issued to allow residents to participate in graduate medical education programs in this State. Such permits are required for U.S. and non-U.S. graduates alike.

Ohio—Yes. No mandatory license.

Tennessee—Yes. The application for this must be sent in by the residency program. The same process is used for USMGs and IMGs.

Texas— Yes.

27. a. In the past year, how many IMGs withdrew their applications before the Board could complete its processing and reach a decision? b.If the previous year was unusual, how many IMG applications are withdrawn in your estimation each year?

Arizona—3.

California—Unknown (Board staff does not collect this type of data).

Florida—See 59R-4.009(8), p.14-15, Florida Administrative Code, (FAC)[2]

Illinois—Statistics not available.

Louisiana—Zero. Note: Once an applicant completes an application, it is very rare for anyone to withdraw an application.

New Jersey—This question was not asked on the pilot version of the survey. Therefore, there is no response from New Jersey.

Ohio—4.

Tennessee—Very few, roughly 1 or 2.

Texas—a. In 1994, 2 applications were withdrawn. b.In 1992, no applications were withdrawn, and in 1993, 4 applications were withdrawn.

28. In your judgement, what are the top three reasons for the withdrawal of an IMG application?

Arizona—Change of plans; incomplete applications; physician decided not to relocate.

California—1) Applicant was not offered an anticipated job/training position in California or, after applying in California, chose to accept a position offered in another state. 2) Applicant anticipated denial of the application based on grounds for denial (usually because of disciplinary history) which he/she has disclosed on application. 3) Applicant anticipated denial of the application based on grounds for denial (such as disciplinary action) reported to the Medical Board by an outside agency after he/she filed the application.

Florida—1) Do not meet statutory requirements for licensure. 2) Unable to prove practice with reasonable skill and safety in order to protect the citizens of the state of Florida.

Illinois—1) Possible denial due to moral character. 2) Possible discipline of physician license. 3) Educational requirements not met.

Louisiana—As mentioned in Question 27, it is very rare for an applicant to withdraw a completed application however, there are instances when an individual decides not to complete an application. Most reasons given are: 1) decided to locate elsewhere, 2) applicant did not want to take SPEX, there is no third reason.

New Jersey—This question was not asked on the pilot version of the survey. Therefore, there is no response from New Jersey.

Ohio—1) To avoid credential denial. 2) To avoid disciplinary action. 3) Relocate.

Tennessee —1) Pursuing employment in another state. 2) Difficulties with immigration. 3) Avoiding a denial (which is reportable).

[2] This regulation outlines the procedures for withdrawal of applications. It does not provide any data regarding the number of applications withdrawn.

Texas—1) Better job opportunity in another state.

29. a. In the past year, how many USMGs withdrew their applications before the Board could complete its processing and reach a decision? b. If the previous year was unusual, how many USMG applications are withdrawn in your estimation each year?

Arizona—5.

California—Unknown (Board staff does not collect this type of data).

Florida— See 59R-4.009(8), FAC.[3]

Illinois—Statistics not available.

Louisiana—1. Note: Once an applicant completes an application, it is very rare for anyone to withdraw an application.

New Jersey—This question was not asked on the pilot version of the survey. Therefore, there is no response from New Jersey.

Ohio—0.

Tennessee—Very few, 4 or 5.

Texas—a. In 1994, 14 applications were withdrawn. b. In 1992, 2 applications were withdrawn and in 1993 10 applications were withdrawn.

30. In your judgement, what are the top three reasons for the withdrawal of a USMG application?

Arizona—Change of plans; incomplete applications.

California—1) Applicant was not offered an anticipated job/training position in California or, after applying in California, chose to accept a position offered in another state. 2) Applicant anticipated denial of the application based on grounds for denial (usually because of disciplinary history) which he/she has disclosed on application. 3) Applicant anticipated denial of the application based on grounds for denial (such as disciplinary action) reported to the Medical Board by an outside agency after he/she filed the application.

Florida— 1) Do not meet statutory requirements for licensure. 2) Unable to prove practice with reasonable skill and safety in order to protect the citizens of the state of Florida.

Illinois—1) Possible denial due to moral character. 2) Possible discipline of physician license. 3) Educational requirements not met.

Louisiana—As mentioned in Question 29, it is very rare for an applicant to withdraw a completed application however, there are instances when an individual decides not to complete an application. Most reasons are: 1) decided to locate elsewhere, 2) applicant did not want to take SPEX, 3) was allowed to withdraw in lieu of formal hearing regarding the Board's intent to deny application (denial is reportable to NPDB[4] but withdrawal is not).

New Jersey—This question was not asked on the pilot version of the survey. Therefore, there is no response from New Jersey.

Ohio—No response.

Tennessee— 1) Pursuing employment in another state. 2) Avoiding denial (which is reportable). 3) Once we look at the malpractice histories—when we look into things that they did not reveal or they lied about.

Texas—1) Better job opportunity in another state.

31. What is the normal process for Board follow-up to obtain missing items for applications submitted by USMGs and IMGs?

Arizona—30 day update letters.

California—Within 30-45 days after receipt of an application, licensing staff returns all original documents to the applicant and notifies the applicant, in writing, of any missing items or improperly completed documents.

Florida—1) Incomplete notice mailed. 2) As the parts of the application come in applicant notified of additional information need and/or file complete. 3) Burden of proof on the applicant.

Illinois—Upon receipt, application is evaluated and if determined deficient, a deficiency notice is forwarded to applicant.

Louisiana—Applicants are written listing missing items.

New Jersey—This question was not asked on the pilot version of the survey. Therefore, there is no response from New Jersey.

Ohio—Statutory requirement to send certified letter requesting missing items per Section 4731.29, Ohio Revised Code.

[3] This regulation outlines the procedures for withdrawal of applications. It does not provide any data regarding the number of applications withdrawn.

[4] National Practitioner Data Bank (NPDB)

Tennessee—A deficiency letter is sent out and 60 days are given to make up the deficiencies. Often IMGs will ask for an extension to deal with immigration or to get transcripts. These have typically been granted. Another letter is sent out after 60 days. The same process is used for IMGs and USMGs

Texas—A series of Lacking Letters are sent to all applicants.

32. a. How long are incomplete applications held by the Board before being returned to the applicant or discarded?

b.To what extent, if at all, do the procedures differ for handling such incomplete applications for IMGs and for USMGs?

Arizona—a. 1 year from date of processing applications. b. No difference.

California—a. A minimum of one year, per Section 1306 of Title 16, California Code of Regulations. b. No difference

Florida—a. One year; Applications are official records of the state. b. Statutory requirements Administrative Code Rules.

Illinois—a. Three years from date of receipt. b. The procedure is the same.

Louisiana—a. Incomplete applications are held for at least 6 months. b. No difference.

New Jersey—This question was not asked on the pilot version of the survey. Therefore, there is no response from New Jersey.

Ohio—Six months. Sent a 30-day letter, if no response application is abandoned. If there is an enforcement file, the application is place within, if not, it is destroyed. b.Same process for IMG and USMGs.

Tennessee—After approximately 4 months the application is closed and a letter is sent to the applicant to communicate this. No applications are closed without communication with the applicant prior to this action. b.The same process is used for IMGs and USMGs.

Texas—a. Two years. b. No difference.

33. What does the Board do with applications that are never completed?

a. From IMGs

b. From USMGs?

Arizona—a. Withdraw and kept for three years, then sent to Archives (records mgmt.) b. Withdraw and kept for three years, then sent to Archives (records mgmt.)

