

Licensure of Foreign Medical Graduates: An Historical Perspective

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Although it has been demonstrated elsewhere that the progressive liberalization of immigration policy has attracted large numbers of foreign medical graduates (FMGs) to the U.S. health care system (Stevens and Vermeulen, 1975), the current debate over FMGs has largely neglected the corresponding developments in state licensure policies as they have affected the entry of FMGs into this country's medical profession. It is essential to understand that the fluctuations in the nation's immigration policies and the response of the states through their licensure policies reflect broad historical pressures.

These pressures date back to the 1920s, when the world center for medical education shifted from Germany to the United States. At this time, many foreign physicians, despite the restrictive immigration quotas of the period, came to America seeking a higher level of training. These foreign physicians received official support in 1926 from both the Council on Medical Education and the American Medical Association, which opposed restrictions on FMGs desiring graduate medical education in this country. But this receptiveness diminished in the 1930s when the financial hardship of the Depression made American physicians resent the influx of foreign doctors. In 1938 the AMA House of Delegates passed a resolution declaring that U.S. citizenship should be required of all FMGs (Stevens and Vermeulen, 1975), and many state boards adopted this requirement in an attempt to limit the licensing of foreign physicians.

In contrast to these restrictive licensure policies of the states, the federal government began, after World War II, to implement a set of immigration policies favorable to foreigners seeking advanced education in this country. Before this time, an FMG who wished to stay in the U.S. for more than a brief visit could enter the country only as immigration quotas permitted. But, in 1948, the Smith-

Mundt Act extended the Fulbright exchange program to include FMGs and created the exchange visitor visa (J visa) to allow FMGs to remain in the U.S. until completion of their studies, thus providing a much more accessible alternative to immigration. This visa became FMGs' major vehicle for entry into the U.S., to the extent that, in the 1960s, approximately two-thirds of the FMG inflow consisted of exchange visitors. The recognition of physician shortages after the Second World War and the Korean War resulted in the further easing of U.S. immigration laws for FMGs. In 1965, Congress amended the Immigration Act by abolishing the quota system for countries, establishing ceilings on immigration which favored immigrants from the Eastern Hemisphere, and allowing preference to be given to professionals in occupations with manpower shortages in this country. Because a U.S. physician shortage was declared by the Department of Labor, the 1965 revision of the Immigration Act gave FMGs a distinct advantage over other potential immigrants.

The law was liberalized still further in 1970 by legislation which facilitated the conversion of exchange visas into immigrant visas. Previously, most exchange visitors who wished to alter their status had been required to leave the U.S. for two years before applying for immigrant status. This policy was changed to allow the prospective immigrant to remain in the U.S. during the conversion process if his application for an immigrant visa had been approved.¹ The number of FMGs taking advantage of this opportunity has grown significantly: in 1970, before the law took effect, 890 foreign physicians were approved for conversion, whereas by 1973, the number had increased to 4,140 (Stevens et al., 1975). The overall effect of these changes has been a dramatic flow of foreign medical graduates into this country over the past twenty years; since 1953, the number of FMGs in the U.S. has increased sixfold, and, at the present time, one out of every five physicians practicing in the U.S. was educated abroad (Stevens and Vermeulen, 1975).

Although these immigration policies have undoubtedly been

¹Exceptions to this policy were exchange visitors financed by their own governments or by the U.S. government, and those whose country of last permanent residence has declared a need for the exchange visitor's skills as indicated on the "skills list" prepared by the State Department.

viewed by the federal government as at least partial solutions to perceived physician shortages in the U.S., their success in that regard has largely been determined by state governments whose jurisdiction encompasses the crucial matter of licensure. At this point, it must be noted that in discussing the licensure policies of the states one is actually talking about two different sets of policies for each state: the first concerns full licensure, which allows the physician the full scope of independent medical practice; the second covers what we will refer to as "less-than-full" licensure which is the system of different licenses authorizing limited and/or temporary practice within the state. The relationship between these two licensure systems will be treated more fully later in this discussion, but it should be noted at this point that both the full and less-than-full licensure systems of the states have changed in response to the large influx of FMGs over the last few decades.

In 1935, ten states did not under any circumstances grant full licenses to graduates of foreign institutions. Through the next ten years this number declined steadily, leaving only Arkansas, Louisiana, and Nevada in 1962; in 1968, Louisiana began to license FMGs, followed by Arkansas and Nevada in 1971. During this time the states generally modified their full licensure systems by gradually eliminating requirements unrelated to the competency of physicians and by developing more uniform qualification standards for licensure. An even more obvious receptiveness to FMGs has manifested itself in the less-than-full licensure systems. The tremendous expansion of less-than-full licensure in the last two decades is at least partially attributable to the growing presence of FMGs in this country's health care system, a correlation which is strengthened by the fact that FMGs use less-than-full licenses to a much greater extent than USMGs do.

In this analysis of trends in the development of both full and less-than-full licensure systems during the last two decades, we have drawn on the following major sources of information: for the period between 1953 and 1973, data from *Medical Licensure Statistics*, published annually in *JAMA*, were used; data for 1974 and 1975 were taken from a report which was prepared for the Department of Health, Education, and Welfare entitled *State Policies on the Limited and Temporary Licensure of Foreign Medical Graduates*

(NTIS No. PB-253073).² For the purpose of establishing a basis for detecting changes in the full licensure system, we have dealt principally with the five basic requirements for full licensure and the policies regarding licensure endorsement that exist in the fifty states and the District of Columbia. These requirements concern citizenship and visa status, the basic science examination, postgraduate training, certification by the Educational Commission for Foreign Medical Graduates (ECFMG), and the Federation of State Medical Boards' Licensing Examination (FLEX). In the case of trends in less-than-full licensure, the only information consistently available in *JAMA* refers to the number and types of less-than-full licenses authorized by different states at different times. Because *JAMA* tables did not yield sufficient data to describe the changes in requirements for and durations of less-than-full licenses during the past two decades, an historical perspective could not be developed, and the presentation of these aspects of less-than-full licensure had to be limited to the information gathered in 1974 and 1975 from the medical boards.

