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MEDICAL ACCREDITATION FOR FOREIGN-EDUCATED REFUGEES: AN UNDUE BURDEN

Katherine Jolley¹ and Alex Hansen²

I. INTRODUCTION

Layla Sulaiman and her family were forced to flee their home in Iraq in 2007, where Layla had practiced as a primary care obstetrician-gynecologist for seventeen years. After applying for refugee status, the United Nations assigned Layla and her family to resettle in the United States. When she arrived in Pennsylvania, Layla was devastated to discover that her medical license was invalid. Had she been relocated to Australia like her sister, she could have been placed on an accelerated track for foreign doctors. Similarly, Canada offers foreign doctors semi-restricted practice while obtaining their full license. Instead, Layla was forced to start from scratch by volunteering at her child's elementary school. For Layla to practice in the United States, she would have to apply for residency (training that brand-new medical school graduates complete), likely move from her initial host city to complete the residency and pass extensive testing.³ Layla's situation is not unique.

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 - 3 Michael Nedelman, *Why refugee doctors become taxi drivers*, August 9, 2017, <https://www.cnn.com/2017/08/09/health/refugee-doctors-medical-training/index.html>.

Refugees face significant adversities when they resettle in their host countries. Some difficulties include language barriers, mental and physical trauma, and complicated health situations, in addition to the challenge of moving across the globe. While institutions and organizations are set up to ensure their successful resettlement and employment, refugees are disappointed to discover that licensure and certification for foreign-educated medical professionals are stringent and difficult to navigate.⁴ Many foreign-educated refugees come to the United States and are pushed towards low-skill level jobs, like driving a taxi or manual construction, despite years of experience in their specialized fields.⁵

In the year 2020 alone, there were 82.4 million forcibly displaced people around the world, one-quarter of which were refugees.⁶ In light of the current worldwide refugee crisis, as heightened by the COVID-19 pandemic, the economic turmoil in Venezuela, and political upheaval in Afghanistan, our attention is called to the plight of thousands of refugees who are entering or will soon enter the United States. Approximately 12,000 refugees were resettled in the United States in 2020, with a large increase initially anticipated for 2021.⁷ Due to an “unforeseen emergency refugee situation,” President Biden curtailed the presidential designation to 15,000 but has plans to increase them in 2022.⁸

This paper illustrates that the current process for accreditation of foreign medical professionals in the United States places an undue

4 Ann M. Philbrick et al., *Make refugee health care great [again]*, 107 AMERICAN JOURNAL OF PUBLIC HEALTH 656–658 (2017).

5 Jeanne Batalova, Michael Fix, *Tapping the Talents of Highly Skilled Immigrants in the United States: Takeaways from Experts Summit*, MIGRATION POLICY INSTITUTE, August 2018, https://www.migrationpolicy.org/sites/default/files/publications/Tapping%20the%20Talents-Summit_Summary%20Report-Final.pdf.

6 UNHCR: REFUGEE DATA FINDER, The UN Refugee Agency, <https://www.unhcr.org/refugee-statistics/>.

7 Andorra Bruno, Congressional Research Service, FY2021 Refugee Ceiling and Allocations (2020).

8 Presidential Determination No. 2021-02, 85 Fed. Reg. 71219 (Nov. 06, 2020).

burden on foreign-educated refugees. Beginning with a brief background on the definition of a refugee, the paper discusses the barriers refugees face after entry into the United States and the provisions of the Refugee Act of 1980 that protect their right to employment and proper healthcare. Next, the paper will compare the current accreditation system for domestic medical professionals to that of foreign medical professionals. Finally, the paper argues that the current accreditation system places an undue burden on refugees by referencing modifications made to accreditation processes during the COVID-19 pandemic and suggests comparable modifications for the future.