California—(Process in identical for both groups) If the file remains inactive for over one year, staff warns the applicant in writing to notify the staff of their intention to pursue licensure in California.If the applicant fails to respond within 30 days, staff closes and mails the application to the applicant's last address of record. Applicants may maintain their files in inactive status by updating the file annually as long as they are making reasonable efforts to meet the licensing requirements.

Florida—a. Applications are official records of the State. Warehoused after 4-5 years. b. Applications are official records of the State. Warehoused after 4-5 years.

Illinois—a. After three years, applications are destroyed. b. After three years, applications are destroyed.

Louisiana—All applications, IMG and USMG, after about six months are reviewed. Depending on how far along an application was and what information had been received, the application may be discarded or it may be closed and filed under a "not licensed" label. These are kept indefinitely in case the applicant wants to reactivate his application file.

New Jersey—This question was not asked on the pilot version of the survey. Therefore, there is no response from New Jersey.

Ohio—a. Abandoned—If there is an enforcement file, the application is place within, if not, it is destroyed. b. Same process for USMGs.

Tennessee—a. Files are closed and retained. b. Files are closed and retained.

Texas— a. Applications are destroyed. b. Applications are destroyed.

Appendix D — Letter from Califonia

To: Michelle Morey
Macro International, Inc.

From: Pat Park
Medical Board of California

RE: DHHS SURVEY RESULTS

This is a followup to our telephone conversation today regarding the reasons behind some of the long processing times you noticed among some of our international medical graduates. While completing the DHHS survey, I also noticed some unusually long processing times. In each case, I studied the chronology of events and made notes for future reference. Attached are copies of my notes with the individuals' names removed.

As we discussed, California's application packet is a multi-purpose application. The same application is used to apply to take FLEX, to apply for permission to begin post-graduate training in California and to apply to take California's oral examination. The individuals with the longest processing times are those who applied at the earliest stage of taking the FLEX exam. After passing FLEX Component 1, they may begin a post-graduate training program in California. After sucessfully completing one year of ACGME-accredited training, they may take the oral examination.

Looking over the attached list, you will notice that some processing delays were caused by applicants failing the FLEX or rescheduling their participation until a more convenient date (Cases #19 & #23). Other delays were caused when applicants did not successfully match with postgraduate training programs on their first attempt (Cases #9, #14, #29 & #39). The longest delays were experienced by six applicants who matched with postgraduate training programs outside California and delayed returning to California to take the oral exam until near the end of their training programs (Cases #19, #22, & #23). We will hold applications in pending status indefinitely as long as the applicant updates his file annually and is deligently attempting to meet the licensing requirements.

Also remember that the survey period captured data pertaining to applicants who applied for licensure before the United States Medical Licensing Examination (USMLE) became available. The USMLE system eliminates the traditional hurdle of IMGs having to take FLEX prior to beginning postgraduate training. With an ECFMG certificate based on passing scores on USMLE Steps 1 and 2, IMGs can now enter postgraduate training immediately after graduating from medical school, a chronology equivalent to their domestic counterparts.

Case #5:

Processing time: 8/14/92 - 9/7/94 (2 years + 1 month)

PG 92-94 in Nevada. 7/23/94 oral. Requested license be issued in Sept.

Case #9:

Processing time: 7/31/92 - 8/17/94 (2 years + 1 month)

FLEX 12/92 in Pa. PG 6/93 - 6/94 in Calif. 7/23/94 oral.

Case #14:

Processing time: 3/13/92 - 11/9/94 (2 years + 7 months)

FLEX 6/92 in Calif. PG 6/93 - 6/94 in Calif. 9/17/94 oral.

Case #19:

Processing time: 3/11/92 - 12/28/94 (2 years + 9 months)

Sched. For 6/92 FLEX. Asked to be resched. To 6/93 FLEX. PG 7/92 - 6/95 in Texas. 11/19/94 oral.

Case #22:

Processing time: 11/5/91 - 11/30/94 (3 years + 3 weeks)

FLEX 6/92 in Calif. PG 7/92 - 6/93 in Texas. 7/23/94 oral.

Case #23:

Processing time: 10/17/91 - 10/26/94 (3 years + 1 week)

Passed 6/92 FLEX Comp. 2 in Calif. (failed Comp. 1). Passed 12/92 FLEX Comp. 1 in Calif. PG 7/92 - 6/93 in Boston. 5/14/94 oral.

Case #26:

Processing time: 10/25/91 - 8/3/94 (2 years + 10 months)

FLEX Comp. 1 in Pa., 12/91. FLEX Comp. 2 in Calif., 12/92. PG 7/92 - 6/93 in Mich. PG 93-94 in Calif. 7/23/94 oral.

Case #27:

Processing time: 4/8/92 - 8/17/92 (2 years + 4 months)

PG 7/89 - 6/92 in N.Y. 7/23/94 oral.

Case #29:

Processing time: 2/10/92 - 8/10/94 (2 years + 6 months)

FLEX 6/92 in Calif. PG 6/93 - 6/94 in Calif. 7/23/94 oral.

Case #32:

Processing time: 3/17/92 - 12/7/94 (2 years + 9 months)

FLEX 12/92 in Penna. PG 6/93 - 6/94 in Calif. Sched. for 9/94 oral. Asked to be resched. for 11/94 oral.

Case #39:

Processing time: 9/23/92 - 10/12/94 (2 years + 1 month)

FLEX 6/92 in Penna. PG 8/93 - 7/94 in Calif. 9/17/94 oral.

Appendix E — State License Application Requirements

Each State surveyed was asked to provide a copy of their most current State regulations covering the process by which physicians become licensed and a copy of the application kit that is given to applicants. Exhibits E-1, E-2, E-3, and E-4 summarize the data that was pulled from these materials. Exhibits E-1 and E-2 chart the requirements for the licensure of USMG and IMG applicants, respectively. These data were largely pulled from the policy statements. Exhibits E-3 and E-4 track the documentation that the States require the applicant to submit with their application. The specific data elements and documentation required illustrates the level of proof that is necessary to assure each Board that the requirements tracked in Exhibits E-1 and E-2 have been met. This data was pulled primarily from the application kits.

Exhibit E-1: Requirements for Licensure for Graduates of U.S. or Canadian Medical Schools

Requirement	*AZ*	*CA*	*FL*	*IL*	*LA*	*NJ*	*OH*	*TN*	*TX*
General Requirements									
Complete Application and Payment of Fee	✔	✔	✔	✔	✔	✔	✔	✔	✔
Age Requirement (Minimum age indicated)			21		21	21	18		21
Of Good Moral and Professional Character	✔		✔	✔	✔	✔	✔	✔	✔
Evidence of Citizenship or Being Legally Entitled to Work in the U.S.				✔	✔[1]	✔		✔	
Personal Appearance	✔[2]		✔[2]	✔	✔[2]	✔[2]		✔[2]	✔
Education Related Requirements									
High School Diploma or Equivalent							✔		
Pre-Medical Education (length indicated in years)		2	2[3]	2		2✔	2		2✔
Graduation from an LCME Accredited Medical School	✔[5]	✔	✔	✔	✔	✔	✔	✔	✔
Exam Related Requirements									
USMLE Recommended Exam Combinations and Passing Scores	✔	✔	✔	✔	✔	✔	✔	✔[6]	✔
English Competency			✔[7]				✔[8]		
Jurisprudence Exam									✔
Oral Exam		✔							
Experience Related Requirement									
Post Graduate Training from an ACGME Approved Program (Number of years indicated)	1	1	1	2[9]	1	1	1	1	1
Additional Requirements for Endorsement Applicants									
SPEX[10]	✔	✔	✔	✔	✔		✔	✔[11]	✔

