Appendix B
Statement passed by Vermont Board of Medical Practice on February 4, 2026

The Board of Medical Practice unanimously passed a motion on January 7, 2026 expressing opposition to S.142, which proposes a pathway to license physicians who have not completed an accredited training program in the United States, based upon having been licensed to practice medicine in a country other than the United States. This is to express the reasons underlying the Board's opposition to S.142. The main reason the Board opposes S.142 is that it does not adequately protect Vermont patients by ensuring that participants in such a program have adequate training and experience to successfully and safely practice in Vermont. Specific areas of concern with the program created by S.142 follow.

1. At page 3, lines 11-16, the bill states: "The applicant has provided sufficient evidence to the Board that the applicant has […] completed a three-year post-graduate program in the applicant's country of training. This presents three distinct concerns.
    - The Board has no expertise even to evaluate the authenticity of documentation that purports to show an applicant has completed a foreign residency. The Board is not aware of established entities that might be relied upon to do this. This function is completed by the Educational Commission for Foreign Medical Graduates to confirm validity of educational credentials. There are entities that validate educational credentials, but the Board is unaware of any organization with worldwide expertise and knowledge to validate medical residency training documentation. There would need to be a trusted partner established to take on this role.
    - The requirement is only for completion of a program; there is no qualitative element. US medical graduates are required to complete <u>accredited</u> residency training. The bill would make applicants eligible based on completion of any program, no matter how deficient. Patients should be protected by a requirement for completion of training that is accredited based upon quality.
    - If the bill was amended to include a requirement for completion of a foreign residency that is accredited by an accrediting body acceptable to the Board, that would address a major concern. However, at this time, there are no programs meeting that standard. The Board acknowledges that there is a program called Accreditation Council for Graduate Medical Education – International. At this time the ACGME-I does not accredit international residency programs for US licensure. ACGME-I, which began as a pilot in 2009, was created to improve the quality of physician training programs outside the US. There are now 193 programs in 14 foreign nations, mostly in Asia and the Middle East. (For context, there are 13,762 ACGME accredited programs in the US.)

2. At page 3, lines 17-18, the bill includes a requirement that an applicant must have: "practiced as a medical professional performing the duties of a physician outside the United States for at least three of the last five years." This assigns the Board the responsibility to confirm practice in an overseas setting, which would present an additional practical challenge. How would practice be confirmed? Is a letter signed by a physician on behalf of the applicant's practice site supposed to be adequate? What organization has the capacity to verify the existence of any medical practice in the world, or in a region of the world, and vouch for the authenticity of the documentation? The Board has the responsibility to ensure that applicants meet licensing requirements. Absent a reliable and acceptable means of confirming self-reported experience the Board would not be fulfilling its obligation to protect Vermont patients.

3. At page 4, lines 8-13, the bill refers to standards for "an assessment and evaluation program designed to develop, assess, and evaluate a provisionally licensed physician's clinical and nonclinical skills and familiarity with standards appropriate for medical practice in Vermont according to criteria approved by the Board by rule." Nowhere in the bill does it call for the Board to oversee compliance with those standards. A set of standards that has no form of oversight is meaningless. It would be irresponsible to license foreign trained physicians based upon completion of a program of training and evaluation that is not subject to oversight of any kind. Graduates of US medical schools are required to complete accredited programs that go through regular reviews to verify that standards are maintained. There is no reason to expect less of the programs that would establish eligibility for medical licensure of foreign trained physicians.

Perhaps the lack of a program to confirm program compliance with standards was an error in drafting the bill, or perhaps it was assumed program oversight would be an implied duty for the Board. Whichever the case, oversight of training and evaluation programs would be an essential component of the proposed licensing pathway. However, the Board has neither the expertise nor the resources to take on the role played by the ACGME for existing US residency programs. Confirmation of adherence to standards would be essential for verifying both the readiness for practice of those completing the program and the safety of patients receiving care from participants in the program.

4. At page 5, lines 15-18, the bill provides that applicants are ineligible for the pathway if they "previously had a license or other authorization to practice medicine suspended, revoked, limited, conditioned, or otherwise restricted on the basis of the applicant's unprofessional conduct." Verification that an applicant meets that standard would present challenges. With approximately 200 nations in the world how is the absence of disqualifying discipline verified? It would be a significant tasking for the Board to overcome the practical challenges of establishing communication with a single country's medical regulators, but applicants might have practiced in many different countries. Across the world's ≈ 200 countries, how many have regional medical regulatory agencies (as we do in the US, with each state regulating medical practice)? How many countries have national reporting

entities like the United States National Practitioner Data Bank? The International Association of Medical Regulatory Authorities (IAMRA) has established the Physician Information Exchange (PIE), but that is a voluntary program and at present very few nations participate. While confirmation of the absence of unprofessional conduct would be an essential element of an alternative licensure pathway, this eligibility requirement would require the Board to commit additional resources and establish new expertise.

