



Regulation of Physicians in Training

Adopted by FSMB House of Delegates, April 2024

Introduction

It is only in recent decades that state medical boards have established a more formal regulatory relationship with physicians-in-training (also referred to as resident physicians, residents or fellows.) Prior to that time, physicians-in-training who obtained their medical degrees in the United States or abroad progressed through accredited graduate medical education (GME) with little to no contact with state medical boards until they applied for a full and unrestricted medical license. This left many state medical boards with inadequate or no knowledge of these physicians, including of their supervised management of patients or their educational and professional progression through GME, because no formal nexus (e.g., training license) existed for reporting to the licensing community.

Background

Since the FSMB's House of Delegates adopted a policy on *Licensure of Physicians Enrolled in Postgraduate Training* in 1996, much has evolved in relation to how state medical boards regulate resident physicians. This has included an increase in the number of states that now require a form of training licensure, improved administrative processes to issue and maintain those licenses, increased efforts to support physician wellness, and an increasingly mobile resident workforce that seeks training in more than one state or territory.

The Workgroup on the Regulation of Physicians in Training ("Workgroup") was established by FSMB Chair, Jeffrey Carter, MD, in April of 2023 to bring together representatives from state medical boards and organizations representing medical and osteopathic medical education, graduate medical education, and international medical graduate certification to develop recommendations for state medical boards related to the regulatory oversight of physicians enrolled in post-graduate training programs within their jurisdiction.

The Workgroup was chaired by FSMB Board of Directors member and chair of the District of Columbia Board of Medicine, Andrea Anderson, MD, M.Ed. The assigned charge was the following: conducting a comprehensive review of state medical and osteopathic board licensure and other regulatory requirements related to the oversight of physicians in postgraduate training programs; reviewing and evaluating existing FSMB recommendations related to the oversight of physicians enrolled in postgraduate training programs, with particular focus on the appropriate timeline to meet requirements for full and unrestricted licensure; evaluating current research related to the current state of graduate medical education, physician workforce projections, and the experience of states offering alternate licensure categories; reviewing current programs to support the wellness of physicians enrolled in postgraduate training programs and explore the role of state medical boards in supporting those efforts; and identifying barriers and developing recommendations designed to facilitate the ability of residents to participate in clinical rotations in remote jurisdictions, as may be necessary to meet training requirements.

The Workgroup met five times over the course of a year to work through the elements of the charge, reviewing current statutes and regulations, receiving presentations from state medical board staff and subject matter experts, and drafting this report and recommendations. The recommendations detailed in this report focus on the administrative processes of state medical boards in their interactions with resident physicians and postgraduate training programs.

State Medical Board Administrative Processes

At the time of the FSMB's 1996 report, 56% of states that were surveyed said they offered training licenses while 5% said they offered institutional licenses to training programs. A 2024 survey by FSMB staff, conducted in support of this Workgroup, demonstrated that nearly all states now have in their statutes or procedures a licensing process for the regulation of resident physicians, wherein a license is granted to the resident participating in a qualifying GME program. The GME program is often involved in the initial application process, but the license is usually granted to the individual. There is only one jurisdiction that still utilizes an "institutional license," wherein the resident physician does not receive an individual license from the state medical board but instead practices under the authority granted by the state medical board to the institution where the resident trains.

All jurisdictions in the United States now require some form of oversight of physicians-in-training, with at least 65 state medical and osteopathic boards (out of 70) requiring an individual resident license. These licenses, however, differ by the name given to the license, its length of issue, and the administrative processes that underpin its issuance and maintenance. The resident license may be referred to as a resident license, training license, limited license, permit, etc. Regardless of the name, state medical boards appear to be managing high volumes of resident licenses, including those held by physicians completing clinical rotations in their jurisdictions for only short periods of time (e.g., 1-3 months.)

Resident License Renewal Timeline

The Workgroup reviewed state-specific resident licensing requirements and sought input from state medical board staff in multiple jurisdictions to identify areas that may offer opportunities to recommend ways to reduce administrative burden and cost. A variety of approaches exist for the duration of the training license, from annual issuance and then renewal for each year of training to a term covering the full duration of the program.

A fundamental question arose during Workgroup discussions was the consideration of the practice of renewing a resident license annually. This approach may place a significant administrative burden on state medical board staff, GME programs and resident physicians. Experience from medical boards suggests that issuing a license for the duration of the relevant GME program may lessen that burden and should be strongly considered. The Workgroup strongly believes, however, that residency program directors or Designated Institutional Officials (DIO) overseeing such training provide annual information to state medical boards about the status and progress of such resident licensees within their programs.

The scope and extent of communications between state medical boards and GME programs appear to differ significantly. Insight gained from the experiences of administrative staff serving on several medical boards suggests that regular communication and outreach (e.g., email, webinars, Zoom meetings)—particularly when timed to coincide with key dates in an annual GME

calendar, such as orientation—reflect a best practice to optimize coordination of administrative functions.