Exhibit E-2: Requirements for Licensure for Graduates of International Medical SchoolsRequirement

Requirement	*AZ*	*CA*	*FL*[12]	*IL*	*LA*	*NJ*	*OH*	*TN*	*TX*
General Requirements									
Complete Application and Payment of Fee	✔	✔	✔	✔	✔	✔	✔	✔	✔
Age Requirement (Minimum age indicated)			21		21	21	18		21
Of Good Moral and Professional Character	✔		✔	✔	✔	✔	✔	✔	✔
Evidence of Citizenship or Being Legally Entitled to Work in the U.S.				✔	✔			✔	
Personal Appearance	✔[2]		✔[2]	✔[2]	✔	✔[2]		✔[2]	✔
ECFMG Certification	✔[13]	✔	✔[14]	✔	✔	✔	✔[15]	✔	✔
English Competency Beyond that Measured by the ECFMG	✔				✔	✔[16]			
Education Related Requirements									
High School Diploma							✔		
Pre-Medical Education (length indicated in years)		2	2[3]	2[17]		2[18]	2		2[18]
Graduation from a Medical School Recognized by WHO	✔	✔	✔	✔	✔[20]	✔	✔	✔[21]	✔
Eligible for Licensure in Country of Education		✔				✔			✔[22]
Exam Related Requirements									
USMLE Recommended Exam Combinations and Passing Scores	✔	✔	✔	✔	✔	✔	✔	✔	✔
Jurisprudence Exam									✔
Oral Exam		✔							
Experience Related Requirement									
Post Graduate Training from an ACGME Approved Program (Number of years indicated)	3	1	3	2	3	3[24]	2	3[25]	3
Additional Requirements for Endorsement Applicants									
SPEX[10]	✔	✔	✔	✔	✔		✔	✔[11]	✔

Exhibit E-3: Data Elements and Documentation Required of USMG Applicants

Data Element	*AZ*	*CA*	*FL*[26]	*IL*	*LA*	*NJ*	*OH*	*TN*	*TX*
General Elements									
Application and Fee[27]	✔	✔	✔	✔	✔	✔	✔	✔	✔
Photo (quantity indicated)	1	2	1[28]		1	3		1	
Statement of Legal Name Change (if applicable)	✔		✔		✔[29]	✔	✔		✔
Proof of Citizenship or Evidence of Being Legally Entitled to Live and Work in the U.S.[30]	✔[31]			✔	✔[32]			✔	✔
Affidavit of Good Moral and Professional Character[33]	✔	✔	✔	✔	✔	✔[34]	✔	✔	✔
Letters of Recommendation (quantity indicated)			2		2		2	2	
AMA Profile	✔		✔			✔	✔		✔
National Practitioners Data Bank Report					✔				✔
Medical Society Membership (if applicable)			✔						
Military Service Release Form (if applicable)	✔		✔			✔			✔
Curriculum Vita						✔			
Verification of Work History	✔			✔		✔			
Fingerprint Cards		✔							✔
Education Related Elements									
Post Secondary Education Transcript		✔	✔	✔		✔			✔
Medical School Transcript		✔	✔	✔		✔		✔	✔
Medical School Diploma	✔	✔	✔	✔	✔		✔		✔
Dean's Medical School Certification	✔	✔				✔			✔
Exam Related Elements									
Exam Scores Received From the Entity Administering the Exam[35]	✔[36]	✔	✔	✔	✔	✔	✔	✔[36]	✔[36]
Jurisprudence Exam									✔
Oral Exam		✔[37]							
Medical Council of Canada Certificate of Standing (if applicable)							✔		

Continued next page

Data Element	*AZ*	*CA*	*FL*[26]	*IL*	*LA*	*NJ*	*OH*	*TN*	*TX*
Training Related Elements									
Letter From Director of Post-Graduate Residency/Internship/Fellowship								✔	
Certificate of Completion of Post-Graduate Residency/Internship/Fellowship	✔[36]	✔	✔[38]	✔	✔	✔	✔	✔	✔[36]
Certificate of Affiliation for Clinical Training		✔							
Written Evaluation from Each Facility in Which the Applicant Trained or Had Staff Privileges Within 10 Years									✔
Specialty Board Certification (if applicable)	✔		✔						✔
Additional Elements Necessary for Endorsement Applicants									
SPEX[10]	✔	✔	✔	✔	✔		✔	✔[11]	✔
Other State License Verification Forms	✔	✔[39]	✔[40]	✔	✔	✔	✔	✔	✔
Actual Licenses From Other States					✔				✔
Endorsement Form[✔1]					✔	✔			✔
Certification from State in Which Applicant is Licensed by Exam							✔		✔

Exhibit E-4: Data Elements and Documentation Required of IMG Applicants

Data Element[1][2]	*AZ*	*CA*	*FL*	*IL*	*LA*	*NJ*	*OH*	*TN*	*TX*
General Elements									
Application and Fee[27]	✔	✔	✔	✔	✔	✔	✔	✔	✔
Photo (quantity indicated)	1	2	1[28]		1	✔		1	
Statement of Legal Name Change (if applicable)	✔		✔		✔[29]	✔	✔		✔
Proof of Citizenship or Evidence of Being Legally Entitled to Live and Work in the U.S.[30]	✔[41]			✔	✔[42]			✔	✔
Affidavit of Good Moral and Professional Character[44]	✔	✔	✔	✔	✔	✔[44]	✔	✔	✔
Letters of Recommendation (quantity indicated)			2		2		2	2	
ECFMG Certificate[44]	✔	✔	✔	✔	✔	✔	✔[44]	✔[45]	✔
Fifth Pathway Certificate						✔	✔[46]		✔
Test of Spoken English Scores							✔		
AMA Profile	✔		✔[47]			✔	✔		✔
National Practitioners Data Bank Report					✔				✔
Medical Society Membership (if applicable)			✔						
Military Service Release Form (if applicable)	✔		✔			✔			✔
Curriculum Vitae						✔			
Verification of Work History	✔			✔		✔			
Fingerprint Card		✔							✔
Education Related Elements									
Post Secondary Education Transcript		✔	✔	✔[48]		✔			✔
Post Secondary Education Diploma			✔[49]						
Medical School Transcript		✔	✔	✔	✔	✔[50]		✔	✔
Medical School Diploma	✔	✔[51]	✔	✔	✔	✔	✔		✔
Medical Education Verification Form	✔	✔		✔		✔			
Letter of Recommendation from MD School Dean					✔				✔[52]
Certificate of Eligibility for Licensure in Country of Graduation		✔[54]				✔[54]	✔		✔[54]
Exam Related Requirements									
Exam Scores Received From the Entity Administering the Exam[55]	✔	✔	✔	✔	✔	✔	✔	✔[56]	✔[56]
Jurisprudence Exam									✔
Oral Exam		✔							

Continued next page

Exhibit E-3: Data Elements and Documentation Required of USMG Applicants

Data Element[42]	*AZ*	*CA*	*FL*	*IL*	*LA*	*NJ*	*OH*	*TN*	*TX*
Medical Council of Canada Certificate of Standing (if applicable)							✔		
Training Related Elements									
Letter From Director of Post-Graduate Residency/Internship/Fellowship			✔		✔			✔	
Certificate of Completion of Post-Graduate Residency/Internship/Fellowship	✔[57]	✔	✔[58]	✔	✔	✔	✔	✔	✔
Certificate of Affiliation for Clinical Rotations		✔		✔		✔[59]			✔
Written Evaluation from Each Facility in Which Applicant Trained or Had Staff Privileges Within 10 Years									✔
Specialty Board Certification (if applicable)	✔		✔						✔
Additional Elements Necessary for Endorsement Applicants									
SPEX[10]	✔	✔	✔	✔	✔		✔	✔[11]	✔
Other State License Verification Forms	✔	✔[49]	✔[40]	✔	✔	✔	✔	✔	✔
Actual Licenses From Other States					✔				✔
Endorsement Form[41]					✔	✔			✔
Certification From State in Which Applicant is Licensed by Exam							✔		