Full Licensure of FMGs: 1953–1975

1. *Citizenship and Visa Status*

During the past two decades, the states have frequently altered their requirements concerning the citizenship and visa status of FMG applicants for full licensure. Although the fluctuation in state policies has been considerable, there has been a clear tendency among the states since the late 1960s to relax their citizenship and visa require-

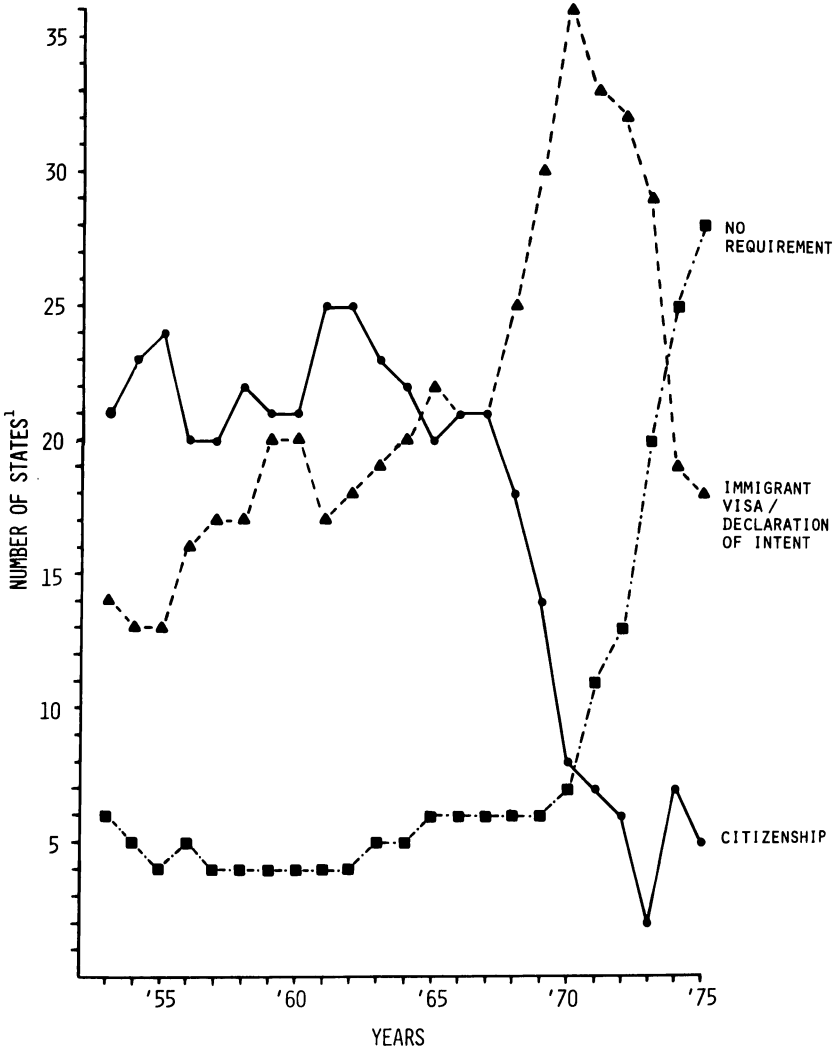
²The HEW report was based on three partially interrelated and overlapping surveys: the first was a comparative tabulation of statutes and rules and regulations in the fifty states and the District of Columbia; the second, a telephone survey of these fifty-one licensure boards, was a follow-up to the first survey to determine actual practice in the administration of the laws; and the third was a detailed on-site investigation of twelve states selected because of their varying dependencies on FMGs. A substantial number of discrepancies existed between the *JAMA* data and the findings compiled for the HEW report. In cases of disagreement, it was assumed that the information elicited directly from the licensure boards in the surveys was more accurate and the *JAMA* data were revised accordingly; unfortunately, nothing could be done to corroborate the *JAMA* data from 1953 to 1973. For a more comprehensive discussion of the *present* state of both the full and less-than-full licensure systems, see Butter (1976).

ments. Such requirements involve either an immigrant visa, a declaration of intent to become a citizen, or naturalized citizenship. The most stringent of these requirements is naturalized citizenship since the attainment of this status requires an immigrant visa and five years of U.S. residence; the requirement of the immigrant visa alone is obviously a less stringent prerequisite for licensure. Although the states report that they regard the declaration of intent as a more stringent requirement than the immigrant visa, it seems more realistic to treat these as essentially the same requirement, since anyone with an immigrant visa can easily file a declaration of intent with the Immigration and Naturalization Service, and the declaration itself has not even been required for citizenship since 1952.

The states' imposition of these requirements changed dramatically in the late 1960s, as Fig. 1 indicates. For every year between 1953 and 1968, at least twenty states required naturalized citizenship of FMGs seeking full licensure, while only a handful of states did not impose any citizenship-related requirements. During this time, a steadily increasing number of states adopted the requirement of the immigrant visa or the declaration of intent as a kind of middle ground between no requirement at all and the requirement of full citizenship. But in 1969 the number of states requiring naturalization of FMG candidates for full licensure dropped to sixteen and in 1970 dropped to ten. This sharp decrease continued; in 1975 only five states,³ Montana, New Hampshire, South Carolina, Wisconsin, and Wyoming, required that FMG applicants for full licensure become U.S. citizens.

Between 1967 and 1970 the number of states requiring the immigrant visa or declaration of intent rose dramatically, apparently in response to the concurrent decline in the number of states requiring citizenship. However, after reaching a peak of twenty-eight in 1970, the number of states electing this middle ground dropped sharply and has leveled off in the last few years at eighteen. But the

³This total includes Wisconsin which eliminated all citizenship and visa-related requirements for full licensure in June 1976. Ohio and California offer FMGs two paths to full licensure, two alternate sets of requirements, and in each state, one of these sets includes the requirement of full citizenship. However, these states were not counted among the states requiring citizenship for licensure since more FMGs in these states choose the other path, which couples a lesser visa-related requirement with increased postgraduate training.



¹States which did not grant licenses to FMGs in a given year were not included in the totals for that year.

FIG. 1. Citizenship and Visa Status Requirements for Full Licensure of FMGs, 1953–1975.

most significant change has occurred in the number of states which do not explicitly impose any visa or citizenship related requirement

upon foreign applicants for full licensure. Whereas no more than six states licensed FMGs regardless of citizenship status in any year between 1953 and 1970, since then this number has risen, at first gradually, and then very rapidly, to the present total of twenty-eight. In short, between 1953 and 1975, twenty-eight states lessened their citizenship-related requirements, while only two states increased them.

