REFORMING AMERICAN MEDICAL LICENSURE

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INTRODUCTION: THE NEED TO RECONSIDER A VARIETY OF OCCUPATIONAL LICENSING LAWS

Occupational licensing requirements have existed in the United States since colonial times.[1] For most of our history, the number of workers subject to licensing requirements was quite small, approximately five percent.[2] That number, however, has steadily increased since the 1950s. Today, approximately thirty percent of all workers are subject to such a requirement, with

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1. *See* JAMES W. ELY, JR., THE GUARDIAN OF EVERY OTHER RIGHT: A CONSTITUTIONAL HISTORY OF PROPERTY RIGHTS 20–22 (3d ed. 2008); S. DAVID YOUNG, THE RULE OF EXPERTS: OCCUPATIONAL LICENSING IN AMERICA 9–14 (1987); Lawrence M. Friedman, *Freedom of Contract and Occupational Licensing 1890–1910: A Legal and Social Study*, 53 CAL. L. REV. 487, 494–501 (1965).

2. *See* MORRIS M. KLEINER, LICENSING OCCUPATIONS: ENSURING QUALITY OR RESTRICTING COMPETITION? 1 (2006).

service industry professionals most likely to be regulated by licensing requirements.[3]

Those requirements have recently come under sharp and repeated criticisms from a variety of commentators in professional journals and the media. Scholars in economics,[4] law,[5] and public

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3. *See* Aaron Edlin & Rebecca Haw, *Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny?*, 162 U. PA. L. REV. 1093, 1096 (2014).

4. *See, e.g.*, DENNIS W. CARLTON & JEFFREY M. PERLOFF, MODERN INDUSTRIAL ORGANIZATION 687–88 (4th ed. 2004); W. KIP VISCUSI ET AL., ECONOMICS OF REGULATION AND ANTITRUST 382 (4th ed. 2005); Asheesh Agarwal, *Protectionism as a Rational Basis?: The Impact on E-Commerce in the Funeral Industry*, 3 J.L. ECON. & POL'Y 189 (2007); Alex Maurizi, *Occupational Licensing and the Public Interest*, 82 J. POL. ECON. 399 (1974); Simon Rottenberg, *The Economics of Occupational Licensing*, *in* ASPECTS OF LABOR ECONOMICS 3, 18 (Nat'l Bureau of Econ. Research ed., 1962); Alan B. Krueger, *Do You Need a License to Earn a Living? You Might Be Surprised at the Answer*, N.Y. TIMES (Mar. 2, 2006), http://www.nytimes.com/2006/03/02/business/yourmoney/02scene.html [https://nyti.ms/2mwMHKJ]; Ryan Nunn, *The Future of Occupational Licensing Reform*, BROOKINGS INST. (Jan. 30, 2017), https://www.brookings.edu/opinions/the-future-of-occupational-licensing-reform/ [https://perma.cc/764U-598U]. Professor Morris Kleiner has been a particularly outspoken critic of occupational licensing schemes. *See, e.g.*, KLEINER, *supra* note 2; MORRIS M. KLEINER, THE HAMILTON PROJECT, REFORMING OCCUPATIONAL LICENSING POLICIES (2015); Morris M. Kleiner, *Enhancing Quality or Restricting Competition: The Case of Licensing Public School Teachers*, 5 U. ST. THOMAS J.L. & PUB. POL'Y 1 (2011); Morris M. Kleiner, *Occupational Licensing*, 14 J. ECON. PERSP. 189 (2000); Morris M. Kleiner & Alan B. Krueger, *Analyzing the Extent and Influence of Occupational Licensing on the Labor Market*, 31 J. LAB. ECON. S173 (2013); Morris M. Kleiner & Alan B. Krueger, *The Prevalence and Effects of Occupational Licensing*, 48 BRIT. J. INDUS. REL. 676 (2010); Morris M. Kleiner & Robert T. Kudrle, *Does Regulation Affect Economic Outcomes? The Case of Dentistry*, 43 J.L. & ECON. 547 (2000); Janna E. Johnson & Morris M. Kleiner, *Is Occupational Licensing a Barrier to Interstate Migration?* (Nat'l Bureau of Econ. Research, Working Paper No. 24107, 2017), http://www.nber.org/papers/w24107.pdf [https://perma.cc/4SGD-CMVF].

5. *See, e.g.*, BERNARD H. SIEGAN, ECONOMIC LIBERTIES AND THE CONSTITUTION (2d ed. 2006); Rebecca Haw Allensworth, *Foxes at the Henhouse: Occupational Licensing Boards Up Close*, 105 CAL. L. REV. 1567 (2017); Paul Avelar & Keith Diggs, *Economic Liberty and the Arizona Constitution: A Survey of Forgotten History*, 49 ARIZ. ST. L.J. 355, 383 (2017); John Blevins, *License to Uber: Using Administrative Law to Fix Occupational Licensing*, 64 UCLA L. REV. 844 (2017); Edlin & Haw, *supra* note 3; James W. Ely, Jr., *The Constitution and Economic Liberty*, 35 HARV. J.L. & PUB. POL'Y 35 (2012); Adam W. Kersey, *Ticket to Ride: Standardizing Licensure Portability for Military Spouses*, 218 MIL. L. REV. 115 (2013); Paul J. Larkin, Jr., *Public Choice Theory and Occupational Licensing*, 39 HARV. J.L. & PUB. POL'Y 209 (2016); Steven Menashi & Douglas H. Ginsburg, *Rational Basis with Economic Bite*, 8 N.Y.U. J.L. & LIBERTY 1055 (2014); Clark M. Neily III, *Coaxing the Courts Back to Their Truth-Seeking Role in Economic Liberty Cases*, *in* ECONOMIC LIBERTY AND THE CONSTITUTION: AN INTRODUCTION 25, 27–31 (Paul J. Larkin, Jr. ed., Heritage Found. Special Report No. 157, 2014) http://www.heritage.org/the-constitution/report/economic-liberty-and-the-

policy[6] have criticized occupational licensing requirements as ordinarily being little more than legalized cartels,[7] noted for their

constitution-introduction [https://perma.cc/NDU6-6PA5]; W. Sherman Rogers, *Occupational Licensing: Quality Control or Enterprise Killer? Problems that Arise When People Must Get the Government's Permission to Work*, 10 J. BUS. ENTREPRENEURSHIP & L. 145 (2017); David Schleicher, *Stuck! The Law and Economics of Residential Stagnation*, 127 YALE L.J. 78 (2017); Roger V. Abbott, Note, *Is Economic Protectionism a Legitimate Governmental Interest Under Rational Basis Review?*, 62 CATH. U.L. REV. 475 (2013); Alexandra L. Klein, Note, *The Freedom to Pursue a Common Calling: Applying Intermediate Scrutiny to Occupational Licensing Statutes*, 73 WASH. & LEE L. REV. 411 (2015); Joseph Sanderson, Note, *Don't Bury the Competition: The Growth of Occupational Licensing and a Toolbox for Reform*, 31 YALE J. ON REG. 455 (2014).