Endnotes

1. Native born U.S. Citizens are exempt.
2. By request only.
3. Only applies to applicants who graduated from medical school after October 1, 1992.
4. Sixty credits.
5. Or one the Board deems as equivalent quality.
6. Will also accept predecessor FLEX Days I and II.
7. Only if the language of instruction of the medical school is other than English.
8. Necessary if the US medical school is not LCME accredited.
9. Only one year if applicant entered a training program prior to December 31, 1987.
10. Only required if it has been over ten years from the date of their FLEX or NBME exams.
11. Requires SPEX at Board discretion and for an applicant who is applying for an initial license and whose exams were taken over 5 years prior to application.
12. Florida has two categories of IMGs, those who attended foreign schools which are certified by the state and those who attended foreign schools not certified by the state. Students in the former category have the same requirements as USMGs. The requirements identified here are for those applicants from the latter category. A list of certified schools was not provided by the state but the criteria can be found in their regulation S. 458.314. Florida also has a special program for graduates of foreign medical schools located in a country in the Western Hemisphere with which the U.S. does not maintain diplomatic relations, another program for citizens of Nicaragua, and another program for resident nationals of Cuba.
13. Fifth Pathway Certificate or 36 months as a full time assistant professor in an approved school of medicine are acceptable substitutes.
14. Or a ECFMG Results letter for Fifth Pathway applicants.
15. Or a Fifth Pathway Certificate.
16. Exempt if the applicant is in a Fifth Pathway Program or if they have been practicing in the US for the 5 years immediately preceding the date of application.
17. Requirement waived if applicant graduates from an approved foreign medical school prior to December 31, 1987 and was licensed in another U.S. jurisdiction prior to January 1, 1988.
18. Sixty semester hours.
19. Sixty semester hours.

20. And a school not affirmatively disapproved by the Board.
21. A medical school whose curriculum is judged to be acceptable by the Board. Criteria provided in Rule 0880-2-.04(3)
22. Waived for Fifth Pathway applicants.
23. Only one year if the applicant entered a training program prior to December 31, 1987.
24. Only one year if the applicant graduated before July 1, 1985.
25. An LCME approved program.
26. All copied documents must be notarized and all documents in a language other than English must have a literal translation.
27. All applications contained an affidavit to be signed and all applications must be notarized.
28. Application indicates one photo is required while Florida Administrative Code 59R-4.009(2) indicates that two photos are required.
29. Required of anyone whose name is not the same name as the name on the diploma received from the medical school.
30. Through documents such as a birth certificate, naturalization papers, or current visa status.
31. These documents required as evidence of name and date of birth. Certificate of Naturalization must be an original, other documents can be photocopies.
32. Exempt if applicant is a native born U.S. Citizen.
33. Actual questions in the affidavit vary from state to state but typically ask the applicant to identify whether or not they have ever been convicted of any crime, been denied a license or had hospital privileges revoked, been involved in a malpractice suit or Medicare fraud, or have any ailments or other conditions which could interfere with their practice of medicine. Any question which the applicant answers "yes" to must be accompanied by a notarized explanation and copies of any applicable court documents.
34. Including Malpractice Certification and Medical Conduct Reform Act Form.
35. Score requests to the National Board of Medical Examiners for a Certificate of Endorsement of the scores and to the Federation of State Medical Boards for an examination and Board Action History Report. The USMLE recommends that states accept certain combinations of exam scores. The recommended combinations can be found in Table 4.
36. If the applicant does not need to request scores from the FSMB, they must submit an FSMB Board Action Data Inquiry Form.
37. Only required if the applicant applies more than five years after the issuance of a medical school diploma or National Board certificate.
38. Or a letter from the Director of the post graduate residency/internship/fellowship.
39. Letter of good standing.
40. In addition to the receipt of the verification from the state, a copy of each request for verification sent to a state is required to be submitted with the application.
41. A license verification form to be filled out by the state who's license the current state is being asked to endorse.
42. All documentation in languages other than English are to be accompanied with a literal, notarized translation.
43. Or ECFMG Results Letter for Fifth Pathway applicants.
44. Rather than producing the certificate, the applicant must forward an ECFMG Certificate Verification Form to the ECFMG which they must complete and return to the state.
45. Mexican Medical School graduates can substitute a letter from the ECFMG stating that all requirements are met.
46. Rather than producing the certificate, the applicant must forward Fifth Pathway Certificate Verification Form to the Director of their Fifth Pathway Program which they must complete and return to the state.
47. In addition to receipt of the AMA profile, a copy of the request for this profile is required to be submitted with the application.
48. Requirement waived if applicant graduated from an approved foreign medical school prior to December 31, 1987 and was licensed in another U.S. jurisdiction prior to January 1, 1988.
49. Only required of Fifth Pathway applicants.
50. Must be translated by one of the twelve identified translation agencies.
51. Report of junior and senior year clinical rotation plus Certificate of Clinical Training
52. Deans Certificate Form.
53. Actual license required for foreign national educated in their own country. In California, requirement is waived for endorsement applicants.
54. Waived for Fifth Pathway applicants.
55. Score requests to the National Board of Medical Examiners for a Certificate of Endorsement of the scores and to the Federation of State Medical Boards for an Examination and Board Action History Report. The USMLE recommends that states accept certain combinations of exam scores. The recommended combinations can be found in Table 4.
56. If the applicant does not request scores from the FSMB they must submit an FSMB Board Action Data Inquiry Form.
57. Or a letter from the Director of the Training Program.
5.8 A certificate of completion must be presented for each of the three years of training.
59. Includes official evaluation from supervisor on each rotation. Only required of applicants whose clinical rotations were at sites geographically distant from the medical school.

Appendix F–
A Review of the Literature Regarding the Licensing of International and Domestic Medical Graduates

OVERVIEW OF THE PROBLEM

Medical licensure in the United States is currently and historically reserved to the States. Although State laws and regulations have begun to converge on common standards, States continue to reserve the right to define and promulgate the specific rules by which physicians are licensed within their jurisdictions. States assert this authority on the basis that their citizens need to be protected adequately from the improper, unprofessional, incompetent, and unlawful practice of medicine (Federation of State Medical Boards, 1991).

Many graduates of medical schools outside the United States and Canada have come to believe that the approach taken within the United States to license physicians discriminates unfairly and to no productive purpose against graduates of international medical schools. A study by the Government Accounting Office (GAO) in 1990 found that State medical licensing boards employed different examination and experience requirements for international medical graduates (IMGs)—candidates who graduate from medical schools outside the United States and Canada. In addition, the study found that, although the educational requirements for IMGs were the same as those for domestic medical graduates (DMGs), it was more difficult for IMGs to obtain the necessary documentation. In response, the U.S. Congress has mandated the Department of Health and Human Services (DHHS), in Public Law 102-408, to *"review the policies and practices of the States (including any relevant laws) in licensing international medical graduates and in licensing domestic medical graduates, and determine the effects of the policies."*

This paper reviews the existing literature on the licensure of physicians and the differences between licensure of IMGs and DMGs. First, a brief history of State medical licensing boards and an overview of the trends in the influx of IMGs are presented. Second, the role of the Educational Commission for Foreign Medical Graduates (ECFMG) in the licensure of IMGs is examined. The ECFMG is especially relevant to the inquiry because it performs a valued service in certifying documents and medical knowledge held by IMGs. Third, using the "three pillars" of medical licensure identified in the 1990 GAO study—education, examination, and experience—the paper outlines the differences that still exist in State policies and advances that have been made in recent years. Finally, additional requirements for IMGs are presented.