It is difficult to completely account for the pattern which emerges from these figures, that is, the tendency of the states since 1969 to drop the requirement of full citizenship, frequently by first substituting the less stringent requirement of the immigrant visa or declaration of intent, and then abolishing citizenship and visa requirements altogether. The rapid disappearance of the naturalization requirement can, to a large degree, be explained by recent legal decisions which affirm the equal protection of the laws under the Fourteenth Amendment, and which hold the requirement of citizenship for licensure as an unconstitutional denial of this right.⁴ It is likely that the increasing number of such court decisions also accounts for the decline in the number of states imposing any requirement related to citizenship or visa status. In any case, elimination of citizenship and visa requirements for licensure can be viewed as one aspect of the general tendency of the states to do away with requirements which bear little relation to the competency of physicians.

2. *Basic Science*

In the past twenty-two years, the number of states requiring FMGs seeking full licensure to pass a special basic science examination has decreased significantly, from seventeen in 1953 to seven in 1975. The tendency to eliminate the basic science requirement is further underscored by the fact that six of the seven states presently requiring a basic science examination will waive the requirement under

⁴Two recent opinions of the Office of the Attorney General in Michigan (OAG 1971-1972, No. 4755 and OAG 1972-1973, No. 4776) struck down the state's requirement of citizenship for licensure, citing US Const., AM XIV, § 1, and *In re Griffiths*, 406 US 966 (1973), *Graham v. Richardson*, 403 US 365 (1971), and *Truax v. Raich*, 239 US 33 (1915) among other cases.

certain circumstances. This development can be partially traced to the nearly universal adoption by the states of FLEX, which by administering its own basic science test has made another basic science examination superfluous. Indeed, three of the states still maintaining a basic science requirement will waive it if the candidate has passed the basic science portion of FLEX. The claim that FLEX has hastened the demise of the basic science requirement is further supported by the fact that the states have been dropping basic science at a faster rate since the advent of FLEX in 1968: thirteen states eliminated the requirement between 1968 and 1975, while only ten states had abolished it during the fifteen years prior to the introduction of FLEX.

The seven states⁵ still requiring the basic science examination are Arkansas, Colorado, Kansas, South Dakota, Tennessee, Texas, and Washington. The basic science substitutions currently available in these states include FLEX, academic background in the basic sciences and differing amounts of medical practice in this country.⁶ Only one state, Colorado, will not waive the examination under any circumstances. During the period under consideration, twenty-five states made no changes at all with respect to the basic science requirement, other than arranging for waivers. Four of these states (Colorado, South Dakota, Tennessee, and Washington) have consistently required a basic science examination, while twenty-one states have never had a basic science requirement during this period.

3. Postgraduate Training

The fact that an FMG has graduated from a foreign medical school recognized by the U.S. and has acquired basic medical skills does

⁵This total does not include Utah, which does not normally impose a basic science requirement, but which does examine physicians in the basic sciences if they are requesting Utah to endorse an out-of-state license based on a state board examination (not FLEX) taken within the last three years.

⁶Kansas, South Dakota, and Washington will waive the basic science exam for those FMGs who have passed FLEX; South Dakota, in addition to its FLEX substitution, will waive the examination for applicants who have practiced five years or more in the U.S. Arkansas allows ten years of U.S. practice to substitute for its basic science test; Texas will waive the requirement if the applicant's academic background shows sufficient strength in the basic sciences, and Tennessee does not impose the requirement upon FMGs seeking endorsement of out-of-state licenses if they have lived in the U.S. for two years.

not guarantee that he will function adequately within the American medical profession. Exposure to American medical procedures and technology, as well as an understanding of the various social and cultural patterns of American life, appears to be a further prerequisite for competent participation in the American health care system. In recognition of the fact that important preliminary experience is most commonly obtained through postgraduate training in American hospitals, a growing number of states have made postgraduate training a prerequisite for full licensure, and have stipulated that this training be pursued in AMA-approved programs.

This attitude represents a change of emphasis for the states. Up until the late 1950s it appears that more importance was attached to assessing the quality of the FMG's undergraduate medical background. Requirements for licensure aimed at assuring the quality of this background varied greatly from state to state and were not nearly so clear cut as the present requirement of participation in AMA-approved programs. Up until 1963, in an attempt to screen out unqualified FMGs, some state licensure boards imposed additional standards upon the qualifications of foreign physicians for licensure, such as the requirement in seven states that FMGs spend an additional year in an approved U.S. medical school after graduating from an approved foreign institution, or the stipulation in five states that the FMG's school of medical education be either equivalent to schools within these states or subject to board approval. In a similar vein, in 1950 the Council on Medical Education (CME) of the AMA and the Executive Council of the Association of American Medical Colleges (AAMC) began to compile a list of foreign schools which met with their approval, and, as of 1956, nineteen states had made graduation from a school on this list a prerequisite for the licensure of foreign physicians. The list was limited in a number of ways; chiefly, it was incomplete and contained a disproportionate number of European schools, therefore restricting the licensure of non-Europeans. During this period, several states also required National Board certification of FMGs seeking licensure; however, since graduates of foreign schools had been barred from taking the National Boards since 1952, this stipulation represented a thinly disguised means of excluding FMGs from licensure. Though these requirements may have reflected the understandable desire of the state boards to assure the competence of FMGs, they also

perpetuated the FMG-USMG dichotomy in licensure standards, and some of them actually excluded FMGs from full licensure altogether.