6. *See, e.g.*, DANA BERLINER ET AL., FEDERALIST SOC'Y, REG. TRANSPARENCY PROJECT, OCCUPATIONAL LICENSING RUN WILD (2017), https://regproject.org/wp-content/uploads/RTP-State-Local-Working-Group-Paper-Occupational-Licensing.pdf [https://perma.cc/FPQ6-P3UZ]; DICK M. CARPENTER II ET AL., INST. FOR JUST., LICENSE TO WORK: A NATIONAL STUDY OF BURDENS FROM OCCUPATIONAL LICENSING (2d ed. 2017), https://ij.org/report/license-work-2/ [https://perma.cc/5XQW-SCVV]; JAMES C. COOPER ET AL., FEDERALIST SOC'Y, REG. TRANSPARENCY PROJECT, STATE LICENSING BOARDS, ANTITRUST, AND INNOVATION (2017), https://regproject.org/wp-content/uploads/RTP-Antitrust-Consumer-Protection-Working-Group-Paper-Occupational-Licensing.pdf [https://perma.cc/LFJ4-F8NV]; SARAH CURRY, PLATTE INST. FOR ECON. RES., 2017 OCCUPATIONAL LICENSING REVIEW (2017), https://www.platteinstitute.org/library/doclib/2017-Occupational-Licensing-Review.pdf [https://perma.cc/2RCU-DKBU]; DAVID N. MAYER, LIBERTY OF CONTRACT: REDISCOVERING A LOST CONSTITUTIONAL RIGHT (2011); TIMOTHY SANDEFUR, THE RIGHT TO EARN A LIVING: ECONOMIC FREEDOM AND THE LAW (2010); DANE STANGLER, PROGRESSIVE POL'Y INST., OCCUPATIONAL LICENSING: HOW A NEW GUILD MENTALITY THWARTS INNOVATION (2012), http://progressivepolicy.org/wp-content/uploads/2012/04/03.2012-Stangler_Occupational-Licensing_How-A-New-Guild-Mentality-Thwarts-Innovation1.pdf [https://perma.cc/34KA-6FMY]; ADAM B. SUMMERS, REASON FOUND., OCCUPATIONAL LICENSING: RANKING THE STATES AND EXPLORING ALTERNATIVES (2007), https://reason.org/wp-content/uploads/files/762c8fe96431b6fa5e27ca64eaa1818b.pdf [https://perma.cc/RZN9-HR8W]; Timothy Sandefur, *State "Competitor's Veto" Laws and the Right to Earn a Living: Some Paths to Federal Reform*, 38 HARV. J.L. & PUB. POL'Y 1009 (2015).

7. Contemporary denunciations of occupational licensing rules have their origins in the criticisms levied by experts long ago. *See, e.g.*, Allen v. Tooley, (1614) 80 Eng. Rep. 1055 (K.B.); Darcy v. Allen (The Case of Monopolies), (1603) 77 Eng. Rep. 1260 (Q.B.); 1 WILLIAM BLACKSTONE, COMMENTARIES *428; EDWARD COKE, THE SECOND PART OF THE INSTITUTES OF THE LAWS OF ENGLAND 47 (1642); MILTON FRIEDMAN, CAPITALISM AND FREEDOM 137–60 (1962); WALTER GELLHORN, INDIVIDUAL FREEDOM AND GOVERNMENTAL RESTRAINTS 105–51 (1956); ADAM SMITH, AN INQUIRY INTO THE NATURE AND CAUSES OF THE WEALTH OF NATIONS 118–29 (Edwin Cannan ed., Random House 1937) (1776); Walter Gellhorn, *The Abuse of Occupational Licensing*, 44 U. CHI. L. REV. 6 (1976); George J. Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3 (1971). Today's critics, however, are far more numerous than yesterday's.

proclivity to reduce supply and raise prices without producing any corresponding increase in quality.[8] Officials in the legislative,[9] executive,[10] and judicial[11] branches have responded to

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8. *See*, *e.g.*, Larkin, *supra* note 5, at 222–24 (discussing alleged benefits and costs of occupational licensure); *see also, e.g.*, *id.* at 235–37 ("Occupational licensing requirements have been criticized on several grounds. The most common has been that they hijack state power for the benefit of a few. They limit the number of service providers, thereby allowing the members of a given trade to avoid competition and raise prices, without supplying the corresponding service quality improvement promised to consumers. . . . The effect of licensing is to create a cartel that supplies its members with economic rents on an ongoing basis because entry restrictions operate like a 'hidden subsidy' to licensees. . . . Licensing requirements give licensees a 'premium' of four to thirty-five percent above the competitive price." (internal citations omitted)).

9. *See, e.g.*, PAUL J. LARKIN, JR., RECONSIDERING OCCUPATIONAL LICENSING IN VIRGINIA (Heritage Found., Legal Memorandum No. 227, 2018); Editorial Board, *A Model for Licensing Reform*, WALL ST. J. (Apr. 3, 2018), https://www.wsj.com/articles/a-model-for-licensing-reform-1522795235 [https://perma.cc/994M-6KZC] (discussing licensing reforms in Nebraska). Earlier this year, Kansas, Nebraska, and Tennessee revised their occupational licensing schemes to eliminate or ameliorate some licensing disqualifications imposed on offenders after their release. *See, e.g.*, *Kansas most recent state to revise occupational licensing law*, COLLATERAL CONSEQUENCES RESOURCE CTR. (May 11, 2018), http://ccresourcecenter.org /2018/05/11/kansas-the-most-recent-state-to-revise-its-occupational-licensing-law/ [https://perma.cc/E7LE-MMZA]; *Two more states regulate consideration of conviction in occupational licensing*, COLLATERAL CONSEQUENCES RESOURCE CTR. (Apr. 25, 2018), http://ccresourcecenter.org/2018/04/25/two-more-states-regulate-conviction-in-occupational-licensing/ [https://perma.cc/XD4X-YTPJ]. Congress has not enacted licensing reform, but there are members who are interested in doing so. *See, e.g.*, Alternatives to Licensing that Lower Obstacles to Work Act (ALLOW Act) of 2016, S. 3158, 114th Cong. § 2 (2016); PAUL J. LARKIN, JR., A POSITIVE STEP TOWARD OCCUPATIONAL LICENSING REFORM: THE ALLOW ACT (Heritage Found., Legal Memorandum No. 212, 2017) (discussing the ALLOW Act).

10. *See, e.g.*, *Occupational Licensing: Regulation and Competition: Hearing Before Subcomm. on Regulatory Reform, Commercial & Antitrust Law of the H. Comm. on the Judiciary*, 114th Cong. (2017) (prepared statement of Maureen K. Ohlhausen, Acting Chairman of the Federal Trade Commission), https://www.ftc.gov/system /files/documents/public_statements/1253073/house_testimony licensing and rbi act sept 2017 vote.pdf [https://perma.cc/6TP2-QNMZ]; WILLIAM BLUMENTHAL, FED. TRADE COMM'N, BACKGROUND MATERIALS: A PRIMER ON THE APPLICATION OF ANTITRUST LAWS TO THE PROFESSIONS IN THE UNITED STATES (2006), https://www.ftc.gov/sites/default/files/documents/public_statements/primer-application-antitrust-law-professions-united-states/20060929cbablumenthalmaterials_0.pdf [http://perma.cc/GV9M-SASB] (background materials accompanying remarks before the Canadian Bar Ass'n); CAROLYN COX & SUSAN FOSTER, BUREAU OF ECON., FED. TRADE COMM'N, THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION 21–27, 40 (1990), www.ramblemuse.com/articles/cox_foster.pdf [https://perma.cc/UEJ3-R4FE]; DEP'T

these criticisms by gradually starting to re-examine the merits of various occupational licensing requirements. The bulk of the discussion has focused on occupations such as barbering, cos-

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OF THE TREASURY OFFICE OF ECON. POLICY ET AL., OCCUPATIONAL LICENSING: A FRAMEWORK FOR POLICYMAKERS (2015), https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf [https://perma.cc/4Z6G-7T5P]; FED. TRADE COMM'N, ECONOMIC LIBERTY (2018), https://www.ftc.gov/policy/advocacy/economic-liberty [https://perma.cc/3YP3-2YN9]; OCCUPATIONAL LICENSING TASK FORCE & OKLA. DEP'T OF LABOR, OCCUPATIONAL LICENSING TASK FORCE REPORT: A STUDY OF OCCUPATIONAL LICENSING IN OKLAHOMA (2018), https://www.ok.gov/odol/documents/FINAL%20Report.pdf [https://perma.cc/S28P-DY9N]; *see also* Timothy J. Muris, *Principles for a Successful Competition Agency*, 72 U. CHI. L. REV. 165, 170 (2005) (Muris was the Chairman of the Federal Trade Commission (FTC) from 2001–04). The Federal Trade Commission has a long history of opposing occupational licensing requirements. *See generally* Letter from Tara Isa Koslov, Acting Dir. Office of Policy Planning, Fed. Trade Comm'n, et al., to Laura Ebke, Neb. State Senator 2–3 nn. 4–41 (Jan. 17, 2018) (regarding Nebraska Occupational Board Reform Act), https://www.ftc.gov/system/files/documents/ advocacy_documents/federal-trade-commission-staff-comment-nebraska-state-senate-regarding-nebraska-lb299-occupational/v180004_ftc_staff_comment_to_nebraska_state_senate_re_lb_299_jan-18.pdf [perma.cc/9U59-6CGN].