5. At page 5, line 18, the bill provides that physicians are ineligible if they "have been convicted of a crime." This requirement would present another challenge for the Board: ensure each applicant has a clean criminal history. At present, with IMGs who complete US residency training, this is not necessary because the screening for the J-1 or H-1B visas needed to train in US programs covers criminal history.

6. At page 10, line 8, the bill tasks the Board with establishing rules: "determining which countries' licensure or other authorization to practice medicine is acceptable to the Board for purposes of provisional and limited licensure." This is important because the safety of Vermont patients would be riding on the adequacy of practice standards elsewhere if foreign training and experience is to serve as a proxy for appropriate training in the US. This would present a significant challenge for the Board. In addition to the adequacy of standards of practice, it also involves the legitimacy of the system of medical regulation in other countries. The Board would need to determine if a country's medical regulatory authorities are competent, adequately funded, and not undermined by nepotism or other forms of corruption. The Board would need additional resources to determine which nations' medical systems operate at a level that is sufficiently comparable to the US system such that practice there indicates an ability to practice competently in the United States, and whether there is an effective system of medical regulation that can be relied upon to identify and document unprofessional practice.

Those are concerns about the details set forth in the bill for the new pathway to licensure. In addition, the Board has more general concerns.

The Board understands that representatives from some potential participating facilities have expressed their confidence that they can successfully train and evaluate foreign physicians in a program as described in S.142, and all while ensuring that the patients receiving care are safe and receiving the quality of care they deserve and expect. The Board believes that facility representatives may be underestimating the difficulty of taking on all the obligations a facility would bear.

All of the Board's physician members have completed residency training; many of them have been residency instructors and understand the demands on programs. The challenges of training and evaluating medical trainees, all while ensuring patients receive safe and appropriate care, are many and complex. Residency programs receive substantial funding. The amount varies, but it is well over $100,000 per trainee, per year from federal funding sources. Virtually every discussion about medical care in Vermont touches on lack of resources and the challenges faced by medical practices today. Taking on the same tasks faced by residency programs without the resources provided to those

programs would create strong potential for risks to patients, inadequate training, and insufficient evaluation.

One facet of the challenge of being a participating facility that may be underestimated is the degree to which cultural biases and perspectives may play a role. Many physicians who come to train in US residency programs arrive with cultural assumptions and perspectives. Different views on gender, gender identity, and sexual orientation can affect patient safety and the quality of the care provided. This is just one example of the reality of training foreign physicians that could demand much greater resources than potential facilities anticipate. Diverse cultural experiences can also enrich patient care; the concern of the Board is addressing cultural assumptions as they affect patient safety.

Finally, when considering the challenges, potential risks, and resources that would be needed for the new licensing pathway proposed in S.142, it is necessary to consider the limited upside. The Board understands that there are medical workforce shortages in Vermont, and that the shortages are more acute in some regions. However, there are reasons to believe that S.142 would do little to ease workforce shortages. As noted in an August 2025 Guidance Document released by the Advisory Commission on Additional Licensing Models (ACALM), federal immigration and visa requirements and the limited options available to a physician who lacks US residency training will limit the potential number of physicians who might use such a pathway. In the Commission's words:

Furthermore, the ubiquity of specialty-board certification as a key factor in employment, hospital privileging, and insurance panel inclusion decisions is likely to impact the efficacy of non-traditional licensing pathways. States may, therefore, wish to consider other healthcare workforce levers that may be more effective in increasing access to care, such as advocating for increased state and Medicare/Medicaid funding to expand U.S. GME training positions, offering some means of transition assistance to IMGs, and expanding the availability and utilization of enduring immigration programs like the Conrad 30 waiver program, U.S. Department of Health and Human Services (HHS) waivers, regional commission waivers, and United States Citizenship and Immigration Service (USCIS) Physician National Interest Waivers.

In addition to ACALM's assessment that programs similar to S.142 are unlikely to be effective sources of licensed physicians, we can look to New York, which has long offered a program of licensure for foreign trained physicians based on an assessment of education, training, and experience. In a state with approximately 120,000 MDs, the program yields about 150 to 175 licensees per year. Vermont has approximately 6,000 licensed MDs, or about one twentieth the number licensed in New York. Even ignoring the fact that New York has a much more internationally diverse population and a significantly higher overall percentage of physicians who are international medical graduates than Vermont, the New York numbers suggest Vermont would gain no more than 10 licensees per year.

For all these reasons, the Board of Medical Practice finds that creation of a new pathway for foreign trained physicians is not advisable at this time.