II. BACKGROUND

A. Defining a Refugee

Immigrant healthcare providers often meet the definition of a refugee. According to the 1951 Refugee Convention held by the United Nations, to which the United States is a party, a refugee is defined internationally as someone “unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.”⁹ Domestically, the Immigration and Nationality Act defines a refugee as:

Any person who is outside any country of such person’s nationality or, in the case of a person having no nationality, is outside any country in which such a person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or

9 Convention relating to the Status of Refugees (189 U.N.T.S. 150, entered into force April 22, 1954). United Nations. 1951.

political opinion” or “in such special circumstances as the President after appropriate consultation may specify.”¹⁰

B. Means of Refugee Relief

The Refugee Act of 1980 provides the U.S. government a means of caring for and ensuring the success of refugees when they arrive in the country. As established by the Refugee Act of 1980, the number of refugees that are admitted into the United States is released in an official Presidential Determination on Refugee Admissions on an annual basis.¹¹ Refugee allocations under President Trump were historically low, declining from 45,000 in fiscal year 2018 to 18,000 in fiscal year 2020, as compared with the 110,000 allotments from President Obama in fiscal year 2017.¹² President Biden set the admissions cap to 62,500 for the fiscal year 2021 and intends to increase the admissions to 125,000 in the fiscal year 2022.¹³

In consideration of the United States’ decision to accept refugees, they are guaranteed certain rights upon arrival through the Refugee Act of 1980. Their rights include resettlement assistance, the right to stay and work in the United States, the right to reunite with overseas family members, the right to travel, and the right to health care. The Refugee Act of 1980 set forth “a permanent and systematic way procedure for admission to this country of refugees.” The law mandates creation of project grants and contracts

(1) to assist refugees in obtaining the skills which are necessary for economic self-sufficiency, including projects for job training, employment services, daycare, professional refresher training, and other recertification services;

10 Immigration and Nationality Act § 101(a), 8 U.S.C. § 1101(a)(42)

11 Refugee Act of 1980, Pub. L No. 96-212, 94 Stat. 102. (Codified as 8 U.S.C. §§ 1157-1159 (1980)).

12 Bruno, *supra* note 7.

13 Statement on United States Refugee Admissions, 2021 Daily Comp. Pres. Doc. 366 (May 3, 2021)

(2) to provide training in English where necessary (regardless of whether the refugees are employed or receiving cash or other assistance); and

(3) to provide where specific needs have been shown and recognized by the Director, health (including mental health) services, social services, educational and other services.¹⁴

Currently, this system includes funding to cover refugees' food, rent, furnishings, and clothing for their first 90 days in the United States. There are other programs under the Office of Refugee Resettlement in the Department of Health and Human Services to provide longer-term cash and medical assistance, such as Match Grant. These programs seek to provide economic self-sufficiency by providing job training, job referrals, and budget planning, as well as access to English language training and help with social and cultural adjustments.¹⁵

Additionally, the Refugee Act of 1980 details the healthcare provided for new arrivals. Refugees are assured that the Secretary, in consultation with the Coordinator, shall—

(A) assure that an adequate number of trained staff are available at the location at which the refugees enter the United States to assure that all necessary medical records are available and in proper order;

(B) provide for the identification of refugees who have been determined to have medical conditions affecting the public health and requiring treatment;

(C) assure that State or local health officials at the resettlement destination within the United States of each refugee are promptly notified of the refugee's arrival and provided with all applicable medical records; and

14 Refugee Act of 1980, 8 U.S.C. §§ 1157-1159

15 *Voluntary Agencies Matching Grant Program*, OFFICE OF REFUGEE RESETTLEMENT, October 15, 2021. <https://www.acf.hhs.gov/orr/programs/refugees/matching-grants>.

(D) provide for such monitoring of refugees identified under subparagraph (B) as will ensure that they receive appropriate and timely treatment.¹⁶

Refugee health care is overseen by the Division of Refugee Health.¹⁷ Refugees are eligible for federally funded Refugee Cash Assistance and Refugee Medical Assistance for their first eight months in the United States, as well as Temporary Assistance for Needy Families (TANF) and Medicaid coverage, as expanded under the Affordable Health Care Act.¹⁸ After the eight-month period, they are held to the same qualification standards as other state residents. Delays in state coverage registration and activation intensify the frustration as refugees navigate a fairly complex medical coverage system on their own.¹⁹ Even after acquiring state insurance, refugees must pay copayments and costs not covered by Medicaid.²⁰

C. Undue Burden

The undue burden test has frequently been used as a means to measure the validity of legislation when weighed against the hardship it imposes. In 1944, Irene Morgan was arrested on a segregated Greyhound bus for refusing to give up her seat while en route to Maryland from Virginia.²¹ She was arrested and convicted of violating the Virginia state segregation ordinance. Morgan appealed the decision and her case was taken on by the National Association for the Advancement of Colored People (NAACP) in *Morgan v. Virginia* (1946).

