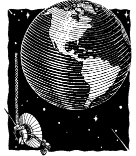
At least 12 US states refuse to recognize physician training accredited in Canada



Features

Chroniques

Milan Korcok

Milan Korcok is a freelance writer in Lauderdale-by-the-Sea, Fla.

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In brief

THE EASING OF TRADE RULES has done little to ease the movement of physicians between Canada and the US. Borders may be breaking down when it comes to the transfer of goods, Milan Korcok reports, but for physicians the moats in front of those borders appear to be getting deeper and more difficult to cross.

En bref

L'ASSOUPLISSEMENT DES RÈGLES COMMERCIALES a peu contribué à faciliter la circulation des médecins entre le Canada et les États-Unis. Si les frontières semblent s'effacer pour les échanges de biens, rapporte Milan Korcok, pour les médecins, le fossé paraît au contraire se creuser et devenir plus difficile à franchir.

When Canada and the US set out on the free-trade trail a decade ago, they did a lot to relax the cross-border shipping rules that apply to computers and cucumbers but little to ease the transfer and resettlement of doctors between the countries. Today, these cross-border movements face the same bureaucratic logjams and parochial imperatives that existed 10 years ago.

Consider the case of the South Carolina physician who offered a grateful Canadian specialist a job in his growing and thriving practice. The state licensing board quickly nixed the job offer — it rejected the applicant because South Carolina considered his Canadian qualifications inadequate. Canadian physicians thinking of heading south soon learn that cases like this aren't limited to South Carolina.

According to the most recent listing from the Accreditation Commission for Graduate Medical Education (ACGME) in the US, at least 11 other states do not recognize Canadian qualifications. Some Canadians were recently denied licensure by Utah's medical board because state law does not recognize postgraduate accreditation by the Royal College of Physicians and Surgeons of Canada. It accepts only programs accredited by the ACGME, which recognizes 6800 programs in 1500 medical institutions in the US. This means that Canadian doctors wanting to set up shop in Utah will need to complete successfully at least 2 years' training in an ACGME-sanctioned (US) program.

Canada has its own set of rules. Americans who want to relocate here will find their postgraduate training either rejected or only partially credited by licensing authorities. At the same time, they will encounter growing provincial restrictions on physician migration.

Even though Canadian and American medical schools are jointly accredited by the Committee on Accreditation of Canadian Medical Schools and/or the Liaison Committee on Medical Education (LCME), and neither country views graduates of the other's schools as "foreign," physicians wishing to practise in the "other" country will find moving anything but easy. They will have to navigate a shifting obstacle course that is poorly mapped and laden with booby traps. The

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experts who track free trade's impact on the cross-border movement of health professionals say the much-touted treaties — first between Canada and the US, and then between Canada, the US and Mexico — have done nothing to ease the flow of physicians.

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The Royal College, Canada's provincial licensing authorities and the Federation of State Medical Boards in the US all offer the same advice: rely only on information obtained from licensing authorities in the state where you want to be licensed. Dr. James Winn, executive vice-president of the Federation of State Medical Boards, is frustrated by the inconsistencies and conflicting requirements in jurisdictions that are supposed to be equal.

He says there is no problem at the medical school level because LCME accreditation of Canadian and US schools provides proof of their equality. "But the postgraduate training process is different and that directly affects licensing. States [like provinces] are empowered to develop their own requirements. Some regulate licensure by legislative statute, giving licensing boards no discretion — the law is the law. Others license by administrative rule, and they have more discretion. Whether they choose to use it is up to them, and that makes consistency elusive."

Karen Reimherr, bureau manager in Utah's Division of Occupational and Professional Licensing, says Utah's Medical Practice Act states that an applicant for licensure must have "successfully completed 24 months of progressive resident training in an ACGME-approved program after receiving a degree of doctor of medicine."

This means all Canadian programs are excluded. Reimherr says several Canadian graduates have already had their applications rejected because of this refusal to accept training accredited by the Royal College. She says the problems surrounding Canadian applicants only became an issue in 1997, but cannot understand why. She declined to provide names of rejected Canadian applicants.

Reimherr is preparing an amendment that she expects the Utah legislature to consider. Although it would give her division more discretionary power when considering Canadian postgraduate training, she still has trouble "understanding" Canada's training system. She complains that Canada has "4 or 5 different accreditation groups. There's no consistency, and it's not just Utah that has a problem with that."

Utah's response will be news to many Canadians, who thought ACGME and Royal College accreditation were considered equivalent. "That comes as a complete surprise to me," Sheila Waugh, head of the credentials section at the Royal College, said of the Utah rules.