HISTORY OF STATE MEDICAL LICENSING BOARDS AND TRENDS IN THE INFLUX OF IMGS

Today, the United States has one of the most advanced medical education systems in the world. But, medical education in the United States has not always been as highly regarded as it is today. State medical licensing boards played a large role in bringing about the medical education reform that is formalized in Abraham Flexner's 1910 report, *Medical Education in the United States and Canada.*

Between 1830 and 1870, there was virtually no legal control of licensure in any State, which created chaos in the medical profession (Hudson, 1985). Some States accepted a diploma as a license, promoting the development of for-profit diploma mills where medical degrees were bought and sold (Numbers and Warner, 1985). The extreme in lax State control of medical practice occurred in 1838 when Maryland made it legal for *"any citizen of that State to charge and be paid for medical service"* regardless of their education or experience (Hudson, 1985). In 1848, Nathanial Chapman, President of the AMA, lamented, *"The profession to which we belong...has become corrupt and degenerate"* (Numbers, 1985). In 1850, another observer commented, *"Anyone, male or female, learned or ignorant, an honest man or a knave, can assume the name of a physician, and 'practice' upon any one, to cure or to kill...without accountability"* (Numbers, 1985). Medical education in the United States deteriorated to the point that Americans in search of quality medical training traveled to Europe to study. As a result, many of the most respected U.S. physicians were IMGs including William Olser, William Welch, and George Rosen (Husain, 1994).

The confusion and lawlessness between 1830-1870 convinced lawmakers that State regulations were proper and necessary. States began writing and enforcing licensure laws that mandated certain minimum levels of education and experience. By the turn of the 20th century, every State had some sort of medical

licensure procedure that dealt with three primary issues: education, examination, and experience. These requirements, mandated by the licensing boards, forced educational institutions to develop stringent curricula and to institute rigorous internal and external evaluation mechanisms to ensure that their students would be able to meet the licensure requirements. In 1895, the Journal of the American Medical Association asserted that *"medical legislation alone...[has done] more in destroying the dangerous work of the low grade college than all other factors combined"* (Numbers, 1985). In 1910, the reforms in American medical education, which the licensing boards catalyzed, were formalized in the Flexner Report, which outlined the foundation for the high-quality medical education system that the United States has today.

In the mid-1960s, a number of things happened at the national and Federal levels that dramatically increased the number of IMGs entering the United States to practice and altered the international composition of the IMG community. First, amendments made to the Immigration and Naturalization Act in 1965 terminated the national origins quota system. Second, the Medicare and Medicaid legislation opened employment opportunities for physicians and increased the country's demand for doctors. Third, preferential immigration status was given to professions which were perceived to have nationwide shortages including the medical profession (AAMC Task Force Report, 1974; Aronson, 1994). As a result, there was a rapid increase in the number of physicians, who had attended international medical schools, entering the United States to practice. By 1972, 46 percent of all initial licenses were granted to IMGs; in 1972, more physicians entered the United States as IMGs than were graduated by U.S. medical schools (AAMC Task Force Report, 1974). Since then, the number of IMGs applying for licenses has declined and, over the past 10 years, IMGs have received roughly 20 percent of the licenses granted (Bidese, 1994).

In addition to the increase in the number of IMGs, these legislative changes created a major shift in the nationality of physicians coming to the United States as they facilitated the immigration of physicians from Asian and other developing countries. In 1963, almost 50 percent of IMGs came from Europe and Canada and 12 percent came from Asia; by 1972 only 19 percent came from Europe and Canada and 70 percent of IMGs were from Asia[1] (AAMC Task Force Report, 1974). Currently, the overwhelming majority of IMGs received their medical degrees in India, Pakistan, and the Philippines and are nationals of these countries (ECFMG, 1993).

[1] Although graduates of Canadian medical schools are categorized as IMGs in the 1974 AAMC Task Force Report, they are no longer considered international medical graduates.

Like most legislation, licensing laws are modified or amended in response to the social concerns of the times (Osteen, 1991). Therefore, State medical licensing boards can become reactive to situations that arise in their State and that are publicized in the media. Constant amendments over the years have created what is an extremely complex licensure process. Not only is each State's process intricate but, since each State has developed its licensure laws independently, considerable variety in requirements exists currently among States.

Most State licensure legislation defines the practice of medicine as a privilege, not the natural right of individuals, and defines the primary responsibility of the State medical board to be protection of the public (Federation of State Medical Boards, 1991). With this legislative mandate to protect the public, State boards are hesitant to relinquish control over the licensure process, despite the duplication that has been created in the processes used by State boards in licensing physicians who already may be licensed to practice in another U.S. jurisdiction.

THE ROLE OF THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

The Educational Commission for Foreign Medical Graduates (ECFMG) was established in 1956 by the Association of American Medical Colleges (AAMC), the American Hospital Association (AHA), the American Medical Association (AMA), and the Federation of State Medical Boards (FSMB) to assess the readiness of IMGs to enter accredited American residency programs (ECFMG, 1993). The ECFMG certification process is composed of medical education requirements, including a credentials verification component, and exam requirements in the medical sciences and English proficiency. ECFMG certification is a requirement of the Accreditation Council for Graduate Medical Education to enter accredited residency programs and is a prerequisite to licensure for IMGs in 52 of the 54 U.S. licensing jurisdictions (Bidese, 1994). Meeting the ECFMG examination requirements for certification is also a prerequisite for participation in the National Residency Matching Program (Patterson, 1987).

ECFMG Criteria for Certification

Minimum education requirements for ECFMG certification include the following:

1) Completion of 4 credit years in attendance at a medical school listed (at the time of graduation) in the World Health Organization's *World Directory of Medical Schools;*

2) Successful completion of the full medical curriculum prescribed by the medical school and by the country in which it is located (ECFMG verifies the medical school diploma directly with the medical school);

3) Fulfillment of all educational requirements to practice medicine in the country in which the degree was issued; and

4) If a national of the country concerned, possession of an unrestricted license or certificate of registration to practice in that country (ECFMG, 1993).

The examination requirements for ECFMG certification are successful passage of a medical science exam and the ECFMG English test. The ECFMG English test is designed to assess the candidate's proficiency in the comprehension and use of the English language (ECFMG, 1993). An ECFMG certificate is valid for 2 years, based on the date of passing performance on the English test. The Test of English as a Foreign Language (TOEFL)[2] or the ECFMG English test can be used to revalidate expired scores. Once the IMG is admitted into a residency program, the ECFMG certificate is valid indefinitely (ECFMG, 1993).

Currently, the United States Medical Licensing Examination (USMLE) Step 1 and Step 2[3] are the only exams being administered to satisfy the medical science exam requirement. Passage of these exams also qualifies the candidate for a J-1 Visa which is required for the physician to perform medical services and receive graduate medical education in the United States. This single certifying examination replaces a set of other exams used in the past by ECFMG and the National Board of Medical Examiners (NBME). Past tests included

- One-day ECFMG medicine examination[4];
- Two-day Visa Qualifying Exam (VQE);
- Part I and Part II of the National Board of Medical Examiners (NBME);
- Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS);
- Three-day Federation Licensing Exam administered prior to June 1985 (the old FLEX).[4]

These are no longer being administered, but passing scores previously obtained on any of these exams will satisfy the medical science requirement for ECFMG certification. The FLEX exam introduced in June 1985 does not satisfy the ECFMG medical science exam requirement because it has different design specifications and is not derived from the NBME Part I and Part II pool of test items (Bidese, 1994).