16 Refugee Act of 1980, 8 U.S.C. §§ 1157-1159

17 *About Refugee Health*, OFFICE OF REFUGEE RESETTLEMENT, January 14, 2021. .

18 Patient Protection and Affordable Care Act, Pub. L. 111-148 § 124 Stat. 119 (2010).

19 Ann M. Philbrick et al., *Make refugee health care great [again]*, 107 AMERICAN JOURNAL OF PUBLIC HEALTH 656-658 (2017).

20 *Medical Copays and Out-of-Pocket Costs in the URM Program*, OFFICE OF REFUGEE RESETTLEMENT, April 2, 2018. <https://www.acf.hhs.gov/orr/policy-guidance/medical-copays-and-out-pocket-costs-urm-program>.

21 *Morgan v. Commonwealth of Virginia*, 328 U.S. 373-394 (1946).

The NAACP argued that state segregation laws impede interstate commerce by creating an “undue burden,” violating the Commerce Clause. The Supreme Court agreed and created the “undue burden test” in their decision. The undue burden test was originally penned by Associate Justice Stanley Forman Reed, who stated:

There is a recognized abstract principle, however, that may be taken as a postulate for testing whether particular state legislation in the absence of action by Congress is beyond state power. This is that the state legislation is invalid if it unduly burdens that commerce in matters where uniformity is necessary—necessary in the constitutional sense of useful in accomplishing a permitted purpose.²²

The undue burden test provides a means to ensure that the state legislature does not impede or restrict an individual’s fundamental rights. The undue burden test was also notably used in *Planned Parenthood v. Casey* (1992).²³ The Pennsylvania state legislature amended its abortion control law to require informed consent, a twenty-four hour waiting period, and the consent of a parent if the patient was a minor or the consent of the husband if the patient was married. The Supreme Court crafted the undue burden standard to measure the validity of state abortion restrictions by defining an undue burden as a “substantial obstacle in the path of the woman seeking an abortion before the fetus attains viability.”²⁴ Justice John Paul Stevens wrote a partial agreement, partial dissent and expanded the definition of an undue burden by adding that “[a] burden may be ‘undue’ either because [it] is too severe or because it lacks a legitimate, rational justification.”²⁵ The Supreme Court ruled the government could pursue its interest in protecting the health of a pregnant person and maintained all provisions of the Pennsylvania ordinance, except requiring the consent of the husband. Thoughtful application of the undue burden test ensures that states can protect their interests while maintaining

22 *Id* at 377

23 *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992).

24 *Id* at 878

25 *Id* at 924

that legislation should not severely obstruct fundamental, and as will be discussed later in the paper, guaranteed rights.

D. Due Process Clause (1791)

The Due Process Clause is found in both the Fifth Amendment in the Bill of Rights and the Fourteenth Amendment of the U.S. Constitution. Within the Fifth Amendment, it states that no one shall be, “deprived of life, liberty or property without due process of law.”²⁶ The Fourteenth Amendment uses the same wording; however, it incorporates the legal obligation of all states to ensure these same protections.²⁷ A serious concern to many is the impact of the Due Process Clause on non-citizens within the United States. Under the Fourteenth Amendment, the Equal Protection Clause was established in 1868 after the effects of the Civil War. Protections were extended to all natural-born or naturalized citizens, however, there were no clarifications on undocumented immigrants, refugees, or other asylum-seeking individuals. Further case law has expanded upon these questions. For example, in *Yick Wo v. Hopkins* (1886)²⁸, Justice Matthew opined, “The Fourteenth Amendment to the Constitution is not confined to the protection of citizens... These provisions are universal in their application to all persons within the territorial jurisdiction, without regard to any differences of race, of color, or of nationality.”²⁹ In a more recent example, a Texas statute was questioned in *Plyler v. Doe* (1982)³⁰, wherein illegal immigrants and their children were barred from obtaining a free public education. Justice Brennan stated, “Aliens, even aliens whose presence in this country is unlawful, have long been recognized as ‘persons’ guaranteed due process of law by the Fifth and Fourteenth Amendments.”³¹

26 U.S. CONST. amend. V § 1.

27 U.S. CONST. amend. XIV § 1.

28 *Wo v. Hopkins*, 118 U.S. 356 (1886).