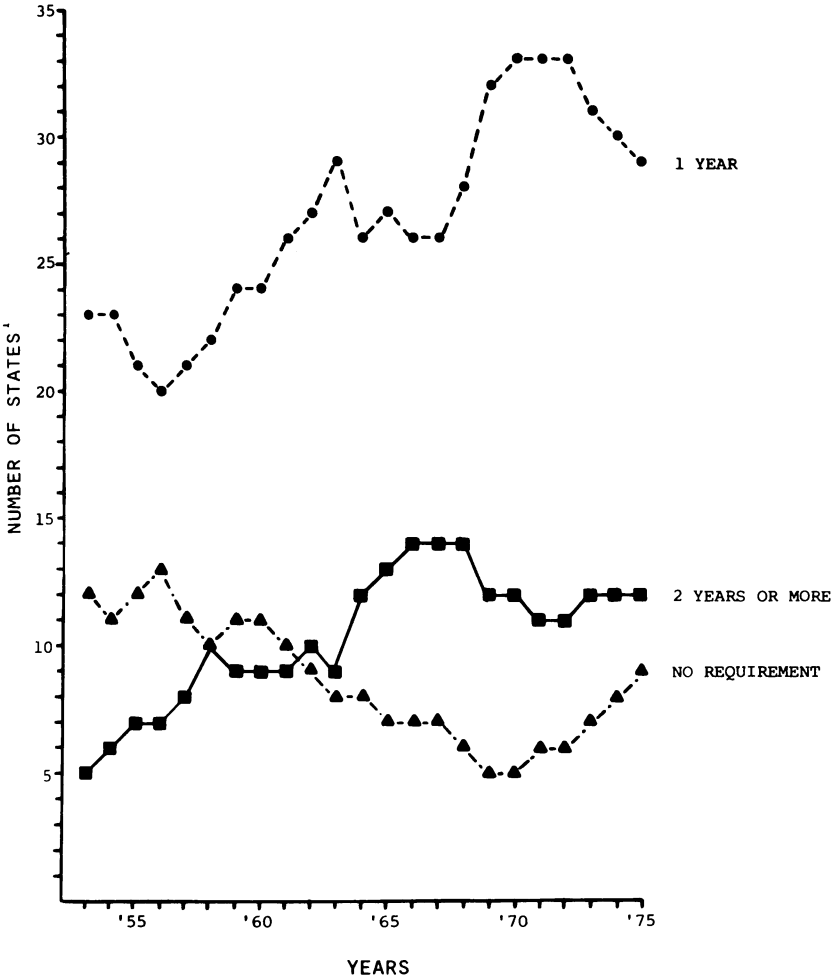
Accompanying the trend of the 1960s away from such idiosyncratic and exclusionary training requirements⁷ has been a modest increase in the amount of AMA-approved postgraduate training required by the states, as is shown in Fig. 2. Between 1953 and 1975, only four states decreased the amount of postgraduate training required of FMG applicants for full licensure, while twenty-five states maintained the same requirements throughout the period, and thirteen states increased their requirements. It must be noted, however, that because the postgraduate training of U.S. physicians has become lengthier and has emphasized specialty programs more than was the case in the early fifties, the moderate increase in the amount of postgraduate training required of FMGs may also reflect the generally increased emphasis upon specialization in the American medical profession.⁸ But, whatever the reason, these increases in postgraduate training requirements parallel the trend noted above toward more concrete, equitable, and organized measures for assuring the competence of foreign graduates and integrating them into this country's health care system.

4. ECFMG Certification

One of the earliest products of the trend toward more systematic review of FMG qualifications was the examination administered worldwide by the Educational Commission for Foreign Medical Graduates (ECFMG). Since its introduction in 1957, this examination has become the primary method for screening foreign applicants to U.S. postgraduate training programs, and is required for

⁷In 1975, Illinois and New York continued to use lists to determine the amount of postgraduate training to be required of FMGs from various countries. Illinois has been designated here as requiring one year of training of most FMGs while New York has been counted as a two-year state because it requires two years of postgraduate training of FMGs from most non-European countries.

⁸Along these lines, the AMA has recently recommended that two years of approved postgraduate training be required both of USMGs and FMGs who are seeking full licensure (see *American Medical News*, American Medical Association, December 8, 1975, p. 3).



¹States which did not grant licenses to FMGs in a given year were not included in the totals for that year. California's postgraduate training requirement involves a number of different options which made it impossible to include California in any one category; for this reason, California was not included in the totals for any year.

FIG. 2. Postgraduate Training Requirements for Full Licensure of FMGs, 1953-1975.

entrance into all training programs approved by the Liaison Committee on Graduate Medical Education of the American Medical Association. In replacing the list of foreign medical schools approved by the Council on Medical Education of the AMA and the Executive Council of the Association of American Medical Colleges, ECFMG has contributed greatly to the standardization of licensure requirements and has also made full licensure more acces-

sible to qualified FMGs throughout the country.

During the period between 1957 and 1975, a steadily increasing number of states adopted the requirement of ECFMG certification for full licensure (ECFMG certification is a two-part process consisting of approval of foreign credentials and a written examination). Within a year of its introduction, fifteen states had opted for ECFMG over the CME-AAMC list of approved foreign schools, while seven states continued to use the list alone, and ten more states required both ECFMG certification and graduation from an approved foreign institution. After 1958, *JAMA* tables no longer listed graduation from a CME-AAMC-approved foreign school as a separate requirement for full licensure. As of 1975, forty-six states required that FMG applicants for full licensure be certified by ECFMG; two of the states which do not explicitly require ECFMG certification for licensure do demand a specified amount of postgraduate training in an AMA-approved program, for which ECFMG certification is a universal prerequisite.⁹

In spite of the trend between 1957 and 1975 toward standardization of licensure requirements through the use of ECFMG, we have identified several instances in which the ECFMG examination may be circumvented. Of these, potentially the most significant substitution has been authorized by the Commission itself: in February 1972 it began certifying FMGs who had passed FLEX, even if they have not taken ECFMG's examination. As of this writing, few FMGs have actually taken advantage of this provision, but its potential effect is great, inasmuch as twelve states currently allow FMGs who have not taken ECFMG to sit for FLEX, and twenty-seven of those states which do require ECFMG certification as a prerequisite for FLEX will accept a FLEX score obtained in another state. In other words, an FMG could, conceivably, apply for licensure in a state requiring ECFMG, sit for FLEX in a state which does not demand ECFMG as a prerequisite, obtain ECFMG certification on the basis of a passing FLEX score, and receive a full license in the original state without having taken the ECFMG examination. But, although opportunities do exist to circumvent ECFMG, it must be pointed out that such substitutions do not grant

⁹California, Connecticut, Illinois, Indiana, and Tennessee do not explicitly require ECFMG for full licensure; however, Illinois and Indiana do require AMA-approved postgraduate training. California requires its own special oral clinical examination instead of ECFMG.

easier access to licensure (since FLEX is by no means less difficult than ECFMG), and ECFMG, as a prerequisite to FLEX and AMA-approved postgraduate training, as well as a licensure requirement in its own right, remains the principal means of channeling foreign medical graduates into the American health care system.

5. *FLEX*

The nearly universal adoption of FLEX throughout the United States epitomizes the trends we have been discussing and has hastened their progress immeasurably. Among the original aims of the Federation of State Medical Boards in creating FLEX were the standardization and improvement of licensing examinations and the normalization of the endorsement process. These goals must be recognized as having been at least partially achieved by the almost national acceptance of FLEX as the single licensing examination for foreign medical graduates. The introduction of FLEX in 1968 was itself the nucleus of the gradual standardization of licensure policies and the movement toward adopting a uniform standard for physician competency. As has been previously mentioned, there is undoubtedly a connection between the use of FLEX and the accelerated disappearance of the basic science requirement. Similarly, FLEX has simplified the endorsement process and made it somewhat more equitable and accessible to FMGs.