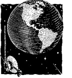
The good news is that most states do consider Royal College and ACGME accreditation interchangeable, and many also accept programs accredited by the College of Family Physicians of Canada. Some — Arizona is an example — go even further by accepting "any similar body in the United States or Canada whose function is that of approving training programs."

However, variations from state to state, and even within each state from year to year, create havoc for both information providers and licensing applicants. The Royal College's Waugh says applicants must do their homework. "Don't rely on [third-party] listings. Get all the rules and requirements from each state — directly."

A quick survey indicates that this is good advice. A listing of state licensure policies produced by the American Medical Association indicates that the District of Columbia (DC) does not accept Canadian postgraduate programs — it does — but that Utah does accept them, which it does not.

Even the most recent listing of requirements for initial licensure produced by the Federation of State Medical Boards in the US contained several errors. It said both Florida and the District of Columbia accepted only ACGME-accredited programs, but licensing boards in both places indicated that the listings are incorrect.

"We treat Canadians the same as Americans," said a spokesperson in DC. In Florida, a spokesperson said that state considers Royal College programs equivalent to their ACGME-accredited counterparts. "It's the LMCC [Licentiate of the Medical Council of Canada] that we don't accept," she said. This means that a Canadian who has the LMCC would still be required to pass the 3-part US Medical Licensing Examination (USMLE). The USMLE, which is generally considered equivalent to the 2-part Medical Council of Canada Qualifying Examination (MCCQE), was established as a common testing sys-



tem by the Federation of State Medical Boards and the National Board of Medical Examiners. Both the MCCQE and the USMLE require specific postgraduate training.

Sorting through the rules south of the border is daunting work, but Winn says Canada has to look in the mirror before it considers assigning blame because the situation is even tougher for American graduates considering locating in Canada.

In Ontario, licensure (or registration) requires American graduates to pass the 2-part MCCQE or an "acceptable alternative." Those stated alternatives are the MCCQE, if taken before 1992, the diploma of the National Board of Medical Examiners, if completed before 1992, or a score of at least 75 on the Federation of State Medical Boards Licensing Examination, if taken before 1992. If taken in 1992 or later, these don't count. The applicant must then take the MCCQE; the USMLE, which many deem equivalent, simply won't do.

Before taking part 2 of the MCCQE, however, the applicant must have completed at least 12 months in an accredited postgraduate program, which is acceptable, but the College of Physicians and Surgeons of Ontario also forces American graduates to take at least 1 postgraduate year of training in a Canadian program. If that isn't enough, the Ontario Ministry of Health and ministries in most other provinces continue to impose additional restraints on where new registrants may practise.

"It seems to me," Winn says bemusedly, "that in some provinces the government may not want more doctors."

Winn says the Federation of State Medical Boards would like to see freer and more consistent standards in medical education and training requirements between Canada and the US, but notes the Canadian tendency to refuse to give full credit for residencies completed in the US. For instance, someone who completes a 3-year program may get credit for 1 year or none, yet at the same time Canadians seeking licensure south of the border insist their postgraduate programs are equal to those in the US. "The proper thing to advocate," says Winn, "is that the accreditation processes are essentially the same and therefore should be deemed equivalent in both countries."

Ironically, the free-trade agreements were supposedly to act as moderating influences that would help heal such rifts. In fact, the tri-nation NAFTA agreement specified that member governments and their agencies, including those overseeing medical licensure, were not to impose additional licensing burdens on professionals from the other countries. They didn't have to do away with existing regulations but couldn't establish new or more burdensome ones.

That's not what happened, says Greg Boos, an attorney from Bellingham, Wash., who specializes in immigration and free-trade visas. He says various agencies, and especially the US Immigration and Naturalization Service, are openly flouting NAFTA rules and constructing ever wider moats along borders.

For example, NAFTA created a visa that allowed certain professionals to obtain temporary, renewable work permits in the US. This proved a boon for Canadian nurses who were deemed in short supply in the US, who could enter almost as soon as applying and later obtain permanent status. However, a new immigration law scuppered that by requiring foreign nurses to take a test administered by a national agency. Now Congress can't agree which test they should take. NAFTA also allowed this fast-track TN visa to be used by Canadian doctors, but only to work as researchers or teachers — not to practise.

It has long been boasted by both sides that Canada and the US share the world's longest undefended border. This may be so, but for the many Canadian doctors who seek licensure in the US each year, crossing that border can be a nettlesome business that requires the diligence of a detective and the patience of Job.