11. *See, e.g.*, N.C. St. Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101 (2015) (holding that a state board could be sued under the federal antitrust laws for an order prohibiting non-dentists from providing teeth whitening products or services); Edwards v. District of Columbia, 755 F.3d 996 (D.C. Cir. 2014) (holding a tour guide licensing requirement unconstitutional); St. Joseph Abbey v. Castille, 700 F.3d 154 (5th Cir. 2012) (holding a state law prohibiting the sale of caskets by anyone other than a licensed funeral director unconstitutional); Merrifield v. Lockyer, 547 F.3d 978 (9th Cir. 2008) (holding that a state pesticide licensing control scheme violated the Equal Protection Clause because it arbitrarily included non-pesticide, mechanical pest control devices); Craigmiles v. Giles, 312 F.3d 220 (6th Cir. 2002) (same); Brantley v. Kuntz, 98 F. Supp. 3d 884 (W.D. Tex. 2015) (holding that it was irrational to require schools that teach only hair braiding to have facilities to teach barbering as well); Bruner v. Zawacki, 997 F. Supp. 2d 691 (E.D. Ky. 2014) (holding that regulations that allowed existing residential moving companies to protest and effectively veto the entrance of competitors into the industry were unconstitutional); Clayton v. Steinagel, 885 F. Supp. 2d 1212 (D. Utah 2012) (concluding that it was irrational to require a natural hair braider to first obtain a cosmetology license); Cornwell v. Hamilton, 80 F. Supp. 2d 1101 (S.D. Cal. 1999) (holding that the State could not force the plaintiff to take a 1600-hour cosmetology course to practice African hair braiding); Patel v. Tex. Dep't of Licensing & Regulation, 469 S.W.3d 69 (Tex. 2015) (holding a Texas state law requiring "commercial eyebrow threaders"—viz., people who use cotton twine wrapped around their fingers to remove loose eyebrow hair—to complete 750 hours of instruction in chemistry, anatomy, physiology, electricity, nutrition, and "color psychology" violated the state constitution).

metology, floristry, taxi drivers, interior design, and the like.[12] Less attention has been paid to the health care professions. This Article seeks to address that deficiency.

America currently has a lack of qualified physicians to meet the needs of a growing—and aging—population.[13] That shortage is a serious problem, and it is attributable in part to the current medical licensure process.[14] Fortunately, the shortage of qualified physicians in the United States is a problem that can be addressed through policy. Reforms to medical licensure can have a material impact on access to care.[15] Although there are certainly other worthwhile reforms to address the paucity of medical providers,[16] this Article proposes two possible reforms

12. *See, e.g.*, Dick Carpenter & Lisa Knepper, *Do Barbers Really Need a License?*, WALL ST. J. (May 10, 2012), http://www.wsj.com/articles/SB10001424052702304451104577389691765508790 [https://perma.cc/VJ2R-XAT5]; Editorial Bd., *A license to be a florist? How occupational rules can be a burden on workers*, WASH. POST (Aug. 6, 2015), https://www.washingtonpost.com /opinions/a-license-to-be-a-florist-how-occupational-rules-can-be-a-burden-on-workers/2015/08/06/212ad5b6-3abb-11e5-9c2d-ed991d848c48_story.html?utm_term=.c9b6a563e95c [https://perma.cc/BDE2-J3DM]; Jacob Goldstein, *So You Think You Can Be a Hair Braider?*, N.Y. TIMES MAG. (June 17, 2012), https://www.nytimes.com/2012/06/17/magazine/so-you-think-you-can-be-a-hair-braider.html [https://nyti.ms/Lm66UT]; Eduardo Porter, *Job Licenses in the Spotlight as Uber Rises*, N.Y. TIMES (Jan. 27, 2015), http://www.nytimes.com/2015 /01/28/business/economy/ubers-success-casts-doubt-on-many-job-licenses.html? [https://nyti.ms/1ysVyr6]; Sophie Quinton, *States Don't Understand African Hair Braiding. That Hurts These Small-Business Owners*, NAT'L J. (Oct. 2, 2014), http://www.theatlantic.com/politics/archive/2014/10/states-dont-understand-african-hair-braiding-that-hurts-these-small-business-owners/431361/ [https://perma.cc/X26H-KC3E]; Stephanie Simon, *A License to Shampoo: Jobs Needing State Approval Rise*, WALL ST. J. (Feb. 7, 2011), https://www.wsj.com /articles/SB10001424052748703445904576118030935929752 [https://perma.cc/SG5Y-ZJJ2]; George F. Will, *Supreme Court has a chance to bring liberty to teeth whitening*, WASH. POST (Oct. 10, 2014), http://www.washingtonpost.com/opinions/george-will-supreme-court-has-a-chance-to-promote-cleaner-competition/2014/10/10/13a3a2c0-4fd8-11e4-babe-e91da079cb8a_story.html?hpid=z7 [https://perma.cc/JE2T-GQ2Z]; *see also* Larkin, *supra* note 5, at 216–18 (listing various occupations subject to licensure).

13. *See infra* Part I.

14. *See infra* Part II.

15. *See infra* Part IV.

16. *See generally, e.g.*, KEVIN D. DAYARATNA & JOHN O'SHEA, ADDRESSING THE PHYSICIAN SHORTAGE BY TAKING ADVANTAGE OF AN UNTAPPED MEDICAL RESOURCE 4 (Heritage Found., Backgrounder No. 3221, 2017),

that could ameliorate the current shortage of physicians: (1) states should streamline entry for experienced physicians from abroad, and (2) states should have provisional licensing for medical school graduates who do not find a residency position after graduation.

This Article makes those arguments as follows. Parts I and II describe the current shortfall of physicians in the United States and the sources from which physicians come. Part III describes the current system of American medical licensure and how that system produces an inadequate number of licensed physicians. Part IV discusses the question of whether the current medical training and licensing process is appropriate. It concludes that, although necessary, the current system can be modified and improved. Part V offers some remedies that maintain the necessary features of medical licensing but ensure that a larger number of qualified medical school graduates are available to participate in patient care to help alleviate the current physician shortfall.

I. THE CURRENT SHORTAGE OF PHYSICIANS

Access to medical care has been a problem, especially in rural areas, for decades.[17] Although nearly 20 percent of the

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https://www.heritage.org/sites/default/files/2017-06/BG3221_0.pdf [https://perma.cc/KV7C-Q7ZM]; JOHN S. O'SHEA, REFORMING GRADUATE MEDICAL EDUCATION IN THE U.S. 3 (Heritage Found., Backgrounder No. 2983, 2014), http://thf_media.s3.amazonaws.com/2014/pdf/BG2983.pdf [https://perma.cc/FC5C-MRY9]; Jeffrey S. Flier & Jared M. Rhoads, *The US Health Provider Workforce: Determinants and Potential Paths to Enhancement* (Mercatus Working Paper Series, 2018), https://www.mercatus.org/publications/us-health-provider-workforce [https://perma.cc/ZN24-QXZS].