The adoption of FLEX by the states has progressed at nearly a constant rate since its inception. In 1968, when the Federation first offered FLEX, eight states used the new examination in lieu of the individual state board examinations. They were joined by nine more states in 1969, eight in 1970, nine in 1971, six plus the District of Columbia in 1972, eight in 1973, and one in 1975. Only Florida has not yet adopted FLEX as its licensing examination, a situation which the Florida licensing board expects to change in the near future.

One aspect of FLEX, however, does seem to run counter to the intended effect of the examination. FLEX itself is a three-day examination with a standard passing score set by the Federation, consisting of a weighted average obtained by weighting scores from the three days as $1/6$, $1/3$, and $1/2$ of the total score; however, the states impose differing policies with regard to the attainment of this weighted average. It was not possible to determine how long the

present scoring policies have been in effect, but, as of 1975, twenty-seven states stipulate that FMGs applying for licensure obtain a FLEX weighted average of 75 percent at *one* three-day examination period, while twenty-three states allow FMGs to combine scores from different examination trials. Such policies seem to make it somewhat easier for FMGs to pass FLEX in the states allowing combinations than in the states demanding that candidates for licensure retake the entire examination every time they fail. Variations also exist in that several states require FMGs to obtain various minimum day and/or subject scores over and above the passing score designated by the Federation. At this point, it is hard to assess the effects of these different scoring policies upon the licensure of FMGs; however, there is some indication that the more stringent scoring policies may somewhat inhibit the licensure of foreign physicians.¹⁰ To the extent that they do, these scoring policies qualify the degree to which FLEX has equalized the licensure requirements of the states.

Endorsement

Only in the last several years have the majority of the states expanded their licensure policies to include provisions for the endorsement of FMGs' out-of-state U.S. licenses. As is indicated in Fig. 3, only eight states would endorse licenses which FMGs had obtained from other states in 1953, and it was not until 1974 that all the states and Washington, D.C., had established endorsement provisions for FMGs. One important explanation for the rather belated development of FMG endorsement lies in the changes wrought by FLEX upon the endorsement process as a whole. Until the nationwide adoption of the Federation's standardized licensing examination, each state administered its own unique examination for licensure, thus precluding any uniform standard for endorsement of out-of-state licenses. Before FLEX, the endorsement policies of several states consisted of a series of reciprocal agreements with other states, whereby two states would officially establish the equivalence of their standards for licensure and agree to endorse each other's licenses.

¹⁰The relationship between FLEX scoring policies and the numbers of FMGs obtaining licenses in different states is discussed with the aid of statistical indicators by Butter (1976).

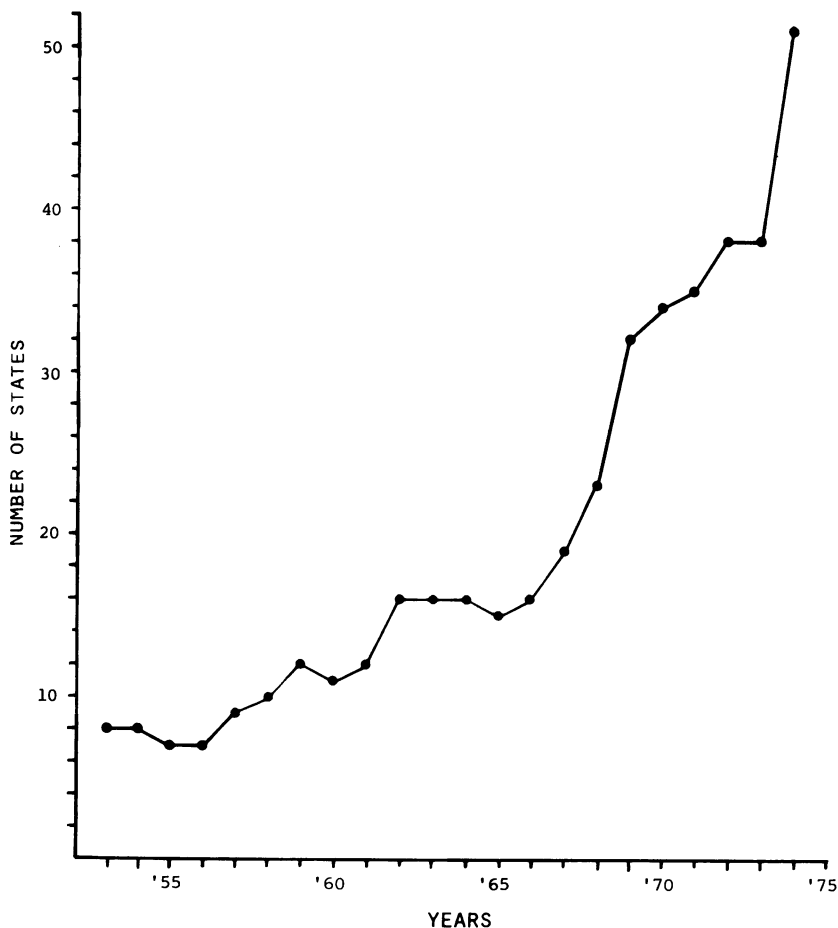


FIG. 3. Number of States Granting Full Licenses to FMGs by Endorsement, 1953–1975.

The complexity of these individualized endorsement systems led the states to seek less cumbersome alternatives. A major reason for the establishment of FLEX by the Federation of State Medical Boards was to “create a rational basis for interstate endorsement” and to promote the uniformity of endorsement policies (Derbyshire, 1969). As a direct result of the adoption of FLEX by the states, a growing number of FMGs have received full licenses through endorsement. In 1967, before FLEX was introduced, nineteen states endorsed the out-of-state licenses of 1,083 foreign medical graduates; by 1973, when most states were using FLEX, the number

of FMG endorsees had quadrupled, with thirty-eight states licensing 4,359 foreign medical graduates through endorsement.

Although the advent of FLEX has greatly simplified the endorsement process for FMGs, there still exist legal opportunities for states to impede the geographic mobility of foreign medical graduates. Because most states officially require that foreign candidates for endorsement meet the same standards demanded of FMGs obtaining their initial U.S. licenses through examination, the endorsement process is significantly affected by variations in the FLEX scoring policies of the states (discussed above). States which do not accept the combinations of day or subject scores from their own candidates for initial licensure usually will not endorse licenses based upon passing averages obtained through score combinations. A similar barrier arises between the states which demand that FMGs obtain certain minimum scores on FLEX in addition to the Federation's passing score, and those states which accept the Federation's standard. Another obstacle to uniform endorsement throughout the country is a carry-over from the pre-FLEX era. The variability among the individual state licensing examinations was so great that many FMGs licensed by state board examinations during the last two decades may not now be eligible for licensure by endorsement in some states without taking FLEX. For example, today Georgia still will not endorse a license based on the pre-FLEX New York State Board Examination.

