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COVID-19 and the Provisional Licensing of Qualified Medical School Graduates as Physicians

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Abstract

Each level of government has its own peculiar responsibilities to address the COVID-19 pandemic. The states are responsible for licensing physicians who can treat the affected people. Each year, a large number of American and foreign medical school graduates do not find a residency position in the United States. Medical school graduates who have passed the qualifying examination have acquired a considerable amount of education and training during their medical studies, far more than physician assistants, nurses, military corpsmen and medics, and civilian paramedics or emergency medical technicians. They comprise a pool of talent that could be immensely useful in ameliorating the shortage of physician care throughout the country during the pandemic. State lawmakers should allow those graduates to receive a provisional license so that they can provide emergency medical care under the supervision of a licensed physician to help treat the ever-increasing number of COVID-19 patients we will see throughout the near future, or those patients who suffer from more common illness and injuries.

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I. Introduction

One of the challenges posed by COVID-19 is finding an adequate supply of physicians to treat the millions of Americans who succumb to the virus (or fear exposure to it) and who themselves will fall victim to the disease by treating patients.[1] For decades, America has lacked an adequate number of qualified physicians, particularly primary care providers in rural areas, to meet the nation's pre-pandemic medical needs.[2] That deficiency

1. Jenny Gold, *Surging Health Care Worker Quarantines Raise Concerns As Coronavirus Spreads*, KAISER HEALTH NEWS (Mar. 9, 2020), https://perma.cc/JYP5-4PCK (last visited Mar. 25, 2020) ("As the U.S. battles to limit the spread of the highly contagious new coronavirus, the number of health care workers ordered to self-quarantine because of potential exposure to an infected patient is rising at an exponential pace.") (on file with the Washington and Lee Law Review); *see also*, *e.g.*, Janet Adamy, *As Coronavirus Cases Mount, Emergency Rooms Struggle to Keep Doctors on the Job*, WALL ST. J., (Mar. 21, 2020, 5:30 AM), https://perma.cc/K4UX-N92Y (last visited Mar. 25, 2020) (on file with the Washington and Lee Law Review); Edwin Leap, *Will COVID-19 Expose Physician Shortfall, EMTALA Shortcomings?*, MEDPAGE TODAY (Mar. 3, 2020), https://perma.cc/ZFB6-7A9Y (last visited Mar. 25, 2020) (on file with the Washington and Lee Law Review); Ezekiel E. Emanuel et al., *Sounding Board: Fair Allocation of Scarce Medical Resources in the Time of Covid-19*, NEW ENG. J. MED., Mar. 23, 2020, at 2, https://perma.cc/67ZX-YQQK (PDF); Bigad Shaban et al., *Coronavirus Creates Doctor, Nurse Shortage as Medical Recruiters Face Surge In Demand*, NBC BAY AREA (Mar. 18, 2020), https://perma.cc/D7SW-87JU (last updated Mar. 18, 2020, 9:52 PM) (last visited Mar. 25, 2020) (on file with the Washington and Lee Law Review).

2. *See*, *e.g.*, *HRSA Fact Sheet: FY 2016—Nation*, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH RES. & SERVS. ADMIN. (2016), https://perma.cc/U8EG-ULV2 (PDF) (finding more than 6,000 areas of the nation underserved by

will hamper our efforts to combat COVID-19. Government officials therefore are looking for short-term ways to augment the number of trained medical professionals.[3]

In the United States, the federal, state, and local governments regulate the delivery of health care in a complementary manner. The federal government, through the Food and Drug Administration, is responsible for approving the interstate distribution of vaccines and drugs for COVID-19 (and other diseases). States license the physicians who can diagnose and treat the virus.[4] Cities and counties, through zoning, make areas available to serve as hospitals. Long-term answers to our physician shortage, such as constructing new medical schools, are desirable, but they cannot remedy the current shortage of physicians. Fortunately, states can take a few actions straightaway to alleviate that problem by increasing the number of trained medical personnel.[5] Those actions could also be part of a long-term strategy to expand the health care workforce.