17. *See* Howard K. Rabinowitz et al., *Increasing the Supply of Women Physicians in Rural Areas: Outcomes of a Medical School Rural Program*, 24 J. AM. BD. OF FAMILY MED. 740, 740 (2011), http://www.jabfm.org/content/24/6/740.full [https://perma.cc/F6TH-UBA4]; Howard K. Rabinowitz et al., *A Program to Increase the Number of Family Physicians in Rural and Underserved Areas: Impact After 22 Years*, 281 JAMA 255, 255 (1999), http://jamanetwork.com/journals/jama/fullarticle/188379 [https:// perma.cc/73Z6-5AAB]; John R. Wheat et al., *Medical Education to Improve Rural Population Health: A Chain of Evidence From Alabama*, 31 J. RURAL

American population lives in rural areas, fewer than 10 percent of primary care providers practice in such areas.[18] In fact, as of 2016, the U.S. Department of Health and Human Services designated more than 6,000 areas of the country, population groups, or health care facilities as having a shortage of primary care physicians.[19] Unfortunately, this problem is only going to worsen over the next decade. The Association of American Medical Colleges (AAMC) projects a nationwide shortage of between 40,800 and 104,900 physicians in both primary and specialty care throughout the country by 2030.[20] Appendix A illustrates the shortage that we are facing.

The reason for this shortfall is that the demand for physician services is expected to grow faster than the supply. Americans are aging. The number of Americans aged 65 and older is forecasted to grow by more than half (55 percent) from 2015 to 2030.[21] Without a comparable increase in the number of practicing physicians, there will be inadequate access to necessary health care services throughout many areas of the country regardless of what medical coverage and payment structure the nation ultimately adopts.[22] The states, which are responsible for

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HEALTH 354, 355 (2015), http://onlinelibrary.wiley.com/doi/10.1111/jrh.12113/epdf [http:// perma.cc/79QR-CKHC].

18. *See* Joshua Ewing & Kara Nett Hinkley, *Meeting the Primary Care Needs of Rural America: Examining the Role of Non-Physician Providers*, NAT'L CONF. STATE LEGIS. (Apr. 2013), http://www.ncsl.org/documents/health/RuralBrief313.pdf [https://perma.cc/2MXF-9YPN]; *Rural Practice, Keeping Physicians In*, AAFP POLICIES (Feb. 26, 2015), http://www.aafp.org/about/policies/all/rural-practice-paper.html [https://perma.cc /V62T-48NM].

19. *HRSA Fact Sheet: FY 2016 – Nation*, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH RES. & SERVS. ADMIN. (2016), https://data.hrsa.gov/data/fact-sheets [http://perma.cc/AMD9-WXWF] (select Geographic Area "Nation" & Fiscal Year "FY 2016" and follow "View Fact Sheet PDF" hyperlink).

20. *See* TIM DALL ET AL., THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND 2017 UPDATE: PROJECTIONS FROM 2015 TO 2030, at 3 (2017), https://aamc-black.global.ssl.fastly.net/production/media/filer_public/a5/c3/a5c3d565-14ec-48fb-974b-99fafaeecb00/aamc_projections_update_2017.pdf [https://perma.cc/YQE2-6KYR].

21. *Id.* at 16.

22. *See id.*

licensing physicians, should take the lead in meeting the needs of the population in (at least) two ways. First, the states should streamline the processes whereby qualified and experienced doctors from foreign countries can practice medicine in this country. Second, the states should allow American medical schools graduates who are not members of a residency program to receive provisional licensure to practice under the supervision of a licensed physician.[23]

This impending physician shortage is a pressing problem that needs to be addressed immediately. Understanding the nature of the problem requires a detailed discussion of the evolution of the education and training of physicians in America.

II. THE CURRENT SOURCE OF PHYSICIANS

In order to become a practicing physician, prospective doctors are required to graduate from an accredited medical school. The Liaison Commission on Medical Education, an entity co-sponsored by the American Medical Association and the Association of American Medical Colleges, accredits American medical schools.[24] Foreign medical school graduates must receive certification from the Educational Commission of Foreign

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23. Another option would be to allow physician assistants to engage in the same medical practices as physicians, but that revision would require redefining the scope of practice rather than increasing the number of physician practitioners. That issue is beyond the scope of this Article.

24. The American Association of Colleges of Osteopathic Medicine (AACOM) accredits Colleges of Osteopathic Medicine. *See* AM. ASS'N OF COLLEGES OF OSTEOPATHIC MED. (2018), http://www.aacom.org/become-a-doctor/us-coms [https://perma.cc/T5XX-VDNZ]. Some states have one board to regulate both allopathic and osteopathic medicine. *See*, *e.g.*, VA. CODE ANN. §§ 54.1-2400, 54.1-2400.01:1.A & .B, 54.1-2930 to 54.1-2932 (2018); *Virginia Board of Medicine: Professions Regulated by the Board*, VA. DEP'T OF HEALTH PROFESSIONS, https://www.dhp.virginia.gov/medicine/medicine_occupations.htm [https://perma.cc/9N6N-SALY] (last visited Oct. 3, 2018); *cf*. D'Amico v. Bd. of Med. Exam'rs, 520 P.2d 10, 27 (Cal. 1974) (holding that the federal and state constitutions require that graduates of osteopathic schools must be eligible to apply to become physicians); Osteopathic Physicians & Surgeons of Cal. v. Cal. Med. Ass'n, 36 Cal. Rptr. 641 (Ct. App. 1964) (describing the history of conflict between allopathic and osteopathic medicine).

Medical Graduates (ECFMG) to enter a residency program.[25] The ECFMG requires that foreign graduates have graduated from an institution listed in the World Dictionary of Medical Schools and have passed the first two steps of the United States Medical Licensing Exams (USMLE).[26] Graduates of an accredited residency-training program can then pursue additional GME training via fellowships to prepare them further to practice in particular subspecialties (e.g., pediatric heart surgery).[27]

Postgraduate medical training already existed for well over the course of the last century. Initially, however, much of this training was offered informally via short courses, apprenticeships, or brief periods of study in Europe.[28] Until the 1960s, American hospitals handled the costs of GME directly. Beginning in 1965, however, the federal government became formally involved in postgraduate medical training by making GME funding a required component of Medicare spending.[29] Other government agencies, such as Medicaid, the Veterans Administration, and the Health Resources and Services Administration (HRSA) also provide financial support for GME, but to a much lesser extent.[30]

In the first three decades following the implementation of Medicare, government spending on GME grew at an alarming

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25. Graduating from an accredited medical school is a prerequisite for obtaining graduate medical education training and practicing under provisional licensure in Missouri, Kansas, Arkansas, and Utah. For further discussion of provisional licensure, see DAYARATNA & O'SHEA, *supra* note 16, at 4.

26. *Requirements for Certification*, EDUC. COMM'N FOR FOREIGN MED. GRADUATES (Sept. 13, 2018), http://www.ecfmg.org/certification/requirements-for-certification.html [https://perma.cc/9NPE-ZNG4].

27. *Specialty and Subspecialty Certificates*, AM. BOARD MED. SPECIALTIES, https://www.abms.org/member-boards/specialty-subspecialty-certificates [https://perma.cc/S4WC-DCXK].

28. John S. O'Shea, *Becoming a Surgeon in the Early 20th Century: Parallels to the Present*, 65 J. SURGICAL EDUC. 236, 237–39 (2008).

29. O'SHEA, *supra* note 16, at 3.

30. *See id*. at 3–4.

rate.[31] As a result, when President Bill Clinton signed into law the Balanced Budget Act of 1997,[32] it included a provision that capped the number of Medicare-funded residency slots at 1996 levels, a cap that has remained in place for the last two decades.[33] Today, taxpayers contribute more than $10 billion per year to GME funding, over $9 billion of which comes from Medicare.[34] Health Research and Services Administration (HRSA) funding constituted slightly under $300 million in taxpayer funds, and the Veterans Administration spends in between $1.4 and $1.5 billion per year. Private sources also supply an unspecified amount of GME funding.[35]

Each September, senior medical students, as well as some medical school graduates, apply for GME training positions through the National Residency Matching Program (NRMP).[36] Postgraduate training can last from three to seven years and training programs receive accreditation from a nonprofit organization known as the Accreditation Council for Graduate Medical Education (ACGME). The curricula are structured according to guidelines from ABMS member groups for each

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31. *See* ELAYNE J. HEISLER ET AL., CONG. RESEARCH SERV., FEDERAL SUPPORT FOR GRADUATE MEDICAL EDUCATION: AN OVERVIEW 6–10 (2016), https://fas.org/sgp/crs/misc/R44376.pdf [https://perma.cc/8S2E-WWYG].