The ECFMG does not test currently for clinical competence among IMG candidates applying for certification. With the increasing amount of direct care that residents are providing in hospitals, clinical competency among IMGs entering residency programs is becoming a larger issue. The ECFMG has developed and pilot tested the use of standardized patients as part of a clinical assessment process to meet this need. The studies to date indicate that the use of standardized patients to assess clinical performance is reliable and valid (Sutnick et al, 1993). The ECFMG is planning to introduce this assessment of clinical competence into its certification process in the near future.

To accommodate the many U.S. nationals who have obtained their medical training outside the United States, a program—The Fifth Pathway—was developed by the American Medical Association. The program is a 1-year intensive clinical clerkship designed to enhance and validate the clinical skills of these graduates prior to their entry into U.S. graduate medical training. A Fifth Pathway certificate qualifies a candidate to enter a U.S. residency program (Pace, 1991). Forty-four States will accept the Fifth Pathway certificate as a substitute for an ECFMG certificate and will allow the candidate to apply for licensure.

Implications for Licensure

As previously stated, 52 licensing jurisdictions require ECFMG certification from IMG licensure candidates. Therefore, the ECFMG plays an important role in the licensing of IMGs. ECFMG certification provides a licensing board with the knowledge that the candidate has been assessed by an independent evaluator and has passed the minimum education and exam standards required to enter a U.S. residency program. And, as a part of that assessment, certain educational credentials have been verified.

Licensing boards require an ECFMG certificate; however, most licensing boards continue to carry out their own credentials verification efforts and, until the implementation of the USMLE in 1994, had tested applicants again for medical knowledge.

For example, the FMGEMS exam—the primary exam administered for ECFMG certification until 1994—does not satisfy the exam requirement for licensure in any State. Therefore, the physician would have to take another exam before he or she could be licensed. In addition, most States conduct their own

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[2] The TOEFL is administered by Educational Testing Service.

[3] Step 1 tests for knowledge and understanding of key concepts of basic biomedical science and Step 2 tests for the ability to apply knowledge that is considered essential for supervised patient care. For more information on the USMLE, please see the Examination Requirements section of this paper.

[4] ECFMG exam and the old FLEX exam cannot be used to obtain a J-1 visa.

credentials verification for each licensure candidate regardless of whether the ECFMG or another State has already verified the credentials. The root of this type of duplication of effort is the State legislative requirement that each licensing board is mandated to protect its constituents through ensuring certain standards are met. State boards do not believe they have the authority to delegate these verification responsibilities to the ECFMG or to any other State.

Education Requirements

"The general purposes of education requirements are to confirm that a physician has a medical degree and to assess the quality of the education and training provided by the medical school." (Government Accounting Office, 1990)

Although not every State has identical educational requirements, the 1990 GAO study found that the education requirements for IMGs and DMGs within a State were similar. For example, the education requirements in New Jersey are as follows:

1) Graduation from an approved 4-year academic high school;

2) Completion of 2 years or 60 credits of premedical collegiate education, including courses in chemistry, physics, and biology; and

3) Graduation from a 4-year medical education program in an American or foreign medical school in good standing in the opinion of the Board (Contee, 1987).

The fact that States employ educational requirements in addition to their tests implies that the examination requirements alone are not sufficient. The examination is viewed as only a snapshot of content knowledge in the medical and basic sciences; this knowledge does not preempt the need for successfully completing the course of premedical and medical education. The States recognize a value in the educational process, not simply the outcome. For example, New Jersey justifies its requirement of 2 years of premedical education on the grounds that it provides a socializing component which they believe to be important.

Although it has been found that the education requirements do not differ for IMGs and DMGs, the process through which the objectives of the requirement are met does differ. The purpose of the education requirement is two-fold. First, the States need to verify that a medical education and various other premedical educational experiences were completed successfully. Second, the States reserve the right to assess the quality of the education that the licensure candidate received.

U.S. medical schools have systems built into their institutions that assist State licensing authorities in obtaining the necessary documents and signatures. In addition, the formal accreditation of U.S. medical schools by an independent accrediting body ensures a minimum level of quality in medical programs. For the IMG, it is not as easy to meet these objectives.

First, it is difficult for a State medical board to assess the quality of medical education in foreign medical schools because there is often no accrediting process or body comparable to those used within the U.S. and Canada. Second, it is more difficult for IMGs to obtain the necessary documentation.

Accreditation

U.S. medical schools are accredited by the Liaison Committee on Medical Education (LCME). The LCME defines its primary responsibility as "to attest to the educational quality of accredited programs" (AAMC and AMA, 1993). The LCME, working cooperatively with the Committee on Accreditation of Canadian Medical Schools, has established a collaborative system to accredit U.S. and Canadian medical schools using one standard. Therefore, State licensing boards can be assured of a minimum standard of education from licensure candidates who graduate from accredited schools in the United States and Canada.

Many foreign countries do not have equivalent accrediting committees. In 1980, a GAO report recommended the accreditation of international medical schools as a means to ensure that the medical knowledge and skills of IMGs were comparable to those of DMGs (Government Accounting Office, 1985). In 1984, the FSMB attempted to apply standards similar to those used by the LCME to assess international medical schools. The FSMB's attempt to serve as an accrediting body for international medical schools failed because the international schools refused to cooperate by filling out the questionnaires (Patterson, 1987). In the 1990 study, GAO asserted that it was infeasible for the United States to establish an international accrediting body because "many foreign medical schools and/or countries have little interest in establishing standards to meet those of U.S. schools, considering they have their own objectives for medical education" (Government Accounting Office, 1990).

The minimum requirement now employed is that the international medical school be listed in the World Health Organization's World Directory of Medical Schools. This directory lists schools which are recognized by the government in which the school is located, as operating legally. This WHO listing is not an accreditation and does not attest to the quality of training at any of the institutions listed. Nonetheless, this minimum standard is required by most State boards and the ECFMG and Fifth Pathway Program in order to receive the respective certification.

Documentation

The 1990 GAO study found that it was more difficult for IMGs to obtain the documentation needed for licensure. This is partly because many States have additional documentation requirements for IMGs. The documentation requirements for IMGs are based on the standards used by the LCME to accredit United States and Canadian medical schools. They are employed in part to overcome the absence of a formal accrediting process that could certify the quality of medical education in medical schools outside the United States and Canada. Additional requirements include curriculum vitae of faculty and clinical supervisors, descriptions of the school and its library, and certifications by the dean, all of which must be sent as original documents by the primary source (Olsen, 1989). The officials of the State boards studied by GAO indicate that differences in documentation requirements for IMGs are due to the lack of an accrediting organization for international medical schools[5] (GAO, 1990).

Reasons for the difficulty in obtaining these documents include the unreliability of international mail, faculty or deans who have left the university, and the inability to obtain responses from schools in countries that do not have diplomatic relations with the United States (Osteen, 1991 and Government Accounting Office, 1990). In addition, some IMGs come to the United States many years after they complete their education, which makes it difficult for them to obtain documents and for staff at the medical school to compare pictures taken as long as 20-30 years apart to verify the identity of an applicant. At a minimum, these problems result in delay and, at a maximum, can make verification impossible.