29 *Id.* at 356

30 *Plyler v. Doe*, 457 U.S. 202, 210 (1982).

31 *Id.* at 202

Additional rulings and clarifications have brought to light the realization of protections for individuals who are non-citizens or non-naturalized. These protections, established under both the Due Process and Equal Protection Clauses, grant refugees the right to once again, not be “deprived of life, liberty, or property without due process of law.”³²

*E. Trump v. Hawaii (2018)*³³

In January 2017, then President of the United States of America, Donald Trump, signed an Executive Order³⁴ that suspended entry for ninety days of foreign nationals who belonged to seven countries that were presumed to present higher risks of terrorism. His campaign promise of a “total and complete shutdown of Muslims entering the United States,”³⁵ was quickly fulfilled after the President’s inauguration. Immediate challenges to the Order came soon after in March of 2017 when President Trump changed his previous list of seven countries to six. On the same day the second Executive Order³⁶ expired, President Trump issued a new Proclamation³⁷ that included the restriction of travel to the United States from citizens of eight countries. The Ninth Circuit Court struck down the Proclamation and the Supreme Court was granted review. In a five-four decision, the Court upheld the Proclamation. They ruled that it did not violate the President’s statutory authority or the Establishment Clause. The Court found that the Proclamation did not practice discrimination

32 U.S. CONST. amend. V § 1.

33 *Trump v. Hawaii*, 585 U.S. __ (2018).

34 Exec. Order No. 13,769, 82 Fed. Reg. 8977.

35 Christina M. Rodriguez, *Trump v. Hawaii and the Future of Presidential Power Over Immigration*, AMERICAN CONSTITUTION SOCIETY, <https://www.acslaw.org/analysis/acs-supreme-court-review/trump-v-hawaii-and-the-future-of-presidential-power-over-immigration/>.

36 Exec. Order No. 13,780 § 1(i), 82 Fed. Reg. 13,209, 13,212 (Mar. 9, 2017).

37 Presidential Proclamation No. 9645, 82 Fed. Reg. 45,161 (Sept. 24, 2017).

against a specific religion since it included individuals from both Muslim and non-Muslim countries.

Arguments quickly arose regarding the power of the president and the future use of the Due Process Clause. President Trump responded by citing his actions to Section 212(f) of the Immigration and Nationality Act³⁸, which gives “the president the power to deny entry to any aliens or class of aliens whose entry would be detrimental to the United States.”³⁹ Persisting arguments stated that the President’s use of Section 212(f) was “inconsistent with the complex statutory scheme Congress had elaborated over the years to screen potential immigrants, including for national security risks.”⁴⁰ As protected powers granted to the President continue to be challenged within the courts, issues within immigration will continue to evolve.

III. PROOF OF CLAIM

A. Refugee Resettlement and Employment in the United States

As guided by research of topics introduced in the background of this paper, we will now support our claim that the current medical accreditation process of foreign-educated medical professionals places an undue burden on refugees. As set forth by the Refugee Act of 1980, the United States is obligated to

Respond to urgent needs of persons subject to persecution in their homelands, including where appropriate, humanitarian assistance for their care and maintenance in asylum areas, efforts to promote opportunities for resettlement or voluntary repatriation, aid for necessary transportation and processing, admission to this country of refugees of special

38 Immigration and Nationality Act § 212, 8 U.S.C. §1182(f).

39 Rodriguez, *supra* note 35.

40 Rodriguez, *supra* note 35.

humanitarian concern to the United States and transitional assistance to refugees in the United States.⁴¹

There are several programs in place to support refugees in their right to work in the United States.⁴² However, the current system provides the bare minimum as opposed to promoting growth in careers of refugees. It appears that most of the efforts to resettle refugees are aimed towards “the very poorest and least experienced immigrants,”⁴³ with refugees frequently being placed in low-income housing and having to rely on food stamps through the Supplemental Nutrition Assistance (SNAP) program. Many high-skilled refugees are pushed towards low-skill work.⁴⁴ A shift in programs that prepare refugees to find employment in the United States would more fully utilize their already-developed human capital, and better comply with the aims of the Refugee Act of 1980.

