CITIZENS RESEARCH COUNCIL OF MICHIGAN

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Michigan May Want to Reconsider Requiring Foreign-Trained Doctors to Repeat Residency Training

In a Nutshell

- Some parts of Michigan – particularly the state's rural areas – have a shortage of primary care providers.
- Foreign-trained doctors are required to repeat post-graduate training in the United States to obtain a medical license in Michigan, but many states have removed or are considering removing this requirement.
- Research is not available to assess how well foreign-trained doctors perform without this requirement, but the state has the ability to enact safeguards to limit the risk if it chooses to pursue this approach to reducing the physician shortage.

The United States has many fewer doctors per capita than other developed countries. While Michigan's total physician workforce is slightly larger than the national average, the state is still well behind many of its national and international counterparts. While there is no "right" number of doctors a state needs to maximize health outcomes, significant attention has been paid to the consequences of an underdeveloped health care workforce.

Much of the conversation in Michigan has focused on the number of primary care physicians, where troubling signs exist for the state. There are 288 Health Professional Shortage Areas (a federal designation for a geographic area, population, or facility that has a shortage of providers according to certain criteria) for primary care spread across the state, with acute shortages concentrated in the northern half of the Lower Peninsula. Shortages are less prevalent in more populated counties. It is projected that the state will be short by 800 primary care doctors by 2030. Lack of access to primary care comes with a host of potential problems due to delays in care that can lead to worse health outcomes and higher treatment costs.

The potential long-term shortage and uneven distribution of primary care providers (PCP) in Michigan has been an area of concern for many years. Resolving this requires consideration of the many reasons for the shortages, which are complex and multifaceted. For instance, many of those who have invested significant time and resources into the training required to become a doctor don't pursue work as a primary care doctor but instead choose more lucrative specialties. Earlier retirement ages for doctors and an aging general population are also contributing to the growing discrepancy between the supply of providers and the demand for medical services. In addition to primary care shortages in many areas of the state, the state also faces issues in the prevalence of some specialties.

The state's ultimate goal should be ensuring the delivery of cost-effective health care to residents, so different kinds of solutions are available. Policy options fall into several different categories: increasing the supply of doctors, allowing doctors to deliver services more efficiently, and expanding the services that can be performed by other health professionals. The Research Council has recently highlighted policies on the efficiency of service delivery and expanding the work performed by other health professionals, but increasing the supply

of doctors is also worthy of attention.

Several specific policy strategies have been proposed, and in some cases implemented, at the state and federal level to address the PCP shortage through the lens of increasing the supply of doctors. These initiatives include increased funding for more residency slots in hospitals with higher needs and student loan forgiveness programs. Many states, including Michigan, have taken various measures to implement some of these strategies, but federal initiatives are likely necessary to carry out some of the larger and more expensive efforts, such as expanded residency slots and loan forgiveness. Notably, efforts to train more doctors in Michigan have not been as successful as hoped, with the state struggling to retain doctors educated and/or trained in the state.

Another option to increase the number of doctors in the state is to make it easier for foreign-educated doctors to obtain a license to practice in the state, which is an idea that has attracted attention around the country as other states face similar challenges maintaining a large enough physician workforce.

Foreign-Trained Doctors Have to Repeat Training

Doctors in the United States are licensed by individual states. To obtain a license, doctors have to obtain a medical degree, complete post-graduate training, and pass a series of exams that test their knowledge of disease management and patient care.

In most states, including Michigan, doctors who graduated from medical school in countries other than the United States and Canada and completed post-graduate training abroad have to repeat their post-graduate training in the United States before they are eligible for licensure (in addition to passing licensing exams).

This barrier to practice deters some physicians from coming to the United States to practice and delays licensure for others. Additionally, it creates additional competition with new domestic graduates for scarce post-graduate training slots. Overcoming this burden is far from impossible, as roughly 29 percent of doctors in Michigan went to medical school abroad, but it is worth considering if this requirement serves the public interest.

Some States Have Lifted Retraining Requirements

Nine states (Florida, Iowa, Idaho, Illinois, Louisiana, Massachusetts, Tennessee, Virginia, and Wisconsin) have enacted legislation allowing qualified, internationally trained physicians to obtain licensure without completing a domestic post-graduate training program. All of these laws were enacted within the last few years. At least 20 other states, including Michigan, have seen proposed legislation to remove the domestic post-graduate training requirement. Three other states allow for a limited licensure for these physicians (California, New York, Washington).

It is also worth noting that this idea does not come solely from desperation and physician shortages, as Massachusetts recently enacted legislation to remove the retraining requirement despite having one of the highest ratios of physicians to patients in the country. Even in a state with plenty of physicians overall, proponents of the law argued it would help increase the number of doctors working in rural communities.

Provisions vary, but these laws generally allow for licensure if the doctor graduated from an eligible medical school, completed the equivalent training and exams in their home country, were in good standing as a practicing physician for some period of time prior to their application, pass the relevant domestic licensing exams, and obtain the proper immigration authorization. In other words, experienced doctors do not have to repeat the post-graduate training programs in these states, but must meet all other requirements.

Analyzing the Value of Retraining

The purpose of professional licensing is to protect the public by ensuring people who offer services as a member of a profession meet a certain level of qualification. This allows people to rest easy knowing that anyone who calls themselves a doctor in the state has met certain criteria established by law and enforced by the

Board of Medicine.

