

Testimony in Support of S:142 Licensure Pathway for Internationally Trained Physicians

To: Vermont Senate Committee on Health and Welfare

From: Andrea E Green, MDCM, FAAP, Pediatrician, Burlington, VT

Re: Testimony in Support of Internationally Trained Physician (ITP) Licensure Pathway

Date: February 24, 2026

Chair Lyons and Members of the Committee,

I offer additional testimony from my original testimony dated December 19, 2025. I appreciate that the Vermont Board of Medical Practice has expressed concerns about its capacity to fully support this bill. However, a lack of familiarity or infrastructure should not preclude thoughtful adoption. Vermont would not be the first state to implement this type of program and can look to other states for models on how to evaluate the authenticity of documentation and the quality of international residency training. The barriers to implementation are real, but they are solvable.

It may be helpful to briefly clarify how medical training works in much of the world.

Many countries use a direct-entry MBBS (Bachelor of Medicine, Bachelor of Surgery) model, a 5–6 year program that integrates pre-clinical and clinical education earlier than the traditional U.S. “pre-med plus medical school” pathway. Students begin hands-on clinical rotations during their undergraduate years, developing strong skills in clinical assessment early in training. Postgraduate training also differs. In countries such as the United Kingdom, Uganda, and Norway, graduates complete general “foundation years” before specialization—similar in concept to the historical rotating internship year in the United States. Of note, the first year of residency in the U.S. is called internship still.

While structures vary internationally, physicians who seek to practice in the United States must still meet rigorous national standards. International medical graduates must pass USMLE Steps 1 and 2 and obtain certification from the Educational Commission for Foreign Medical Graduates.

Respectfully, requiring ACGME-I accreditation as a prerequisite for participation may not reflect the realities of global resource allocation. While accreditation is a worthy goal, participation in international accreditation systems is expensive. For many foreign institutions, those limited resources are directed toward patient care and local workforce development. Ensuring competency is essential—but mandating a specific accreditation pathway may not be the most practical or equitable way to achieve that goal.

Competency, professionalism, and quality assurance can be addressed through structured oversight within Vermont. Mentorship and supervision are key. A Board-directed oversight process could include submission of case records, quarterly reviews by the supervising physician, direct supervision during an initial transition period, and use of specialty-specific standards modeled on ACGME residency competencies. Professionalism is not static; it is an ongoing obligation for all physicians, and international graduates should be held to the same standards of medical practice as any Vermont physician.

I would also urge caution against underestimating the quality of training in non-U.S. health systems. Many countries operate within national health systems that emphasize prevention, cost-awareness, and evidence-based decision-making. Physicians trained in limited-access settings often develop exceptional skills in history-taking, physical examination, diagnostic reasoning, and clinical assessment precisely because they cannot rely on extensive ancillary testing. Cost considerations are routinely incorporated into shared decision-making conversations—something that is not consistently built into U.S. practice. These strengths are especially relevant in rural communities where access to advanced diagnostics may be limited.

As to vetting concerns, the United States already conducts extensive vetting as part of admission and visa processes—most rigorously in refugee admissions. In addition, as the Board has stated, any criminal background concerns while practicing in the United States would appropriately fall under existing state oversight mechanisms.

On a personal note, my daughter, a fourth-year medical student at the University of Pennsylvania, recently completed a six-week obstetrics and gynecology elective in Tanzania. She trained alongside students from Norway, Germany, Switzerland, and Austria who were completing extended rotations under Tanzanian physician supervision. The experience was rigorous and collaborative. High-quality education and strong clinical training are not confined within U.S. borders.

In closing, international medical graduates already meet national standards. With thoughtful oversight, structured mentorship, and clear expectations for competency and board certification, they can safely and effectively serve Vermont communities. The question before us is not whether excellence exists abroad—it does—but whether we are willing to build responsible pathways to welcome it here.

Thank you for your consideration.

Respectfully submitted,

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