32. Pub. L. No. 105-33, 111 Stat. 251 (1997).

33. *See* O'SHEA, *supra* note 16, at 3.

34. *See* CONG. BUDGET OFFICE, OPTIONS FOR REDUCING THE DEFICIT: 2017 TO 2026, at 257 (2016), https://www.cbo.gov/system/files?file=2018-09/52142-budgetoptions2.pdf [https://perma.cc/8PT6-DJZU].

35. *See id.*; *see also* HEALTH RES. & SERVS. ADMIN., DEP'T HEALTH & HUMAN SERVS., FISCAL YEAR 2017 JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEE 37, 186–93 (2017), https://www.hrsa.gov/sites/default/files/about/budget/budgetjustification2017.pdf [https://perma.cc/AH4L-EUJZ]; Renee Butkus et al., *Financing U.S. Graduate Medical Education: A Policy Position Paper of the Alliance for Academic Internal Medicine and the American College of Physicians*, 165 ANNALS INTERNAL MED. 134, 134–37 (2016).

36. *See* Anna Maria Barry-Jester, *Another 34,000 People Are About To Put Their Future In The Hands Of An Algorithm*, FIVETHIRTYEIGHT (Feb. 9, 2015), https://fivethirtyeight.com/features/another-34000-people-are-about-to-put-their-future-in-the-hands-of-an-algorithm [https://perma.cc/27U9-S22E].

specialty.[37] After completing a residency training program, graduates are eligible to sit for the board certification examination specific to their chosen specialty and written by the associated ABMS member group.[38]

III. THE CURRENT SYSTEM OF MEDICAL LICENSURE

The postgraduate requirements to receive a medical license vary by state. All states require some graduate training, from one to three years, in addition to completion of the final step of the USMLE before granting a license.[39] That license enables the trainee to practice medicine in the state in which it is issued.[40] Even though board certification is technically a voluntary process and completing a residency training program is not always a requirement for medical licensure, it is usually in the trainee's interest to do so. Graduation from an ACGME accredited program is a prerequisite for board certification and a physician who is not board certified might find it very difficult, if not impossible, to obtain hospital staff privileges, affordable malpractice insurance, or reimbursement from insurance companies.[41]

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37. *See id.*; *see also About Us*, ACCREDITATION COUNCIL GRADUATE MED. EDUC., https://www.acgme.org/About-Us/Overview [https://perma.cc/Q69C-2ESR] (last visited Oct. 1, 2018).

38. *See* Barry-Jester, *supra* note 36.

39. *See, e.g.*, *State-Specific Requirements for Initial Medical Licensure*, FED'N STATE MED. BDS. (2017), https://www.fsmb.org/step-3/state-licensure [https://perma.cc/NM9L-UQ6x].

40. *See id.*

41. Although each hospital medical staff is free to establish its own bylaws, many require board certification to maintain privileges. *See* Elaine Cox, *Board Certification for Doctors: What Does it Really Mean?*, U.S. NEWS WORLD REP. (Apr. 26, 2017), https://health.usnews.com/health-care/for-better/articles/2017-04-26/board-certification-for-doctors-what-does-it-really-mean [https://perma.cc/ZK3X-YCZB]; *see also Physician Recruitment 101: Board Certification and Eligibility*, PINNACLE HEALTH GRP. (June 18, 2012), http://www.phg.com/2012/06/physician-recruitment-101-board-certification-and-eligibility [https://perma.cc/ZLY2-XM4E]. A number of factors can affect the cost of medical malpractice insurance, such as state medical liability laws and the physician's specialty. Board certified physicians, however, often pay less than their uncertified counterparts do. *See, e.g.*, *How*

Two major nongovernment entities, ACGME and ABMS, occupy key positions in the educational accreditation, licensure, and certification of doctors in this country.[42] Those organizations are technically private entities. Nonetheless, because residency programs accredited by the ACGME are structured according to criteria determined by the ABMS member boards, and all state licensing boards require at least some participation in these programs before granting a medical license, those organizations effectively monopolize the only pathway to physician licensure and certification in America.

The current domestic postgraduate physician training and licensing processes have a negative effect on access to care for a variety of reasons.

A. There Is an Insufficient Number of Training Positions

The number of medical graduates matching into a first-year residency position has increased over the last decade and half from 18,354 in 2001 to 29,040 in 2018.[43] Due to an insufficient number of residency training positions, however, the number of American and foreign medical school graduates in the United States who did not obtain a first-year residency position has also steadily grown over this same period, from 5,627 in 2001 to 8,063 in 2018.[44] The graph at Appendix B illustrates that prob-

Can a Physician or Surgeon Reduce His Medical Malpractice Insurance Premium?, GRACEY-BACKER, INC., http://www.graceybacker.com/how-can-a-physician-or-surgeon-reduce-his-medical-malpractice-insurance-premium/ [https://perma.cc/568S-EPUQ] (last visited Nov. 27, 2018).

42. The Bureau of Osteopathic Specialists and the Council on Osteopathic Postdoctoral Training—both funded by the American Osteopathic Association—perform similar functions for Doctors of Osteopathy. *See* AM. ASS'N CS. OSTEOPATHIC MED., *supra* note 24.

43. *Compare* NAT'L RESIDENCY MATCHING PROGRAM, RESULTS AND DATA: 2018 MAIN RESIDENCY MATCH 15 (2018), http://www.nrmp.org/wp-content/uploads/2018/04/Main-Match-Result-and-Data-2018.pdf [https://perma.cc/3AUZ-ZZ9r], *with* NAT'L RESIDENCY MATCHING PROGRAM, RESULTS AND DATA: 2001 MATCH 5 (2001), https://mk0nrmpcikgb8jxyd19h.kinstacdn.com/wp-content/uploads/2013/08/resultsanddata2001.pdf [https://perma.cc/L873-DHFY].

44. *See* RESULTS AND DATA: 2018 MAIN RESIDENCY MATCH, *supra* note 43, at 5, 15.

lem. Despite the current shortage of physicians in many regions of the nation, those medical school graduates cannot participate in patient care in any meaningful capacity. Unable to find employment in their chosen field, they are often relegated to working in other professions, including driving taxis and selling sunglasses.[45]

B. *There Are Geographic Disparities in the Availability of Qualified Physicians*

GME funding results in geographic disparities of the supply of physicians across the country. For example, a 2014 study found that New York has 77 Medicare-funded residents per 100,000 population members, while California and Florida each have 19 and 14 residents, respectively.[46] Worse still, Arkansas has just 3 Medicare-funded residents per 100,000 people.[47] Because evidence shows that physicians are more likely than not to practice in the region where they have been trained, the unequal distribution of resident placement means some areas of the country are more prone to physician access problems than others.[48]

C. *There Is a Failure to Understand and Respond to Patient Demand*

The current GME system also fails to properly assess the needs of the physician workforce. With government funding going directly to teaching hospitals, the money inevitably is spent on the insular institutional needs of the hospital rather than the health care needs of the population as a whole.[49] This arrangement makes it difficult to meet the evolving needs of the population, such as increasing the supply of primary care

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45. *See id.* at 2–3.
46. *See* O'SHEA, *supra* note 16, at 5.
47. *See id.* at 11.
48. *See Why Rural America Doesn't Attract Doctors*, ADVISORY BD. (Sept. 2, 2014), https://www.advisory.com/daily-briefing/2014/09/02/why-rural-america-doesnt-attract-doctors [https://perma.cc/6PXX-92LM].
49. *See* O'SHEA, *supra* note 16, at 11.

physicians and general surgeons for rural areas or training more pediatric neurosurgeons and trauma specialists.[50]

D. *The Current Training Model Excludes Many Foreign Doctors*

Lastly, the current training model excludes many foreign doctors, both recent graduates and some with considerable experience. In order to obtain a medical license, any doctor, whether educated in the United States or abroad, must complete one to three years of residency training depending on the state, as well as pass all three steps of the USMLE.[51] Statistics indicate that many residency programs have traditionally accepted few, if any, foreign graduates.[52] These restrictions, although not government policy, indirectly constrain the supply of medical doctors in the United States.[53]

In sum, the current postgraduate medical training and licensing process does not produce the appropriate number and composition of medical practitioners for the U.S. population. As discussed earlier, this situation will become increasingly dire in the coming years for both demand- and supply-side reasons. The American population will continue to age and demand more geriatric care, while members of the aging phy-

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50. *See id*. at 12.