The question presented here is whether the requirement that foreign-trained doctors redo training in the United States is a worthwhile component of that baseline criteria.

The argument made in favor of this restriction is that internationally trained physicians go through less rigorous education and training, and that as a result, they have not necessarily shown themselves to be above the threshold we would accept to practice medicine in the United States. Relatedly, post-graduate training also acclimates doctors to U.S.-specific aspects of medical care which is a necessary knowledge base for quality care.

The argument against this requirement is that this additional training does little or nothing to improve the performance of doctors above and beyond the training they received abroad, and that it deters doctors from practicing here and wastes scarce training resources (e.g., residency slots) on qualified doctors rather than those who are fresh out of a domestic medical school.

In the context of a state that would benefit from more physicians, it is worth knowing if the existing requirement has value or if it is a regulation that needlessly depresses the supply of doctors, both through deterring foreign doctors from coming to Michigan to practice and crowding out new graduates with needless residency slot competition.

Unfortunately, evidence in either direction is limited. A 2017 study found that foreign-trained doctors reduced mortality rates compared to domestically-trained doctors. But this is just one study that is limited to a single population group and may not have more general applications. Similarly, the study is based on foreign-trained doctors who all received their license before any state changed the requirement, so at best it shows that foreign doctors who complete the retraining requirement perform as well as domestically educated doctors, not necessarily what would happen if it was changed. While some are concerned about the risks of removing the retraining requirement, they have no data to point to that demonstrates the risks given how recent the new laws are. No concrete evidence exists, either, to say whether concerns about training abroad are well-founded.

The Potential Benefits of Ending Retraining

If the state could ensure that no downside risk existed to removing the retraining requirement, it would be relatively simple to remove it and see what happens. However, changes to health policy such as this often affect people's lives across many dimensions, so change is not that simple. Given the uncertainty about the downsides, it is worth considering the potential scope of the benefits as policymakers grapple with this topic.

Estimates vary, but about 40 percent of foreign-trained doctors living the United States are currently not working as physicians. In Michigan, as many as 6,000 people with foreign health-related degrees are underemployed or unemployed (this covers more than doctors). The potential to grow the workforce simply with those already here is significant, to say nothing of the potential to use this as a recruiting tool for those who want to come to the United States and are looking to choose a state.

Foreign-trained doctors are more likely to work in primary care than those trained domestically, and there is also evidence that it is easier to attract these doctors to rural areas than those trained in the United States.

No guarantee exists that removing the requirement would produce an influx of doctors aimed at resolving Michigan's primary care and rural doctor shortage, but such a law would seem to make it easier for doctors who typically fill these roles to practice in the state. Some states have taken a firmer approach, proposing that these doctors be required to practice in particular areas for an initial period of time as a condition of their license.

Additionally, removing the retraining requirement would directly open up more post-graduate spots for domestic graduates, affording the state at least a better shot to retain its medical graduates compared to states that require retraining.

Weighing the Options for Michigan

Michigan recently enacted a law to study licensing for foreign-trained medical professionals, but the task force created to carry out this mandate stopped short of endorsing removal of the retraining requirement. Similarly, the Federation of State Medical Boards (FSMB) has put forward best practices for states that take this step, without formally endorsing doing so.

Whether the state removes the retraining requirement now versus waiting for the results in the first wave of states who already have is a question of risk tolerance. Certainly, some risk exists that removing this requirement will open the door to a group of doctors who provide substandard care, but there are also costs of existing provider shortages. Waiting for more information has costs, so it is just a matter of which costs the state prefers.

If the state does remove the requirement, the FSMB best practices offer a guide to crafting the legislation, focusing on making sure the foreign post-graduate education was a high-quality program and that doctors have not been out of practice too long before returning to the field. Similarly, a provisional licensure option that offers the state medical board an opportunity to reassess each doctor after a period of time also offers safeguards. Michigan could also sunset the law to ensure proper review.

Finally, policymakers should think about whether they want to craft language requiring these licensees to work in a particular area (e.g., rural shortage area, primary care only) to make sure the law addresses the most pressing issues. There is an obvious logic to requiring doctors work in these areas as a condition of removing the retraining requirement. However, mandating all doctors licensed under this pathway work in rural areas and/or primary care may not produce the best overall outcomes, as sending a renowned cardiologist to practice primary care is not necessarily better than allowing them to work in their established specialty.

Conclusion

Michigan's primary care shortage and especially the lack of providers in rural areas has led to discussions about the best way to solve the problem. One way to increase the supply of doctors in the state is to eliminate the requirement that foreign-trained doctors redo their post-graduate training in the United States before they can obtain a medical license.

Nine states have enacted laws of this nature in the last few years and many others are considering following suit. It is too early to say if removing this requirement will impact care quality or if doing so would help solve the provider shortages. However, the provider shortage is a problem that will likely have to be tackled from multiple directions, and every potential avenue should be taken seriously. Further, while the potential benefit is not guaranteed, the potential risk can be minimized by incorporating safeguards into legislation

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Karley Abramson joined the Research Council in 2022 as a Research Associate focusing on health policy. Previously, Karley was a nonpartisan Research Analyst at the Michigan Legislative Service Bureau where she specialized in the policy areas of public health, human services, education, civil rights, and family law. Karley has worked as a research fellow for various state and national organizations, including the National Institutes of Health and the ACLU of Michigan. She is a three-time Wolverine with a bachelor's degree in sociology, a master's of public health, and a juris doctor from the University of Michigan.

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