Clinical Rotations Within GME

Resident physicians often participate in an “away rotation” during the course of their GME training in order to complete one or more aspects of their training that may not be available at their home institution. In most states, residents who rotate into their jurisdiction for such limited training are still required to obtain a resident license, even in instances when they are only scheduled to be in the jurisdiction for a relatively limited period of time, e.g., 4 weeks. This creates a substantial administrative burden for state medical board staff and rotating residents, as well as the associated programs. Some jurisdictions do not require the “rotating” resident to obtain a new license, as long as the length of their training is less than a specified number of days (i.e. 30 days or less.)

Reducing administrative burdens and streamlining the process for “away rotations” would be beneficial to state medical boards, resident physicians and GME programs and should be treated as a priority for consideration. If all residents were asked to complete a “uniform resident license application” – an instrument that does not yet exist – states may be able to process and file applications for rotating residents more quickly and efficiently.

More than two decades ago, the FSMB’s House of Delegates recognized the value of a standardized medical licensure application to support licensure portability and reduce administrative redundancies for fully licensed practicing physicians. After discussions and engagement with state medical board representatives, the FSMB responded by launching a “Uniform Application for Licensure” (UA) in 2008. The UA has since evolved to become a useful web-based application for both physicians and physician assistants applying for a full and unrestricted initial medical license and this is now used by 27 state medical boards. There may be value in developing a similar application for resident licensure that includes common identifying data points and which implements technological efficiencies that could support portability of resident licensure for “away rotations” and reduce administrative burdens for countless residents and programs.

Statutory and Legislative Considerations

GME Requirements for Full Licensure

The Workgroup reviewed multiple FSMB policies related to resident physicians, including: *Licensure of Physicians Enrolled in Post Graduate Training Programs (1996)*, *Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession (1998)*, and relevant sections of *Guidelines for the Structure and Function of a State Medical and Osteopathic Board (2021, and under review in 2024)*.¹

FSMB policy as adopted by its House of Delegates currently recommends that state medical boards require three years of progressive accredited GME in the United States as a requirement for a full and unrestricted medical licensure. However, as of 2024, only a handful of boards have adopted this requirement. For U.S. and Canadian medical school graduates, 40 boards require only one year of GME, while 21 boards require two years of GME for a full license. Boards also vary on the required number of years of GME they mandate for international medical graduates.

Though the recommendation of three years of progressive accredited GME in the United States has been FSMB policy for 25 years, there has not been significant movement by more states or territories to adopt this recommendation. There are also recent trends suggesting heightened legislative interest and activity that are inconsistent with a 3-year GME standard. (See section below)

While the research literature is substantial and compelling about the value of progressive accredited GME (knowledge, competency and professional development), there is less data from the perspective of medical licensure and discipline. One noteworthy exception is a 2016 study by Louisiana's medical board that correlated fewer than three years of GME with a higher risk of subsequent disciplinary action among licensees.ⁱⁱ Further research exploring the correlation between GME and medical board complaints and/or disciplinary action would be helpful as one means to inform the continued merit of FSMB's recommendation for 3 years of progressive GME training.

Alternate/Additional Licensure Categories

Since 2014, intermittent and periodic legislative efforts have been underway in a number of jurisdictions in the United States to create pathways for medical school graduates (whether they graduated from the United States or abroad) who have not been successful in getting placed in a duly accredited GME program so that they might remain working and training as they await placement. Some of these legislative efforts solicited input/guidance from medical regulators before they were introduced or adopted into law; many others did not. Many of these efforts resulted in a wholly new category/type of license that featured novel titles for such physicians, e.g., Assistant Physician, Associate Physician, Graduate Registered Physician, Bridge Year Graduate Physician, etc.

In most instances, such categories were intended to be temporary and transitional stages—tapping into a physician resource for a specific need but with the ultimate goal that these physicians would ultimately obtain a full, unrestricted license that meets all traditional requirements—but in some jurisdictions such individuals have been allowed by statute to become eligible for full and unrestricted medical licensure, sometimes limited to that jurisdiction, without completion of a full examination (USMLE/COMLEX-USA) sequence or accredited post-graduate training.

In some other instances, these newer licensure categories have modified standard requirements for a full license, e.g., bypassing accredited GME in the United States entirely and/or not completion of the entire 3-step licensing exam sequence. As of February 1, 2024, legislation of this type has been introduced in 23 states and passed into law in nine.

The Workgroup discussed these models and the various considerations that factor into each, e.g., access to care, physician workforce, etc., and felt that state regulators should be cognizant of several key factors as they confront interest in these initiatives. First, any physician license category that features reduced requirements related to GME or licensure examinations should be time-limited and not a permanent category in which an individual may work under supervision or otherwise indefinitely. Second, supervision requirements should call for “meaningful supervision” (e.g., with the supervisor directly overseeing a licensee's work and/or available and accessible on short notice) and be no less stringent than what would otherwise be involved in any other physician supervision context in GME. Current FSMB policy does not address these alternate licensure categories and there is insufficient research and policy analysis on the potential impact

of these moves on physician supply and their impact on patient safety at this time. A collaboration that includes key stakeholders – including those representing state medical boards, medical and osteopathic medical educators, graduate medical education bodies such as the ACGME, specialty certification authorities, as well as international medical graduates and resident physicians, at a minimum – is needed to study and develop consensus recommendations and resources for state medical boards studying existing and future legislative initiatives in this area. FSMB recognizes the important role of accredited GME training in assuring patient safety.