51. *See Chart of Physician Licensing Requirements by State*, SISKIND SUSSER PC (2014), http://visalaw.wpengine.com/wp-content/uploads/Physician-Licensing-Requirements-1st-version.pdf [https://perma.cc/MK34-NL5G].

52. *International Medical Graduates (IMGs) and the US Residency Match*, MATCH A RESIDENT, https://www.matcharesident.com/imgs-and-residency [https://perma.cc/F55B-8B42] (last visited Sept. 25, 2018).

53. An additional issue is whether residency program requirements are biased against community hospitals. On the one hand, it could be argued that ACGME requirements are more favorable to urban academic hospitals than to rural community facilities. Moreover, to the extent that residency program graduates prefer to work in nearby areas, more will remain in large cities than in sparsely populated regions. On the other hand, medical school practical training programs include a substantial amount of time for students to perform a rotation in a community hospital and in outpatient settings as part of the training experience. There are also a number of community hospitals that do serve as primary training institutions. Accordingly, there are reasonable arguments to be made for either side of this issue.

sician workforce will continue to retire or leave the practice of medicine and not be replenished at a sufficient rate to satisfy the increased demand for care.

IV. DO OVERLY RESTRICTIVE MEDICAL LICENSURE LAWS ACTUALLY PROTECT PATIENTS?

With significantly fewer residency positions than candidates applying, the process for obtaining a medical license in this country has become extremely difficult and competitive. Supporters of the current system would argue, however, that such restrictive processes are necessary to protect patients from harm.[54]

The argument goes as follows. States have the authority to legislate to protect the public against injury, a power known as the "police power."[55] One incident of that power is the authority to regulate the practice of medicine by setting qualifications to diagnose disease, prescribe medication, or perform surgery.[56] In 1889, the Supreme Court of the United States upheld a state law requiring a person to obtain a certificate of graduation from a reputable medical school, prove that he had practiced medicine in the state for ten years, or pass a qualifying examination to practice medicine in the state.[57] The Court reasoned that the practice of medicine required specialized education and training that the average person does not possess.[58] Since then, the courts have consistently recognized that states have a strong interest in limiting who may practice medicine.[59]

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54. Associated Press, *Skip residency? State efforts to ease doctor shortage face criticism*, MOD. HEALTHCARE (Dec. 13, 2015), http://www.modernhealthcare.com/article/20151213/NEWS/151219951 [https://perma.cc/MX5G-78ZF].

55. *See, e.g.*, Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905) (noting that the state has authority to adopt reasonable regulations of life, liberty, and property "as will protect the public health and the public safety").

56. *See Chart of Physician Licensing Requirements by State*, *supra* note 51.

57. *See* Dent v. West Virginia, 129 U.S. 114, 115 (1889).

58. *See id*. at 122.

59. *See* Larkin, *supra* note 5, at 209, 278–79 & n.332.

Research over the last several decades, however, has illustrated that overly restrictive licensure laws can be counterproductive. For example, a study published by Chris Paul in the *Southern Economic Journal* argued that physician licensure is primarily the result of organized physicians manipulating the political system to limit entry and raise salaries with no statistically significant impact on quality of care.[60] Two decades later, Chris Conover of Duke University estimated medical licensure to cost Americans $6.5 billion, resulting in $4.7 billion in increased income for health care providers.[61] Other research has suggested that physician licensure laws are often overly stringent, constrict patient choice, limit innovation, and raise costs while offering no meaningful improvements to quality.[62] In some cases, patients may even forgo medical treatment when access to care is exceptionally difficult to find.[63] In an extreme example of the unintended consequences of restrictive professional licensing, a Michigan man gave himself a root canal to avoid having to pay for one at a dentist's office.[64] Those studies and occurrences are consistent with the views of commentators who have analyzed the effects of occupational licensing in general.[65]

60. *See* Chris Paul, *Physician Licensure Legislation and the Quality of Medical Care*, 12 ATL. ECON. J. 18 (1984).

61. CHRISTOPHER J. CONOVER, HEALTH CARE REGULATION: A $169 BILLION HIDDEN TAX 12 (Cato Inst., Policy Analysis No. 527, 2004), https://object.cato.org/sites/cato.org/files/pubs/pdf/pa527.pdf [https://perma.cc/YX6W-2JSB].

62. *See id.* at 10; *see also* Gregory Dolin, *Licensing Health Care Professionals: Has the United States Outlived the Need for Medical Licensure?*, 2 GEO. J.L. & PUB. POL'Y 315 (2004); Barry J. Seldon, *Market Power among Physicians in the U.S.*, 1983–1991, 38 Q. REV. ECON. & FIN. 799 (1998).

63. Darla Mercado, *Here's why a quarter of American families are skipping their doctor visits*, CNBC (June 7, 2017, 12:17 PM), https://www.cnbc.com/2017/06/07/heres-why-a-quarter-of-american-families-are-skipping-their-doctor-visits.html [https://perma.cc/P8C2-Z5DP].

64. Tom Rademacher, *Don't Try This at Home: Man Does Own Root Canals*, ANN ARBOR NEWS, Feb. 9, 1999, at A11.

65. *See* Larkin, *supra* note 5, at 209, 237–38 ("Occupational licensing restrictions can result in more than two million fewer jobs nationwide, with an annual cost to

Occupational licensing is one of the country's "principal forms of economic regulation," subjecting a myriad of fields—including auctioneers, cosmetologists, hair braiders, and florists—in many cases to inane and onerous licensing requirements.[66] Licensure requirements are generally defended on the ground that they mitigate informational asymmetry because consumers ordinarily lack the time necessary to acquire the pertinent expertise to judge an individual's qualifications.[67] Medical licensing rules are the classic example, as the Supreme

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consumers of more than $100 billion. Moreover, government regulators or law enforcement officials enforce licensing rules, sometimes through the criminal law, and tax dollars fund the salaries and expenses of those officials. The result is that consumers lose twice from licensing requirements—through higher prices and higher tax bills—and the beneficiaries do not incur the transaction costs of enforcement. Licensing programs also do not provide guaranteed improvements in service quality. Studies show the difficulty of proving that quality enhancements offset price increases from licensing. One explanation is that many factors affect the quality of a service-provider's work (such as the amount of time a professional spends with a client), and the service provider is free to adjust the inputs not controlled by licensing (by reducing that time, for example). Consequently, even a 'mandated increase in one or several inputs' (satisfying fixed educational or training requirements is one example) 'does not necessarily imply that quality will increase.' Competition, by contrast, spurs quality improvements in order to retain existing customers and attract new ones. The higher prices resulting from licensing requirements also may persuade consumers to attempt 'do-it-yourself' projects, a practice that can prove dangerous for the consumer as well as third parties when, for example, an untrained individual attempts to perform electrical work." (footnotes omitted) (citations omitted)).