Of course, irregularities in endorsing standards also arise from differences in leniency that exist between states. Several states have endorsed FMG credentials other than FLEX, for example, foreign and Canadian licenses, and American Specialty Board certification, and states vary with respect to their standards for the documentation of an FMG's credentials.¹¹ It is impossible to determine the net effect of the various barriers and easements to endorsement outlined here. Some states make it possible to circumvent the licensure requirements of other states, while some states inhibit interstate

¹¹At present, only the District of Columbia at the Board's discretion will endorse a foreign license, but, at one time, as many as thirteen states gave their boards statutory authority to endorse licenses from foreign countries. Today, twenty-five states (and occasionally Rhode Island) will endorse a Canadian license issued by the Licentiate Medical Council of Canada (LMCC), and New York will accept a Canadian license for endorsement when it is accompanied by Specialty Board Certification or a passing score on Day 1 of FLEX. Information regarding the endorsement of Specialty Board Certification was not available before 1974, so that it was impossible

mobility by imposing stricter standards. All that can be said to summarize the historical development of endorsement with respect to foreign medical graduates is that the states made provisions to endorse FMGs only gradually until the advent of FLEX; once a uniform nationwide licensing examination broke down the idiosyncratic differences between the states' individual licensing examinations, many states quickly joined the ranks of those endorsing FMGs. At the present time, all states will license FMGs through endorsement, and many of these endorsement policies have been modified to ease the process; however, states could go still further in promoting uniform licensure standards, thereby eliminating the remaining barriers to the interstate mobility of foreign medical graduates.

Less-Than-Full Licensure

Less-than-full licenses can be viewed either as intermediate steps or as distinct alternatives to the full licensure system. With the development of specialization in medicine in recent years, educational less-than-full licenses have proliferated as preliminaries to the full license, allowing a physician to practice in a limited sphere and under supervision until completion of postgraduate training. On the other hand, governmental, faculty and shortage area less-than-full licenses represent alternatives to full licensure for those physicians who either have no need for full licenses or are unable to obtain them.

Of the nine types of less-than-full licenses presently available to physicians throughout the U.S., we have chosen to limit our discussion to the five less-than-full licenses most relevant to FMGs during the period between 1953 and 1975. They are the licenses which authorize practice in educational settings (i.e., postgraduate training

to trace trends in this endorsement option. At the present time, West Virginia, Massachusetts, and Virginia will issue full licenses by endorsement to Specialty Board diplomates, and New York will endorse certain foreign specialty board certificates. With respect to the documentation of credentials, the Maine licensure board reports that FMGs who possessed only copies of their medical school diplomas, and were therefore unable to obtain initial licenses in other states requiring the original document, were obtaining full licenses in Maine, which will substitute an ECFMG certificate for the diploma, and then seeking endorsement of the Maine license elsewhere.

programs); in government institutions under state, county, or municipal control; in medically underserved areas as designated by the state boards; in faculty positions in medical schools; and in any situation, including that of private practice, until naturalized citizenship is attained, at which time full licensure is conferred.

Four other types of less-than-full licenses have been excluded from our study because they were of little interest to foreign medical graduates: the *locum tenens* license permitting a physician possessing an out-of-state license to assume responsibility for the private practice of a licensed physician during his or her absence; two licenses allowing practice during an emergency, or in a camp or school, for which FMGs are not usually eligible; and the license authorizing practice for a short time until the medical board meets to confer full licenses.

Data on less-than-full licenses for the years 1953 to 1973 were limited in that only those less-than-full licenses which are formally issued by medical boards were recorded in *JAMA*. Provisions for simple registration of physicians and exemptions from the medical practice acts for various situations were not covered in the *JAMA* tables through 1973 and so could not be included in this discussion. This is unfortunate since exemptions have been largely ignored in other literature, although they are especially important: besides permitting practice without a full license, they usually exclude the board from controlling the eligibility requirements of the physicians practicing in the exempted situations, and often the board does not even know the location or number of such practitioners.

Even when the survey is limited to the five types of less-than-full licenses described above, it is obvious that there has been a dramatic increase in the number of states offering less-than-full licenses to FMGs during the last two decades. In 1953, only two types of less-than-full licenses were available to FMGs in only twelve states: these were the educational and governmental licenses. During the next twenty years, the shortage area, faculty, and citizenship licenses appeared for the first time, and the number of states authorizing the educational and governmental licenses doubled. The license allowing practice in postgraduate training programs was the most widely used less-than-full license throughout the period (Fig. 4). This educational license was available in ten states in 1953 and in twenty-seven states in 1975, and, when the educational exemptions are also counted, a total of forty-six states

