Whereas, Thirty-one states have a set time limit of seven years to complete the USMLE licensing sequence, 29 states allow 10 years specifically for MD/PhD student, 37 states allow 10 years for DO/PhD students to complete the COMLEX sequence, and at least 20 states have different time limits for USMLE and COMLEX sequences;¹ and

Whereas, Seven states have no time limit to complete the USMLE sequence, and at least 22 states have no time limit to complete the COMLEX sequence;¹ and

Whereas, Of the state medical and osteopathic boards which have a time limit, 10 years with potential waivers is the greatest of the time limits;¹ and

Whereas, A recent study by Holmes et al. (2017) measures the average time to complete social science and humanities MD/PhDs to be 9 years;² and

Whereas, All state licensing jurisdiction require 1 year of graduate medical education before licensure for US medical graduates, 12 states require 2 years and 25 states require 3 years of accredited graduate medical education for foreign medical graduates;³,⁴ and

Whereas, Current AMA Abolish Discrimination in Licensure of IMGs H-255.966 calls for the elimination of disparities in graduate training requirements for licensure; and

Whereas, Opportunities such as moonlighting can depend on having a full medical license;⁵ and

Whereas, The lack of a nation-wide policy leads to situations where students with identical training timelines have differing ability to obtain a license, simply depending on the state’s policy where they receive training; therefore be it

¹FSMB. State-Specific Requirements for Initial Medical Licensure. Retrieved from https://www.fsmb.org/licensure/usmle-step-3/state_specific
²Holmes, S. M., Karlin, J., Stonington, S. D., & Gottheil, D. L. (2017). The first nationwide survey of MD-PhDs in the social sciences and humanities; training patterns and career choices. BMC Medical Education 17(1), 60.
RESOLVED, That our American Medical Association amend Policy H-275.978, “Medical Licensure,” by addition as follows:

The AMA:

(1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;

(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;

(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;

(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;

(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;

(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);

(7) urges licensing boards to maintain strict confidentiality of reported information;

(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;

(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;

(10) urges all physicians to participate in continuing medical education as a professional obligation;

(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;

(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;

(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;

(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;

(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;

(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of
examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;

(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;

(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;

(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;

(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;

(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement;

(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.

(23) urges the state medical and osteopathic licensing boards which maintain a time limit on complete licensing examination sequences to adopt a time limit of no less than 10 years for completion of a licensing examination sequence for either USMLE or COMLEX. (Modify Current HOD Policy)

Fiscal Note: not yet determined

Received: 04/26/18

RELEVANT AMA POLICY
Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

Our AMA adopts the following principles:(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards that are reported for all licensed physicians. (7) Medical schools are responsible for identifying and remedying and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills. (8) The Dean’s Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.


See also: Abolish Discrimination in Licensure of IMGs H-255.966