National Credentials Verification System

The 1990 GAO study found agreement during their round-table discussion[6] that a central clearinghouse that would verify and maintain information on educational backgrounds and credentials of licensure applicants would be beneficial. In response to this need and in recognition of the AMA's research and field testing of a credentials verification service, Section 307 of Public Law 102-408 mandated the Department of Health and Human Services to obtain advice regarding the operation of the American Medical Association's National Physician Credentials Verification Service® (AMA/NCVS®) and determine whether the system has expedited and improved the efficiency and equity of endorsement licensure. In 1991, the AMA opened the AMA/NCVS®, which served as a national repository for medical credentials for both IMGs and DMGs, to assist the physician as he or she went through the licensure process and to assist the State licensing boards by facilitating the credentials verification process.

The AMA/NCVS® collected and verified information on, among other items, undergraduate/non-medical graduate education, medical education, clerkship, Fifth Pathway certification, ECFMG certification, graduate medical education, licensure, and specialty board certification. During the 3 years of its operation, the AMA/NCVS® acquired 1,500 physician subscribers. Proportionately, IMGs took greater advantage of the service than did DMGs. IMGs constituted 38% of the AMA/NCVS® subscribers but only constitute an estimated 20% of the licensed physicians in the U.S. (AMA, 1994).

The AMA decided in 1994 to cease operation of the AMA/NCVS®. The decision to phase out the AMA/NCVS® was based on an independent AMA evaluation of the system which concluded that the system was not cost effective. The evaluation determined that use of the resources to maintain a high-quality service that met subscriber needs was not cost effective. This was because of low subscription rates and the excess of actual AMA system maintenance labor costs over reasonable fees chargeable for the Service (AMA, 1994).

With the departure of the AMA from the credentials verification business, the need identified in the findings of 1990 GAO Report continues to exist.

Examination Requirements

"Examination standards require the successful completion of standardized exams and may include oral and/or special-purpose exams" (Government Accounting Office, 1990).

The 1990 GAO study found that the examination requirements for IMGs and DMGs were different. At the time of the 1990 GAO study, States licensed candidates based on scores from the NBME or the FLEX exam. DMGs have had the choice of taking either examination while IMGs were only eligible to take the FLEX. To further complicate the issue, the FLEX administered in 1990 (the new FLEX) did not satisfy the ECFMG exam requirements, resulting in the IMG having to take one exam for ECFMG certification and the FLEX for licensure (Bidese, 1994). Also, most States will accept only FLEX scores that have been

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[5] The States studied were California, Florida, New York, Ohio, Texas, and Virginia.

[6] The following organizations were represented at the GAO round-table discussion: Administrators in Medicine, American Medical Association, Association of American Medical Colleges, Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, International Association of American Physicians, National Board of Medical Examiners, New York State Board of Medicine, and U.S. Department of Health and Human Services.

received in a single sitting. In contrast, the NBME was administered incrementally during a student's education. This gave an advantage to the physician from a U.S. school who was able to take portions of the exam during different points of his/her education over an IMG who might come to the United States 10 years after the completion of their education and be required to take a 3-day exam in a single sitting.

In response to the demand for a common evaluation system for all medical licensure applicants, the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME) developed the United States Medical Licensure Examination (USMLE), which is accepted by all 54 licensing jurisdictions to fulfill the examination requirement.

The USMLE was phased in from 1992 to 1994 and is currently the only exam offered for licensure in the United States. The USMLE consists of three Steps, each of which is a 2-day multiple-choice exam. Step 1 tests for knowledge and understanding of key concepts of basic biomedical science. Step 2 tests for the ability to apply medical knowledge considered essential for supervised patient care. Step 3 tests for the ability to apply medical knowledge considered essential for the unsupervised practice of medicine (Bidese, 1994).

The USMLE program recommends that States: (1) set a limit on the length of time it takes a candidate to complete the three Steps, (2) set a limit on the number of attempts allowed to pass a Step, and (3) set an eligibility requirement for Step 3 of the completion, or near completion, of 1 year of postgraduate training (Bidese, 1994). States are currently in the process of making these decisions and the FSMB is collecting their requirements for publication in *Exchange*, a publication of the FSMB. The FSMB anticipates this issue to be ready for dissemination by January 1, 1995. Although the implementation of a single medical licensure exam simplifies some aspects of the licensure process, the definition of requirements regarding the use of USMLE scores opens the door for variety among State policies that will affect endorsement applicants in the future.

These inconsistencies in exam requirements among States represents another source of frustration in the IMG community (Osteen, 1991). For example, inconsistencies are found in the number of years a State will consider test scores valid and the number of sittings in which the FLEX can be taken. In his paper "Licensing and International Medical Graduates," Arthur Osteen (1991) presented the following example:

> *An IMG who is licensed in State A, based on FLEX scores achieved in 1978 and 1979, subsequently applies for a license in State B, which requires that the passing score on the FLEX be achieved at a single sitting. The physician does not see this as a reasonable difference in State laws, but as an example of discrimination against IMGs. In defense of his position, he points out that the great majority of US physicians are licensed through the National Board, which is taken on three different occasions. He is not convinced by the promise that the problem will not occur for future IMGs who will be licensed through the USMLE. He wants help now.*

The physician in Dr. Osteen's example would have used his 1978-79 FLEX score to qualify for both ECFMG certification and licensure. The example could become even more exasperating if the candidate applied for ECFMG certification in 1987 (when the FLEX administered at the time was not acceptable for ECFMG certification), had taken the FMGEMS to qualify for the certification, had taken the FLEX in two sittings to obtain a license in State A, and was now being required by State B to take the FLEX again.

The implementation of the USMLE will rectify this problem for IMGs who have not yet taken an exam. But, these problems will continue to exist for IMGs who were ECFMG certified based on exams taken prior to the availability of the USMLE.

Data provided in the ECFMG 1992 Annual Report on the number of certificates issued can help to provide insight into the number of physicians who will not benefit from the USMLE.[7] Exhibit 1 summarizes some of the data provided in the Annual Report. The following assessment of the number of physicians that might be affected is based on two assumptions—(1)that the trends found in this data will continue and (2)that IMGs seeking ECFMG certification will also seek licensure in the United States:

- As of 1992, there were 162,515 physicians who are ECFMG certified based on exams other than the USMLE; Assuming that the majority of these physicians are still in practice, over 150,000 physicians would encounter a situation similar to that in the example were they to apply for endorsement licensure.
- Only 87% of ECFMG applicants receive their certification within 3 years of sitting for their exams; therefore, not until 1997 can we be assured

[7] The examination data was broken out by the type of exam administered and the date of the administration.

Exhibit 1: The number of ECFMG certificates issued from 1988-1991, based on the year of sitting for the exam that satisfied their examination requirement.

	1988	*1989*	*1990*	*1991*
Total number of certificates issued	4,061	4,092	4,710	4,535
Number of certificates granted based on exams taken within 3 years of certification	3,413 (84%)	3,483 (85%)	4,233 (90%)	4,089 (90%)
Number of certificates granted based on exams taken over 10 years prior to the certification date.	154 (4%)	165 (4%)	122 (3%)	143 (3%)

Exhibit 2: Number of years of accredited graduate medical training required of IMGs and DMGs for licensure.

	Number of States That Have This Requirement for DMGs	*Number of States That Have This Requirement for IMGs*
1 year of graduate training	42	12
2 years of graduate training	10	13
3 years of graduate training	2	29

that even 87% of IMGs are receiving ECFMG certification and initial licenses based on USMLE scores.