Historically, refugees have been strong contributors to the U.S. labor force. In 2020, foreign-born men held a 76.6 percent participation rate as opposed to native-born men at 65.9 percent.⁴⁵ Foreign-born women are slightly lower at 53.2 percent than native-born women at 56.8 percent.⁴⁶ Refugees are immediately eligible for hiring upon arrival to the United States.⁴⁷ However, most refugees begin working at jobs much lower than their skillset. MPI research found that there are approximately two million college-educated

41 Refugee Act of 1980, Pub. L No. 96-212, 94 Stat. 102. 8 U.S.C. §§ 1157-1159

42 *Voluntary Agencies Matching Grant Program*, OFFICE OF REFUGEE RESETTLEMENT, October 15, 2021.

43 Noah Coburn, Timor Sharan, *Out of Harm's Way? Perspectives of the Special Immigrant Visa Program for Afghanistan*, THE HOLLINGS CENTER, September 2016. <https://hollingscenter.org/wp-content/uploads/2016/09/SIV-Full-Report.pdf>.

44 Coburn, Sharan, *supra* note 43

45 B.L.S News Release USDL-21-0905 (May 18, 2021)

46 B.L.S News Release *supra* note 45

47 Refugee Act of 1980, 8 U.S.C. §§ 1157-1159

immigrants who are underemployed.⁴⁸ In the study, immigrants are defined as persons who had no U.S. citizenship at birth, which includes refugees. One study found that “skilled immigrants with very low English proficiency are five times more likely to be underemployed than their fully proficient counterparts.”⁴⁹ No One Left Behind surveyed Afghan refugees who had recently arrived as part of the Special Immigrant Visa program and found that 97 percent of them had graduated high school, 32 percent had a bachelor’s degree, and 9 percent had an advanced degree.⁵⁰ However, 28 percent of those eligible to work were unemployed and 22 percent were underemployed.⁵¹ Many end up working for Lyft or Uber, or temporary manual labor, like landscaping or manufacturing.⁵² The underutilization of the skillset of foreign professionals is stark and contradicts the assurance from the Refugee Act of 1980 that refugees will be provided with “professional refresher training, and other recertification services.”⁵³

B. Refugee Healthcare

Refugees face barriers to receiving proper health care, including cultural and religious challenges. The healthcare system in the United States is often difficult for refugees (as well as native-born citizens) to navigate and understand. Many refugees come from countries where

48 Jeanne Batalova, Michael Fix, *Tapping the Talents of Highly Skilled Immigrants in the United States: Takeaways from Experts Summit*, MIGRATION POLICY INSTITUTE, August 2018.

49 Jeanne Batalova, Michael Fix, *supra* note 48

50 Noah Coburn, *The Costs of Working with the Americans in Afghanistan: The United States’ Broken Special Immigrant Visa Process*, WATSON INSTITUTE, BROWN UNIVERSITY, April 5, 2021. https://watson.brown.edu/costsofwar/files/cow/imce/papers/2021/Costs%20of%20Working%20with%20Americans_Coburn_Costs%20of%20War.pdf.