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physicians); Howard K. Rabinowitz et al., *Increasing the Supply of Women Physicians in Rural Areas: Outcomes of a Medical School Rural Program*, 24 J. AM. BOARD FAMILY MED. 740, 740 (2011); 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); John R. Wheat et al., *Medical Education to Improve Rural Population Health: A Chain of Evidence From Alabama*, 31 J. RURAL HEALTH 354, 355 (2015).

3. *See*, *e.g.*, Emily Deruy, *Coronavirus: Counties Seek Help of Retired Doctors, Silicon Valley Innovators,* MERCURY NEWS (Mar. 19, 2020, 10:03 AM), https://perma.cc/9L5T-K94H (last updated Mar. 19, 2020, 4:30 PM) (last visited Mar. 25, 2020) (on file with the Washington and Lee Law Review); *Gov. Cuomo: Retired Medical Workers, Med School Personnel to Act as 'Reserve Staff' during COVID-19 Outbreak*, ROCHESTER FIRST (Mar. 12, 2020, 5:24 PM), https://perma.cc/3US9-TA56 (last updated Mar. 12, 2020, 5:24 PM) (last visited Mar. 25, 2020) ("Governor Cuomo is calling on retired and former medical worker and medical school personnel to act as 'reserve staff' in the event of a worsening COVID-19 coronavirus outbreak.") (on file with the Washington and Lee Law Review).

4. *See* Patricia J. Zettler, *Pharmaceutical Federalism*, 92 IND. L.J. 845, 849 (2017) ("[C]ourts, lawmakers, and the FDA itself have long opined that state jurisdiction is reserved for medical practice—the activities of physicians and other health care professionals—and federal jurisdiction for medical products, including drugs.").

5. *But see* SCOTT GOTTLIEB ET AL., AM. ENTERPRISE INST., NATIONAL

States can authorize physician assistants to engage in the same emergency medical practices as physicians, permit former military corpsmen or medics to provide emergency medical care, and enlist the aid of third- and fourth-year medical students (viz., the ones who have completed the basic clinical courses and would otherwise be rotating through different departments) in emergency care.[6] Those options likely would require states to redefine the scope of medical practice, rather than simply increase the number of approved physician practitioners, but doing the former would accomplish the latter. Another option would be for states to streamline their licensing process to qualify experienced physicians entering the United States from abroad. Given that COVID-19 is a pandemic, however, that course would evoke worldwide rebukes as other nations screamed that American was trying to steal their own doctors. That option might be available as a long-term remedy to America's physician shortage, but it would not be worth the onslaught of condemnation that the nation would receive during this crisis.

Another option not yet discussed is a state medical licensure reform. States could adopt emergency provisional licensing schemes for medical school graduates who do not find a post-graduate training program in their chosen specialty. Some graduates of approved medical schools cannot find residency

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CORONAVIRUS RESPONSE: A ROAD MAP TO REOPENING (2020), https://perma.cc/GQ53-8Z47 (PDF) (outlining a response plan to COVID-19 that does not include using medical school graduates to assist in the response plan).

6. *See* Bruce Japsen, *Physician Assistants Moving into Specialties Amid Doctor Shortage*, FORBES (July 14, 2016, 9:00 AM), https://perma.cc/4HSM-GLNY (last visited Mar. 25, 2020) ("An increasing number of states are granting physician assistants more autonomy to increase access to patients amid the doctor shortage, which has been exacerbated by an influx of millions of new patients seeking care now that they have health insurance under the Affordable Care Act.") (on file with the Washington and Lee Law Review); *see also Michigan Governor Threatens Doctors Who Prescribe Hydroxychloroquine to Treat COVID-19*, FOX NEWS (March 26, 2020), https://perma.cc/7A37-S27G (last visited March 30, 2020) (interviewing Dr. Jeff Colyer, former Kansas governor and chair of the National Advisory Committee on Rural Health and Human Services, who reported: "I see all sort of interesting things happening here in our community [in response to COVID-19], things like moving more medical students out to help the community out in rural areas") (on file with the Washington and Lee Law Review).

programs in their hoped-for field of practice. They could supplement the work of licensed physicians to assist in the treatment COVID-19 patients or other people in need of medical care for different reasons. The states could authorize and encourage those graduates to provide those medical services for the duration of the COVID-19 pandemic. This Article encourages the states to adopt that remedy.