Supporting the Wellness of Resident Physicians

Physician wellness and burnout has been a priority of the FSMB for several years and was made more urgent in the wake of the COVID-19 pandemic. The FSMB's House of Delegates adopted as policy the *Report and Recommendations of the Workgroup on Physician Wellness and Burnout* in 2018. The Report recognized that the factors impacting physician wellness also apply to residents and medical students.

Our Workgroup heard from representatives from the ACGME about the importance of supporting resident wellness, and from representatives of state physician health programs (PHPs) about services that residents may access within PHPs. Most states allow residents to participate in a PHP and services offered beyond SUD treatment typically include intake and assessment, referrals and evaluations for a variety of health concerns, care coordination, collaboration with training programs, monitoring and verification of health status.

Confidentiality and License Application Questions

The Workgroup discussed concerns about health-related questions on resident license applications that may be too probing and which may discourage applicants from seeking help. The FSMB's Physician Wellness and Burnout Policy specifically addressed health-related questions on applications for initial licensure and renewal, recommending that *state medical boards review their medical licensure (and renewal) applications and evaluate whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use, and whether the information these questions are designed to elicit in the interests of patient safety may be obtained through means that are less likely to discourage treatment-seeking among physician applicants*. The policy included specific recommendations related to the removal of such questions, the need to modify such questions to focus on current impairments (if a state medical board decides to include such questions), and the option of an attestation model.

However, the recommendations adopted in 2018 did not address health-related questions on resident license applications. In a staff review of 19 resident licensure applications, there appears to be significant variation in the presence of, and language utilized in, health-related questions. Variation also exists in some instances between the questions asked on a resident license application versus that contained in an application for full licensure in the same state.

Given these inconsistencies and the probing nature of some of the questions, the Workgroup recommends state medical boards apply the recommendations from the FSMB's Physician Wellness and Burnout policy to all applications for licensure, including those for resident licenses.

Resident Physician Workforce

The Workgroup discussed the importance to public health of a diverse resident physician workforce and recognized that a diverse resident workforce can foster inclusive healthcare

environments and help address disparities in patient care. Communication skills and cultural sensitivity are widely recognized as critical to patient care, with research continuing to show that patient satisfaction and/or adherence to medical advice can improve when there is better physician-patient concordance as it relates to background. FSMB policy provides information on opportunities for pathways into medical education and practice and social determinants of health, including proposed mitigation strategies and resources.ⁱⁱⁱ

Recommendations

Recommendation 1: Consistent with prior FSMB recommendations, state medical boards should issue a training license to all physicians-in-training engaged in ACGME-accredited postgraduate training in their state or territory.

Recommendation 2: State medical boards should issue resident training licenses extending for the duration of a GME program, rather than a license that is renewed annually, as long as the licensee is annually reported to the state medical board by the training program as being actively enrolled and in good standing.

Recommendation 3: The FSMB should solicit participation from state medical boards to pursue research that addresses correlations, if any, between duration of time spent in GME and subsequent incidence of disciplinary actions and/or complaints.

Recommendation 4: Alongside representatives of state medical boards, the FSMB should collaborate with key stakeholders and partner organizations in the House of Medicine to evaluate resources and identify recommendations and best-practice guidelines for state medical boards considering non-traditional, alternate pathways for licensure.

Recommendation 5: State medical boards implementing licensure categories that feature reduced requirements for GME and/or fewer medical licensure examination requirements should be time-limited and temporary, with meaningful supervision requirements to assure public safety.

Recommendation 6: State medical boards should apply recommendations in FSMB's *Report and Recommendations of the Workgroup on Physician Wellness and Burnout*,^{iv} adopted by FSMB's House of Delegates in 2018, related to health-related application questions for full and unrestricted licensure to resident license applications. State medical boards should consider opportunities for periodic outreach to medical students and residents about medical board expectations and concern for their well-being.

Recommendation 7: FSMB should work with state medical boards to explore the feasibility of developing an "online uniform resident license application" to retain oversight of physicians-in-training and lessen administrative burdens for state medical boards, residency program directors and resident physicians.

ⁱ *Guidelines for the Structure and Function of a State Medical and Osteopathic Board (2021)* is available [here](#).

ⁱⁱ Susan Allen, Robert Marier, et. al., "Training Matters: A Retrospective Study of Physician Disciplinary Actions by the Louisiana State Board of Medical Examiners, 1990-2010," *Journal of Medical Regulation* 107, No. 4 (2016): 7-16.

ⁱⁱⁱ *Final Report of the FSMB Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care (2023)* is available [here](#).

^{iv} *Report and Recommendations of the Workgroup on Physician Wellness and Burnout (2018)* is available [here](#).

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