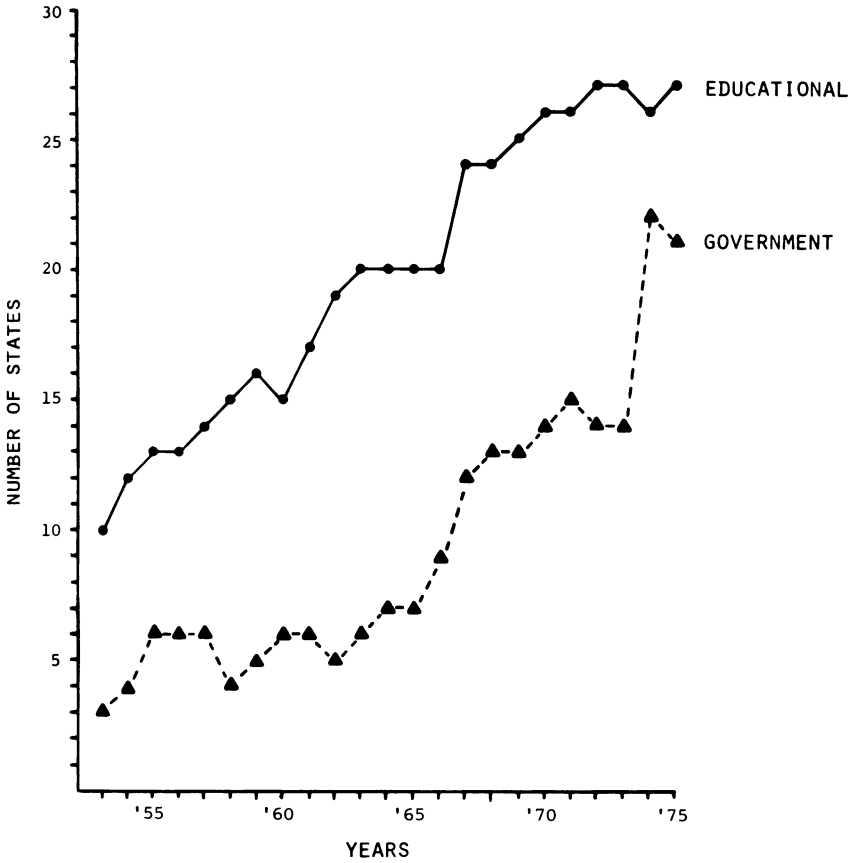


FIG. 4. Number of States Granting Educational or Government Less-Than-Full Licenses, 1953–1975.

today have made provisions for practice in educational settings. As is noted above, the greatly increased use of this license appears to be related to the increased specialization of physicians in the United States, which has necessitated longer periods of postgraduate training. Because a greater number of physicians who were practicing in lengthy training programs were not yet eligible for full licensure, or planned to practice in a state only for the duration of their training, boards recognized the need to provide legal status for these trainees through the use of the educational less-than-full license.

Use of the governmental license has also grown significantly during the last two decades. Such use may have expanded because the governmental license authorizes limited practice in the in-

stitutional settings which are less appealing to U.S. medical graduates; in the last few years some of these institutions have come to depend heavily for their supply of physician manpower upon the growing population of foreign medical graduates. In addition, the governmental license in many of the states allows the FMG to practice while attempting to pass FLEX. For these reasons, we suggest that the growth of the governmental less-than-full license in the last twenty-two years has corresponded to the inflow of FMGs during this period. As is shown in Fig. 4, in 1953 only three states had provided for less-than-full practice in governmental institutions, whereas, by 1975, eighteen more states had established a governmental less-than-full license, and, when exemptions are included, a total of twenty-four states currently authorize less-than-full practice in government institutions.

The other three less-than-full licenses available to FMGs appeared more recently and have been used much more selectively than the educational and governmental licenses. The shortage area license first appeared in 1959 (Fig. 5). It was used by only one state in any given year between 1959 and 1969 (the state varied from year to year); however, the number of states granting this license increased to six by 1975. Despite its limited usage, it is clear that this license offers much potential as a remedy for the current problems of physician supply in underserved areas throughout the country. The license which allows an FMG to practice while waiting to become a naturalized citizen has been authorized by a smaller number of states than those actually requiring such naturalization for full licensure (Fig. 5). In the early 1960s, naturalized citizenship was required by twenty-two states for full licensure, but only two of these states permitted FMGs to practice under the special citizenship license, which authorized practice under more liberal terms than those of any other less-than-full license. At the present time, however, each of the states requiring citizenship for full licensure authorizes this license. Finally, the faculty less-than-full license was available in only one state until 1961, after which time it was dropped for a while and was not used by any state until 1967 when an increasing number of states began to offer it (Fig. 5). This license is designed specifically for those outstanding foreign physicians with short-term medical school appointments who do not intend to become fully licensed in the U.S. In 1974, fourteen states had made provisions for faculty less-than-full licenses in their medical practice

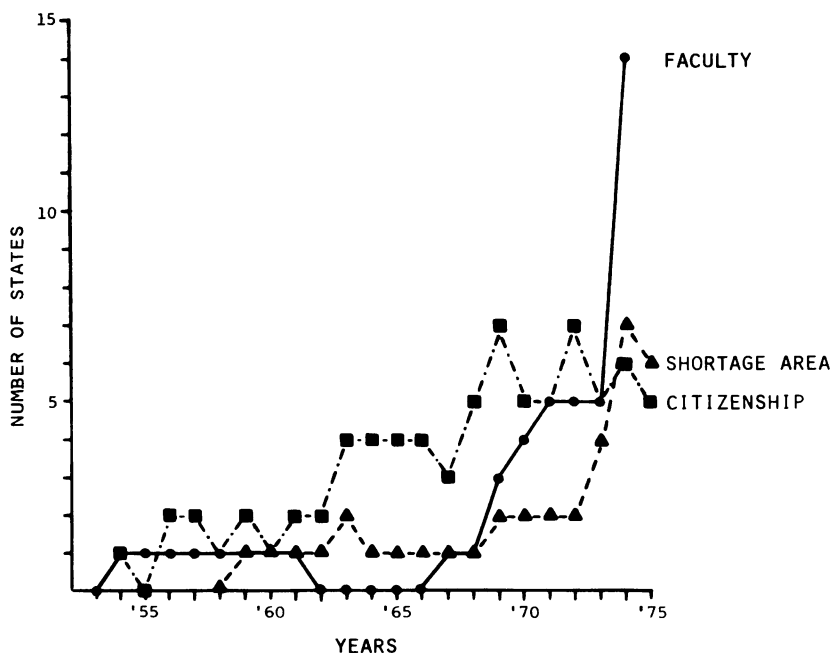


FIG. 5. Number of States Granting Shortage Area, Citizenship, and Faculty¹ Less-Than-Full Licenses, 1953–1975.

¹For FMGs only

acts and six more states exempt such physicians from board regulation.

The available information does not give rise to definitive statements regarding the development of state policies with respect to the eligibility, duration, and renewal standards for limited and temporary licenses during the period between 1953 and 1975.¹² In general, however, we learned from licensing board members and hospital administrators that a growing number of states have consistently imposed at least the requirement of ECFMG certification for less-than-full licensure. In the last several years, most states have established methods for introducing the ECFMG requirement into their less-than-full licensure systems. In fact, by 1975, forty-eight states required at least ECFMG certification for all their less-than-

¹²A comprehensive survey and analysis of requirements, durations, and renewal procedures of states' less-than-full licensure policies in 1975 is presented in Butter (1976).

full licenses, while only two states specified no requirements for their licenses and one state reported minimal requirements (a reputedly easy examination).¹³ The ranges of requirements and durations which the states have established for their less-than-full licensure systems as of 1975 are summarized below.