Part II describes the state medical licensure process. Part III explains how that process and the federal Medicare laws combine to produce an inadequate supply of licensed physicians. Part IV offers a proposal for using medical school graduates to participate in emergency patient care to help alleviate the current pandemic.

II. The State Medical Licensing Process

There are multiple steps in the ordinary course of becoming a licensed physician.[7] To receive a state license,[8] students must first graduate from an accredited domestic or foreign medical school and then pass the United States Medical Licensing Examination.[9] All states require at least some post-graduate training (one to three years) in an approved residency program to receive a license.[10] Most medical school graduates pursue three to seven

7. *See* Kevin Dayaratna, Paul J. Larkin, Jr. & John O'Shea, *Reforming American Medical Licensure*, 42 HARV. J. L. & PUB. POL'Y 253, 261–62 & n.25 (2019) (describing that process).

8. Each state separately licenses physicians as part of its power to regulate occupations, include the practice of medicine. *See* Dent v. West Virginia, 129 U.S. 114, 122–23 (1889) ("The power of the state to provide for the general welfare of its people authorizes it to prescribe all such regulations as in its judgment will secure or tend to secure them against the consequences of ignorance and incapacity, as well as of deception and fraud."). *See generally* Paul J. Larkin, Jr., *Public Choice Theory and Occupational Licensing*, 39 HARV. J.L. & PUB. POL'Y 209, 277–79, & n.332 (2016) (listing health care fields subject to licensing requirements).

9. *See* Dayaratna et al., *supra* note 7, at 262 (summarizing the accreditation of medical schools and the process to become a physician); *Who is USMLE?*, U.S. MED. LICENSING EXAMINATION, https://perma.cc/QD2V-SZZF (last visited Mar. 25, 2020) (on file with the Washington and Lee Law Review).

10. *See, e.g.*, *State-Specific Requirements for Initial Medical Licensure*, FED'N

years of graduate medical training in a particular specialty under the supervision of senior practitioners and in accordance with curricula requirements governing each respective discipline (for example, internal medicine).[11] Residency program graduates are eligible take a national board certification examination for their chosen specialty and pursue additional training via fellowships in particular subspecialties (for example, cardiology).[12] Board certification is not required to practice medicine, but a physician lacking it might find it difficult (or impossible) "to obtain hospital staff privileges, affordable malpractice insurance, or reimbursement from insurance companies."[13]

Prior to the 1960s, such postgraduate medical training already was available via short courses, apprenticeships, or brief periods of study in Europe.[14] Beginning in 1965, the federal government became formally involved in postgraduate medical training by making it a required component of state Medicare programs.[15] To slow what was perceived as an alarming growth of spending on postgraduate medical education over the ensuring three decades,

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ST. MED. BOARDS (2018), https://perma.cc/74RW-LCHQ (last visited Mar. 25, 2020) (on file with the Washington and Lee Law Review); *see also* Dayaratna et al., *supra* note 7, at 262.

11. *See* Dayaratna et al., *supra* note 7, at 262 (discussing residency and fellowship programs).

12. *Id.*; *Board Certification Requirements*, AM. BOARD MED. SPECIALTIES, https://perma.cc/R8W8-CK4C (last visited Mar. 25, 2020) ("Following graduate medical training, physicians can identify themselves as board eligible. They have three to seven years, depending on the ABMS Member Board, to take a specialty certification exam.").

13. Dayaratna et al., *supra* note 7, at 264.

14. Dayaratna et al., *supra* note 7, at 262–63 & n.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) ("Most commonly, a man or woman completed medical school, probably an internship and, with or without some European exposure, entered general practice for a period that lasted usually more than 2 and less than 9 years, before becoming a 'specialist.'").