- Four percent of IMGs receive ECFMG certificates based on exam scores that are over 10 years old (in 1992, 141 IMGs were certified based on scores that were received over 18 years ago); therefore, in the year 2004, 4% of IMGs applying for ECFMG certification, and presumably licensure following certification, might be using non-USMLE test scores to fulfill the examination requirements.

EXPERIENCE REQUIREMENTS

"Experience standards require postgraduate (residency) training at an accredited U.S. or Canadian institution and may involve a review of the physician's character and practice history." (Government Accounting Office, 1990)

The 1990 GAO study found that experience requirements for IMGs and DMGs differed. In 1990, over 30 State medical licensing boards required more years of graduate medical education for IMGs. In 1992, 34 States required more years of training for IMGs (Bidese, 1994).

All States require graduate training before they will issue a license to a physician. As Exhibit 2 illustrates, 42 States require 1 year of training, 10 States require 2 years of training, and 2 States require 3 years of training for DMGs. For IMGs, 12 States require 1 year of training, 13 States require 2 years, and 29 require 3 years of accredited graduate medical training (Bidese, 1994).

New Jersey is one State that requires 3 years of postgraduate medical training for IMGs and only 1 year for DMGs. They cite as their rationale that residency programs seldom disseminate objective feedback regarding the performance of a licensure candidate. Thus, they may report the "successful" completion of all or part of a residency training requirement on the part of a candidate who was actually regarded as a poor performer. In order to prevent such problems New Jersey, increased the experience requirement to 3 years (Patterson, 1987).

Layton Olsen is an attorney who has done research and written reports on this issue for The American College of International Physicians, Liberty for American Minority Physicians, Inc., and the International Association of American Physicians. He argues that there is no justifiable reason for requiring an IMG to

complete more years of graduate training. Olsen contends that this, as well as the other differences cited in the 1990 GAO report, constitutes "conscious or unconscious discrimination (based on 'foreignness,' and the 'non-Anglo European' background of minority physicians who have established their practices in the past two generations) rather than differences needed to determine medical competence... Discrimination arises from the existence of 'separate' and parallel licensing laws for US and internationally trained physicians" (Olsen, 1989).

In addition to the effects on initial licensure applicants, these varying experience requirements for IMGs and DMGs can create difficulties for physicians applying for endorsement licensure. This primarily effects older physicians who legally obtained licenses with little or no graduate education and who, despite demonstrated competence as medical practitioners, might be unable to get a license in another State.

Although the New Jersey example cited above may be unusual, all examples of poor performance by a certified physician can become amplified, leading to a call for greater State control over certification. State boards argue that these regulations help to protect the public and that is their job. IMGs argue that the regulations should be enforced on all physicians, regardless of where they attended medical school.

ADDITIONAL REQUIREMENTS FOR IMGS

The following additional requirements are made of IMGs applying for endorsement licensure:

- Twenty-five States require that the international medical school must be State approved;
- Twenty-one States require that IMGs must have an interview. Of these, two States indicate that it will be a full board interview, one State indicates that two interviews are necessary, and one State indicates that the interview can be substituted by an oral exam;
- Twelve States indicate that the IMG might be required to interview;
- Four States require that IMGs take an oral exam and one State indicates that an IMG might be required to take an oral exam
- Three States require that an IMG take the SPEX exam; and
- One State requires that IMGs participate in an orientation (Bidese, 1994).

Many in the IMG community believe that there is no reasonable justification for imposing additional requirements on a licensure candidate simply because he/she attended a medical school outside the United States and Canada. Imposition of these additional requirements is perceived as discrimination against IMGs. Some leaders in the IMG community believe that this discrimination is rooted in prejudice and based on myths about the international community and IMGs.

Dr. Alexander, president of the American College of International Physicians, argues that *"the origin of discriminatory and unflattering myths associated with foreign medical graduates seems to coincide with the large-scale immigration from the non-white, so-called Third World nations, starting with the 1965 amendments to The Immigration and Naturalization Act. ...Some of those myths have a certain connection not with legitimate concerns about the quality of medical education abroad, but with certain negative stereotypes about the quality of that education when it is obtained in a poor, non-white country"* (Gupta, 1991).

Ajit Varki argues that injustices can be visited on IMG physicians simply from categorizing physicians on the basis of the origin of their medical education. Varki States that the IMG community is a heterogenous group, "with widely differing origins, backgrounds, training, and capabilities," a group from which generalizations cannot legitimately be made. He continues, ". . . the modern physician-scientist insists that valid clinical studies should compare relatively homogenous groups ... with a minimum number of confounding variables... Can we then justify continuing to publish "scientific" studies comparing graduates of U.S. medical schools with an impossibly complex and heterogeneous group called 'FMGs'?" (Varki, 1992). Varki and others argue that, when generalizations are drawn from data collected on the basis of inappropriate groupings, it reinforces a prejudice against IMGs. For example, the quality of medical education internationally varies tremendously, but when taken on average, the quality is lower than that in the United States. The publication of these results reinforce prejudice by implying that all IMGs received an inferior education. Varki would argue that the additional requirements imposed on IMGs are a symptom of the prejudice that the use of the term "IMG" produces. Rather than judging a physician's competency on the origin of their education, physicians should be evaluated "on the strengths of his or her own background, training, abilities, accomplishments, and track record" (Varki, 1992).

CONCLUSIONS

The 1990 GAO study found that IMGs and DMGs were asked to fulfill different examination and experience requirements for medical licensure. The study also identified that it is more difficult for IMGs to obtain the educational documentation necessary for licensure.

Since 1990, improvements have been made regarding the equity of requirements for IMGs and DMGs. The implementation of the USMLE eliminates all differences in examination requirements for future candidates. The fact that USMLE scores satisfy both ECFMG exam requirements and licensure requirements reduces repetition in exam taking for IMGs and expedites their licensure. The AMA/NCVS®'s attempted to expedite the credentials verification process for both IMGs and DMGs. Although this system is being terminated, lessons have been learned that can benefit organizations attempting to develop a similar system in the future.

Despite these significant advances, difficulties remain for international medical graduates. Endorsement policies are extremely complex and might be perceived as discriminatory. In addition, exam differences remain for IMGs who were licensed prior to the availability of the USMLE and apply for endorsement licensure. Continued dialogue among the IMG community, State boards, Federal government, and other organizations that are stakeholders in the licensing of physicians will hopefully hold some of the answers.

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Appendix G— Tennessee Explanation of Three-Year IMG Postgraduate Training Requirements

Tennessee requires one-year of postgraduate training for USMGs and three years for such training for IMGs. The State provided the following explanation for the difference:

1. American cultural norms, and the resulting behaviors, take a long time to learn.
2. American ethical norms, and the resulting appropriate behaviors, take a long time to learn.
3. The United States has a much higher level of technological development than other countries, even European countries. American medicine has a heavy dependence on technology in diagnosis and preventive medicine. It takes a long time to become accustomed to this.
4. Language barriers take time to overcome.
5. International education systems are structured so that there are nonuniform levels of education prior to the medical education. Not all international graduates have four years of college. The three years of training helps to balance any deficit in premedical education by providing time for acculturation and social stability.
6. International curricula have some major differences in some areas, for example, preventive medicine. The additional training time helps IMGs to learn American preventive medicine, etc.

Appendix H—Participants in COGME Medical Licensure Workgroup

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[1] Dr. Wilson served as a Workgroup member from September 1994 through May 1995. On June 1, 1995 Dr. Gary became the President, ECFMG and replaced Dr. Wilson in the Workgroup

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