Educational licenses usually require only ECFMG certification, and permit practice until the completion of postgraduate training, although sometimes the duration of this license is open-ended. Occasionally, the ECFMG requirement is not imposed by the board, but is maintained by the training institution, in order to guarantee the accreditation of the training program. The educational less-than-full licenses of most states are renewable annually: fourteen states specified a maximum duration of from two to five years for this license, while fifteen states allow the trainee to practice for the duration of his program.

In contrast to these fairly consistent policies regarding the educational license, governmental less-than-full licenses run the gamut of requirements and durations. The requirements for this license can include ECFMG, postgraduate training, FLEX, or any combination of these. In a few cases, a full license is required; in fewer cases, virtually no requirements are specified. The variety of the requirements for the governmental less-than-full license throughout the states indicates that the states may be using this license rather flexibly as a mechanism to alleviate manpower shortages. Hawaii, obviously a popular state in which to reside, demands that the physicians working in its state institutions meet the rather stringent requirement of three years of approved postgraduate training, while a relatively less attractive state for physicians such as Mississippi specifies no requirements for its governmental license whatsoever. Another, though narrower, opportunity for states to regulate their licenses according to their needs is afforded by duration/renewal policies. Ten of the twenty-one states offering governmental licenses in 1975 implied that, theoretically at least, their licenses could be renewed annually for an unlimited number of times, provided that all of the states' requirements and conditions

¹³Although ECFMG certification is officially required of FMGs in most less-than-full practice situations in the U.S., the requirement is not always enforced. A large number of FMGs exist in a "medical underground"; uncertified by ECFMG, they have still found employment in hospitals (many of them government institutions) and work "with a high degree of independence . . . in physician roles despite the lack of adequate United States credentials" (Weiss et al., 1974).

are continually met by the licensee. A representative from one state admitted that his state's governmental license is issued only once and can continue in perpetuity. Other states have established more specific maximum durations for their less-than-full governmental licenses, usually ranging from one to five years, with annual renewals.

Both the shortage area license and the citizenship license resemble the full license in the stringency of their qualification standards. The shortage area license usually requires at least ECFMG and several years of postgraduate training, and often FLEX or a U.S. license is required in addition. Physicians may practice under such licenses from one year to an indefinite period of time. The citizenship license is usually granted after the FMG has met all the requirements for full licensure except naturalization, and allows the FMG virtually the full scope of practice while fulfilling the residence requirement for U.S. citizenship. This lack of restriction most likely reflects the prevalent attitude that citizenship is a requirement which has no bearing upon a physician's competence. These licenses usually last a maximum of six to eight years, and are renewed annually. The faculty license also confers a full scope of practice, but limits the FMG to the confines of the teaching hospital and to the duties of a professor. Probably because the physician to whom the license is granted is an internationally eminent member of the medical profession, the explicit requirements for this license are minimal, and usually include only ECFMG. Since this license is designed for visiting faculty, it generally lasts for only one year, the length of the FMG's temporary faculty appointment.

In summary, the less-than-full licensure systems of the states reveal an increase in both the types of licenses and the availability of these licenses throughout the country. Given the growing variety of less-than-full licenses for FMGs and the growing number of states making provisions during the last two decades for FMGs to practice in some capacity, it appears that the less-than-full licensure system has become significantly more accessible to foreign medical graduates since 1953.

Discussion

In 1953, the states were generally less receptive to foreign medical graduates than they are today. At that time they were considerably

more restrictive with regard to full licensure than is presently the case: a number of states employed rigid approval mechanisms for foreign medical schools, or used idiosyncratic screening methods, while others simply excluded all FMGs from full licensure. These policies have relaxed considerably since the middle 1960s, and states are moving toward more standardized screening systems and more uniform qualification procedures. A persistent trend has been to eliminate licensure requirements that are unrelated to physician competency, such as naturalization and visa status. In place of these requirements, ECFMG certification, postgraduate training, and FLEX constitute an interrelated set of requirements with the double potential of indicating physician competence and resolving the more disturbing aspects of interstate differences in the treatment of FMGs.

Although the states have made steady progress in establishing more standardized procedures for competency appraisal, there is potential for even greater consistency. Further progress by the states in reassessing and eliminating the differences in FLEX scoring policies, in endorsement policies, and in the length of postgraduate training requirements could substantially contribute to even greater uniformity in minimum qualification standards, while also enhancing the geographic mobility of FMGs within the nation.

Despite a clear and persistent trend toward national uniformity in competence appraisal procedures, the survey has uncovered little information to suggest that, over time, competency assurance has become more effective. For example, measurement of physician competence remains focused on examination performance even though the evidence demonstrating the validity of the tests in predicting aptitude for competent patient care is limited. Moreover, for the purpose of full licensure, assessment of physician qualifications continues to be confined to a single point in time: the point of career entry. Periodic reevaluation of physician capabilities is only now beginning to enter policy-related discussion.

The past two decades have also seen a substantial growth both in the variety of less-than-full licenses available to FMGs and in the number of states authorizing less-than-full practice for FMGs. The survey documents a rising trend both in preliminary and alternative types of less-than-full licenses. Unfortunately, the perspective provided on less-than-full licensure is, of necessity, rather narrow

because of the lack of documentation on prerequisites, qualification standards, and durations of these more restricted types of licenses. Based on information collected by the authors in 1975–76, it is evident that compared with full licensure, the less-than-full licensure policies of the states contain appreciably greater variability with regard to qualification standards, durations, and types of less-than-full licenses issued. When this fact is considered in light of the varying manpower supplies and deficits confronting the states, it raises the question of whether nationally uniform less-than-full licensure standards constitute a desirable goal. An answer to this query lies beyond the scope of this paper, but has been attempted by the authors in a previously cited study (Butter, 1976).

With regard to the effectiveness of competence assurance, it is our view that the less-than-full licensure system has the potential for serving as a useful adjunct to full licensure in that it can direct physicians of different and changing levels of demonstrated competence into appropriately structured practice situations. By recognizing differing levels of initial competency among physicians, and by acknowledging the function of periodic reassessment of physician capabilities, the states can avail themselves of more options in meeting manpower requirements, while at the same time strengthening their role in competence appraisal.

Admittedly, widespread reform will be required before less-than-full licensure can effectively serve to expand and complement the existing procedures of competence appraisal. During the past two decades the states have demonstrated the ability to coordinate and standardize licensure qualification procedures. Based on their success in this regard, a new commitment by the states to increasing the effectiveness of competence assurance, for FMGs and USMGs alike, appears to lie within their realm of capability and constitutes a logical and promising direction for the future.

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