66. *See id.* at 219 ("Are the health, welfare, and safety of the community really put at risk if society allows unlicensed florists, interior designers, and frog farmers to ply their trades? Is anyone's life cheapened if he or she hires an unlicensed cat groomer, home entertainment installer, or makeup artist? Why do we need to license bartenders? To ensure that they know a grasshopper from a Manhattan? To guarantee that they are good listeners? And how would anyone even go about deciding whether a fortuneteller is qualified? Do you ask, 'Who will win the next Super Bowl?' 'How many fingers am I holding up?' Besides, what is the passing rate? Is two-for-three good enough? And is it an automatic disqualification if the fortuneteller is not richer than Croesus?" (footnotes omitted)); *see also* PAUL J. LARKIN, JR., A BRIEF HISTORY OF OCCUPATIONAL LICENSING (Heritage Found., Legal Memorandum No. 204, 2017); PAUL J. LARKIN, JR., A PUBLIC CHOICE ANALYSIS OF OCCUPATIONAL LICENSING (Heritage Found., Legal Memorandum No. 205, 2017).

67. *See, e.g.*, Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 966 (1963).

Court noted more than a century ago.[68] Nonetheless, occupational licensing regulations are not always necessary, and in most fields are far too onerous to be justified on informational asymmetry grounds. Additionally, licensing requirements encourage incumbents to pursue rent-seeking cartels created by

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68. As the Supreme Court explained in *Dent v. West Virginia*:

> Few professions require more careful preparation by one who seeks to enter it than that of medicine. It has to deal with all those subtle and mysterious influences upon which health and life depend, and requires not only a knowledge of the properties of vegetable and mineral substances, but of the human body in all its complicated parts, and their relation to each other, as well as their influence upon the mind. The physician must be able to detect readily the presence of disease, and prescribe appropriate remedies for its removal. Every one may have occasion to consult him, but comparatively few can judge of the qualifications of learning and skill which he possesses. Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications. Due consideration, therefore, for the protection of society may well induce the state to exclude from practice those who have not such a license, or who are found upon examination not to be fully qualified. The same reasons which control in imposing conditions, upon compliance with which the physician is allowed to practice in the first instance, may call for further conditions as new modes of treating disease are discovered, or a more thorough acquaintance is obtained of the remedial properties of vegetable and mineral substances, or a more accurate knowledge is acquired of the human system and of the agencies by which it is affected. It would not be deemed a matter for serious discussion that a knowledge of the new acquisitions of the profession, as it from time to time advances in its attainments for the relief of the sick and suffering, should be required for continuance in its practice, but for the earnestness with which the plaintiff in error insists that, by being compelled to obtain the certificate required, and prevented from continuing in his practice without it, he is deprived of his right and estate in his profession without due process of law. We perceive nothing in the statute which indicates an intention of the legislature to deprive one of any of his rights. No one has a right to practice medicine without having the necessary qualifications of learning and skill, and the statute only requires that whoever assumes, by offering to the community his services as a physician, that he possesses such learning and skill, shall present evidence of it by a certificate or license from a body designated by the state as competent to judge of his qualifications.

129 U.S. 114, 122–23 (1889). The Court has reaffirmed a state's authority to regulate the practice of medicine on numerous occasions since its decision in *Dent*. *See* Larkin, *supra* note 5, at 278–79 & n.332.

state lawmakers that protect incumbents and politicians while burdening consumers.[69]

Of course, medicine is inherently different from most other fields. Still, overly restrictive licensure laws always result in the same phenomenon: an artificial reduction in the number of practitioners. Those restrictions severely limit access to care, ironically hurting the very people they are designed to help. Thus, especially in light of the impending physician shortage, it is necessary to pursue improvements to the current medical licensure laws to alter the present state of affairs.

V. ADDRESSING THE PROBLEM: POLICY RECOMMENDATIONS

The practice of medicine in America is a highly regulated industry. The resulting insulation from competition contributes to the undersupply and misdistribution of medical providers nationwide. We propose two reforms that would increase the supply of medical care in this country without putting the public's health at risk.

A. Streamline Entry for Experienced Physicians from Abroad

Simply to obtain a license, the current medical system in the United States requires many experienced foreign doctors to complete the same type of postgraduate medical training as a graduate of an American medical school who has no independent practical experience.[70] Faced with the prospect of spending years repeating the same type of internship and residency training they completed decades ago at home, many highly qualified physicians from abroad might simply forgo the idea of practicing in the United States. Although some ac-

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69. *See* Larkin, *supra* note 5, at 241.

70. Catherine Rampellaug, *Path to United States Practice Is Long Slog to Foreign Doctors*, N.Y. TIMES (Aug. 11, 2013), https://www.nytimes.com/2013/08/12/business/economy/long-slog-for-foreign-doctors-to-practice-in-us.html [https://nyti.ms/2k9kgxu].

climation to the American medical system might be necessary for foreign doctors, the current system is far too onerous. To address that issue, state lawmakers should consider legislation that would streamline the process for admitting experienced foreign doctors to the medical workforce.

The Australian medical licensure system is a valuable case study. In Australia, foreign doctors who are licensed in their home countries, and who have passed Australian licensing exams or their equivalents, can obtain a provisional license to practice primary care under a collaborating physician or hospital.[71] The Australian Medical Board suggests four different potential levels of supervision, based on the foreign doctor's qualifications, ranging from constant supervision for those with less experience to regular but significantly less frequent supervision for those who have practiced independently for a substantial amount of time.[72] The Medical Board requires the supervising practitioner to adhere strictly to these regulations.[73] After demonstrating sufficient competence, experienced practitioners can be eligible for a full medical license from the Board.[74]

Canada and the European Union also have policies for accepting foreign doctors that are not nearly as onerous as the American system.[75] In addition, reciprocity agreements allow participating nations to accept training in a different nation as a

71. *Competent Authority Pathway*, MED. BD. AUSTL. (Aug. 22, 2018), https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Competent-Authority-Pathway.aspx [https://perma.cc/P3TR-6EUG].

72. MED BD. OF AUSTL., GUIDELINES: SUPERVISED PRACTICE FOR INSTITUTIONAL MEDICAL GRADUATES 6–7 (2016).

73. *See id.* at 9.

74. *See Competent Authority Pathway*, *supra* note 71.

75. *See Automatic Recognition*, EUR. COMM'N, http://ec.europa.eu/growth/single-market/services/free-movement-professionals/qualifications-recognition/automatic_en [https://perma.cc/Z7GJ-9XKA] (last visited Nov. 30, 2018); *Recognized Training and Certification outside Canada*, C. FAM. PHYSICIANS CAN., http://www.cfpc.ca/RecognizedTraining/ [https://perma.cc/G8S7-FZUK] (last visited Sept. 29, 2018).

first step toward full medical licensure.[76] American licensing boards could benefit from pursuing similar policies. Doing so would not only help attract experienced foreign doctors, but also steer them away from the current graduate medical education system, which, as previously mentioned, depends heavily on federal funding and has a large bottleneck, with more medical graduates applying than slots available.[77]

Some policies are already in place offering limited licenses, advanced standing, and alternative pathways to a select number of experienced foreign physicians on an ad hoc basis.[78] Those policies, however, do not seriously address the physician shortage, and they do not alleviate the strain on the current GME system that has a fixed number of residency positions. Policies that address the issue of foreign doctors who wish to practice in the United States should be broader and need to include the option of allowing the most experienced physicians to practice independently, provided they meet established criteria.

B. Encourage States to Allow Provisional Licensure for Medical School Graduates Not Accepted into Residency Programs

For the years 2014 through 2018, on average each year 8,444 American and foreign medical school graduates did not find a position in a residency program.[79] That surplus of talent could

76. *See Recognized Training and Certification outside Canada*, *supra* note 75.

77. Congress could also pass legislation encouraging states to offer provisional or regular licenses to foreign doctors, giving states the option to opt out of such policy if they desire.