15. JOHN S. O'SHEA, HERITAGE FOUND., BACKGROUNDER No. 2983, REFORMING GRADUATE MEDICAL EDUCATION IN THE U.S. 3 (2014), https://perma.cc/GQ2T-6NSC (PDF). 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. *Id.* at 3–4.

the Balanced Budget Act of 1997 capped the number of Medicare-funded residency slots at Fiscal Year 1996 levels.[16] In theory, over time Congress and the private sector would re-evaluate the cap to ensure that public and private funding for residency positions would keep up with the number of medical school graduates. Unfortunately, that has not happened; the Balanced Budget Act of 1997 ceiling has remained in place for the last two decades plus.[17] The result is that some graduates cannot find and complete residencies and become fully licensed to practice medicine. COVID-19 has exposed a problem with our shortage of residency positions.

III. The Shortage of Licensed Physicians

The number of medical graduates entering first-year residency positions increased from 18,354 in 2001 to 29,040 in 2018.[18] 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.[19] Given the evidence that physicians are likely to remain in the geographic region where they completed their residency program, finding room for graduates not in residency programs could help offset the nationwide disparities as to physician availability in the long term, because they would be able to work in underserved areas.[20] In the short run, those graduates could help staff the hospitals,

16. Balanced Budget Act of 1997, Pub. L. No. 105-33 § 4623, 111 Stat. 251, 477 (1997).

17. Dayaratna et al., *supra* note 7, at 261–62, & n.25. Medicare currently underwrites more than $9 billion of the $10 billion currently spent on graduate medical training. A small percentage comes from other government and private sources. *Id*. at 263.

18. Dayaratna et al., *supra* note 7, at 266, 278 app. B.

19. *Id*. at 266.

20. New York State has 77 Medicare-funded resident physicians per 100,000 people, while Arkansas has a ratio of only 3 such residents per 100,000 people. *Id.*

emergency care centers, and makeshift facilities—like the Combat Support Hospitals (the retronym for MASH units) our military constructs in war zones—for treatment of COVID-19 patients. Yet, in many states, despite the current shortage of physicians, those medical school graduates cannot practice medicine. Some have wound up driving taxis.[21] The result is a waste of valuable resources the nation could now use.

IV. States Should Create Provisional Licensure Schemes for Medical School Graduates Not Accepted into Residency Programs

American and foreign medical school graduates who did not find a residency position in the United States comprise a pool of talent that could be immensely useful in ameliorating the shortage of physician care throughout the country during the pandemic. State lawmakers should allow those graduates to receive a provisional license so that they can provide emergency medical care under the supervision of a licensed physician.[22] Medical school graduates who have passed the qualifying examination have acquired a considerable amount of education and training during their medical studies, far more than physician assistants, nurses, military corpsmen and medics, and civilian paramedics or emergency medical technicians. Under appropriate supervision, those graduates would be a valuable addition to the number of expert medical personnel necessary to treat the ever-increasing number of COVID-19 patients we will see throughout the near future, or the patients who suffer from more common illness and injuries.

State legislatures should empower their medical licensing boards to issue provisional and temporary licenses for graduates of an accredited domestic or foreign medical school who has passed

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21. *Id.*; Michael Nedelman, *Why Refugee Doctors Become Taxi Drivers*, CNN (Aug. 9, 2017), https://perma.cc/KQ28-QXSR (last updated Aug. 9, 2017, 10:10 AM) (last visited Mar. 25, 2020) (on file with the Washington and Lee Law Review).