78. *See, e.g.*, VA. CODE. ANN. § 54.1-2936 (2018); *Advanced Level Entry/Interprogram Transfers*, AM. BD. FAM. MED., https://www.theabfm.org/cert/advlevel.aspx [https://perma.cc/C9NF-29Y2] (last visited Sept. 29, 2018); *International Medical Graduates Alternative Pathway*, AM. BD. RADIOLOGY (Aug. 27, 2018), https://www.theabr.org/diagnostic-radiology/initial-certification/alternate-pathways/international-medical-graduates [https://perma.cc/9Y4P-ZHZ2]; *Training and Certification*, AM. BD. SURGERY, http://www.absurgery.org/default.jsp?certintlgraduates [https://perma.cc/TC7Y-CR8V] (last visited Sept. 29, 2018).

79. *See* NAT'L RESIDENT MATCHING PROGRAM (2018), *supra* note 43, at 15.

be immensely useful in ameliorating shortages of medical care throughout the country. Heritage Foundation research suggested that state lawmakers should allow the provisional licensing of those medical graduates to work under the supervision of a qualified physician.[80] After all, those graduates have acquired a substantial amount of education and training during their medical studies and, under appropriate supervision, could use their knowledge in areas of need.[81]

Requirements for the provisional license, which would be issued by a state's medical licensing board, should include earning a medical degree from an accredited medical school, passing the USMLE, and collaborating with a supervising licensed physician. Details regarding the supervision and the nature of collaboration should be documented by a contract between the medical graduate and the supervising physician subject to medical board approval.

Certainly, most graduates lack independent practical experience and will likely require closer supervision than many foreign doctors who have practiced independently for a number of years. But to prevent those well-educated medical school graduates from participating in any form of patient care and possibly end their hopes of pursuing a career in medicine, simply because the current process for training and licensing doctors cannot accommodate them, is a terrible waste of a valuable resource.

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80. *See* DAYARATNA & O'SHEA, *supra* note 16, at 4.

81. It is increasingly common to see Physician Assistants ("PAs") used to help ameliorate the physician shortage. *See, e.g.*, *Physician Assistants Moving Into Specialties Amid Doctor Shortage*, FORBES (July 14, 2016), https://www.forbes.com /sites/brucejapsen/2016/07/14/physician-assistants-moving-into-specialties-amid-doctor-shortage/#22c062105874 [https://perma.cc/66DA-D9S3]. PAs are seeking greater autonomy through changes in state scope of practice laws. If unsuccessful, they will still be involved in patient care. A medical school graduate who is unable to find a residency position, however, is effectively excluded from the health care workforce.

To address a dearth of primary care providers, four states—Missouri, Arkansas, Kansas, and Utah—have already passed laws to license medical graduates under this type of arrangement.[82] Other states throughout the country could benefit from similar reforms.

VI. CONCLUSION

The current medical training and licensure system in the United States limits the supply of medical practitioners, exacerbating the shortage of care our country is facing. Fundamental reforms to the process of training and licensing medical practitioners in the United States have the potential to expand the supply of medical providers significantly and thus improve patient access to needed medical care. Under the policy recommendations outlined above, experienced and qualified foreign-trained doctors could practice in the United States without having to repeat the same residency training that they have already completed at home. Furthermore, under a system of provisional licensure, recent medical school graduates who cannot obtain a residency training position would have alternative opportunities to participate in the care of patients, help ameliorate the physician shortage, and receive training in the process. These reforms will help alleviate the current and future shortage of qualified physicians.

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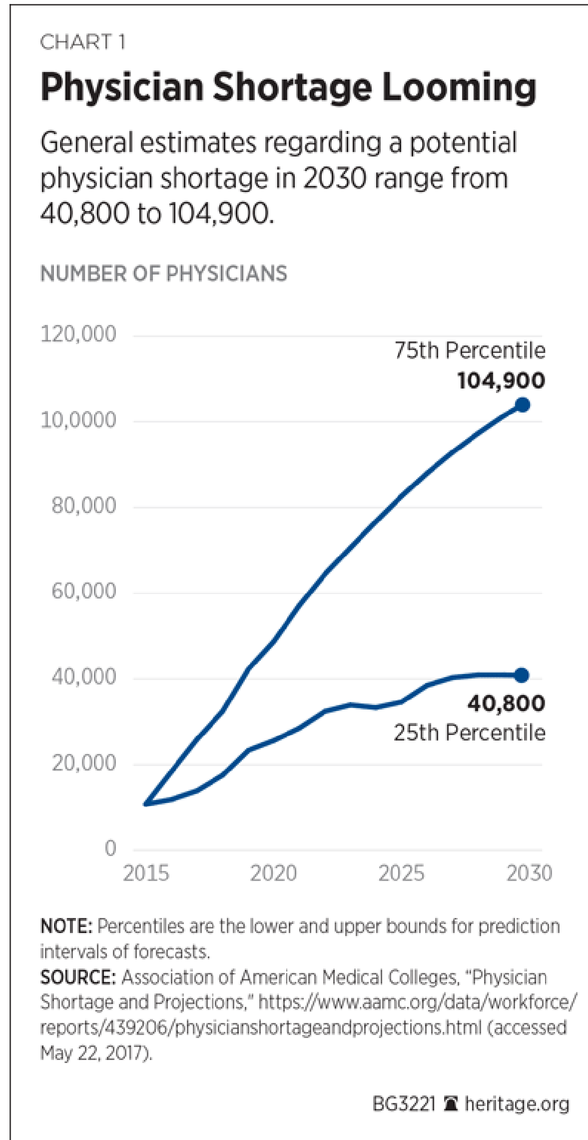
82. *See* ARK. CODE. ANN. § 17-95-903 (West 2015); KAN. STAT. ANN. § 65-2811(a) (2018); MO. ANN. STAT. § 334.036 (West 2018); UTAH CODE ANN. § 58-67-302.8 (West 2018).

APPENDIX A[83]

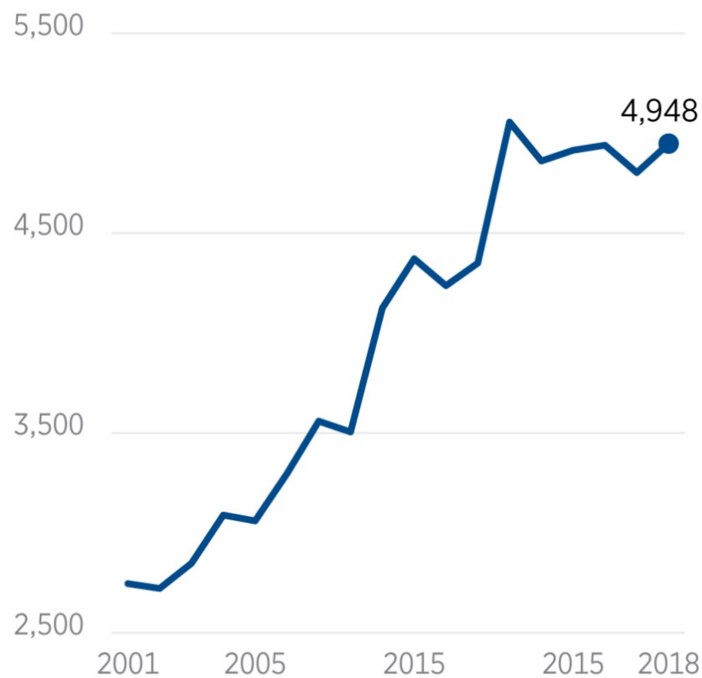


83. DAYARATNA & O'SHEA, *supra* note 16, at 2.

APPENDIX B[84]

Medical Graduates Struggle to Find Work here in the U.S.

MEDICAL GRADUATES NOT MATCHING IN A FIRST-YEAR RESIDENCY DURING THE MAIN RESIDENCY MATCH



NOTE: Statistics include unmatched seniors of U.S. allopathic medical schools, previous graduates of U.S. allopathic medical schools, students/graduates of osteopathic medical schools, and U.S. citizen students/graduates of international medical schools during main residency match.
SOURCES: National Resident Matching Program.

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84. *Id.* at 5.