22. *See* Dayaratna et al., *supra* note 7, at 274–76; KEVIN D. DAYARATNA & JOHN O'SHEA, HERITAGE FOUND., BACKGROUNDER No. 3221, ADDRESSING THE PHYSICIAN SHORTAGE BY TAKING ADVANTAGE OF AN UNTAPPED MEDICAL RESOURCE 4 (2017).

the national licensing examination.[23] The license should have an expiration date—say, one year—and should require that a licensed physician agree to supervise the graduate in a particular field. Each state's medical licensing board should have the authority to provide the necessary details for licensing and supervision, as well as specify the conditions and procedures to extend or terminate a provisional license. Several states already have such laws on their books to license medical graduates under this type of arrangement to address a dearth of primary care providers.[24] Italy and Ireland have expedited the graduation of fourth year medical students so that they can help address COVID-19 by performing triage, running tests, and offering clinic support.[25] The Medical Schools Council in the United Kingdom has endorsed similar actions.[26] Other states throughout the country could benefit from adopting such reforms.

To be sure, medical school graduates cannot replace licensed, trained, and experienced intensivists or pulmonologists. The amount and type of necessary hands-on supervision will also vary greatly from graduate to graduate. It will depend on, for example, the tasks assigned to each provisionally licensed physician, his or her prior experience as a paramedic, corpsman or medic, and the amount of practical training he or she received in medical school.[27]

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23. The United States' examination centers are now closed, due to COVID-19. *See Coronavirus (COVID-19) 3/19/2020 Update: Prometric Closures*, U.S. MED. LICENSING EXAMINATION (Mar. 17, 2020), https://perma.cc/DGG2-XV4Y (last updated Mar. 19, 2020) (last visited Mar. 25, 2020). Graduates who have already passed the exam, however, would be eligible. There also may be ways to offer the examination online.

24. *See* ARK. CODE. ANN. § 17-95-903 (2019); KAN. STAT. ANN. § 65-2811(a) (2020); MO. REV. STAT. § 334.036 (2019); UTAH CODE ANN. § 58-67-302.8 (West 2020).

25. Brendan Cole, *10,000 Med School Graduates in Italy Skip Final Exam, Get Sent Directly into Health Service to Help Fight COVID-19*, NEWSWEEK (Mar. 18, 2020, 12:00 PM), https://perma.cc/VVD4-FSRQ (last visited Mar. 25, 2020) (on file with the Washington and Lee Law Review)

26. *Id*.

27. For example, the U.S. Army trains its Special Forces medics (among other things) to conduct initial medical screening, evaluation, and care of military and civilian personnel, treat emergency and trauma patients, and operate a

Graduates lacking considerable independent practical experience will likely require much closer monitoring than ones with (for example) considerable military battlefield experience treating servicemembers and civilians, and might not be able to do more than assist physicians by performing laboratory tests or offering clinical support. Nonetheless, it would be a mistake to make the across-the-board judgment that only residency program graduates are medically qualified to help the nation respond to the COVID-19 pandemic in any therapeutic capacity.

V. Conclusion

Each level of government has its own peculiar responsibilities to address the COVID-19 pandemic.[28] The states are responsible for licensing physicians who can treat the affected people. A step that states can take to discharge their responsibility is to empower state medical licensing boards to issue provisional and temporary licenses to medical school graduates not already in a residency program so that they may help treat patients who otherwise might go without hands-on medical care at a time when they desperately need it. To be sure, fundamental reforms to the process of training and licensing medical practitioners in the United States would have the potential to significantly expand the supply of medical practitioners and improve patient access to needed medical treatment. In the meantime, however, we should take advantage of the learning and training of medical school graduates not in residency programs. We should not waste that resource simply because Congress has declined to fund a sufficient number of residency positions.

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combat laboratory. *Careers & Jobs: Special Forces Medical Sergeant (18D)*, U.S. ARMY, https://perma.cc/D9VR-MQWQ (last visited Mar. 25, 2020) (on file with the Washington and Lee Law Review). *See generally*, U.S. SPECIAL OPERATIONS COMMAND, SPECIAL OPERATIONS FORCES MEDICAL HANDBOOK (Warren L. Whitlock et al. eds., 2001).

28. *See Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering (CSSE)*, https://coronavirus.jhu.edu/map.html (last updated Mar. 30, 2020, 9:17 PM) (last visited Mar. 30, 2020) (providing updated information regarding the spread of COVID-19) (on file with the Washington and Lee Law Review).