51 Coburn, *supra* note 50

52 Coburn, *supra* note 50

53 Refugee Act of 1980, Pub. L No. 96-212, 94 Stat. 102. (Codified as 8 U.S.C. §§ 1157-1159 (1980))

spiritual healers are considered just as legitimate as a doctor, if not complementary. A refugee's transition to treatment based solely on medication and physical therapy can be hard to navigate and even more difficult to trust. Furthermore, refugees often face significant physical hardships before their arrival to the United States, including exposure to infectious diseases like tuberculosis, parasites, and hepatitis B. They may also have significant dental and nutritional concerns, or even physical injuries as a result of torture and sexual violence. Refugees could also have experienced post-traumatic stress disorder, depression, and anxiety. Treatment for mental health is especially difficult considering varying cultural perceptions of mental health across the world.⁵⁴

Most significantly, language creates a barrier for refugees and their access to healthcare. While physicians should, in theory, provide a certified translator for each doctor visit, individual clinics are often unclear about who should pay for the services. Refugees speak a variety of languages, including dialects that are not common in the United States. Many clinics end up getting by with unprofessional interpreters, such as semi-proficient volunteers or family members. Refugees settled in larger cities have a higher likelihood of being treated at a large clinic with access to more extensive translation services as opposed to refugees being treated in rural communities.⁵⁵ This results in a lack of privacy for sensitive information of refugee patients. The right to privacy is not explicitly stated in the Constitution, but has been established in several notable cases, including *Roe v. Wade*.⁵⁶ The quality of translation services is often questionable as well, considering that lay translators are not trained in medical terminology. Refugees and domestic doctors find difficulty in

54 Ramin Asgary, Nora Segar, *Barriers to Health Care Access among Refugee Asylum Seekers*, 22 JOURNAL OF HEALTH CARE FOR THE POOR AND UNDESERVED. 506-22 (2011). <https://muse.jhu.edu/article/430668>.

55 Michael Timo Hoggard, *Barriers to Health Care Access for Refugees in Cache County, Utah*, UNDERGRADUATE HONORS CAPSTONE PROJECTS, (535) 2016. <https://digitalcommons.usu.edu/cgi/viewcontent.cgi?article=1547&context=honors>.

56 *Roe v. Wade*, 410 U.S. 113 (1973).

communicating with each other; lack of communication and foreign medical systems leave refugees distrustful of the system as a whole.⁵⁷ Adjustments in the accreditation process that allow foreign-educated doctors to obtain licensure more easily may largely eliminate the linguistic barriers and infringement of privacy rights.

C. Accreditation Process in the Medical Field

Upon completion of medical school, students must pass the United States Medical Licensing Examination to receive their license to practice in a specific state. After their time in residency, physicians can become board eligible and take a specialty certification exam. Upon successful completion of the exam, physicians are now considered members of the American Board of Medical Specialties (ABMS). Continuing certification is then required for all certified physicians.⁵⁸ The Federation Credentials Verification Service (FCVS) was created by the Federation of State Medical Boards in 1996 to provide a standard process for state medical boards—as well as private, governmental, and commercial entities—to obtain a verified source for a physician’s credentials.⁵⁹ After receiving such credentials, individuals can openly begin their practice of medicine.

It is interesting to examine examples of how one who is already practicing medicine can retain their certification. For example, physicians in North Carolina are required to renew their medical licenses each year by their birthday. They must pay a \$250 fee and complete sixty hours of continuing medical education (CME) every three years. Failure to renew your medical license results in an inactive

57 Ramin Asgary, *supra* note 54

58 *Board Certification Requirements*, AMERICAN BOARD OF MEDICAL SPECIALTIES, <https://www.abms.org/board-certification/board-certification-requirements/>.

59 *Navigating state medical licensure*, AMERICAN MEDICAL ASSOCIATION, <https://www.ama-assn.org/residents-students/career-planning-resource/navigating-state-medical-licensure>.

status. Inactivity legally restricts you from practicing medicine.⁶⁰ These practices of license renewal are similar across many states in the nation. Renewal of accreditation is a simple and common process for all practicing physicians within the United States. This differs from the lengthy process of reaccreditation that many refugees face when trying to become a licensed physician in the United States. “Clinicians who have obtained their medical degree or residency training outside of the United States or Canada,” are labeled International Medical Graduates (IMGs).⁶¹ Interestingly enough, “Of the 12,142 IMG applicants to residency in the 2018 National Resident Matching Program (NRMP), 7,067 were non-U.S. citizen IMGs.”⁶²

This attests to the fact that a majority of IMGs who are seeking to be reinstated into the healthcare field within the United States are refugees. The first step for refugees to become licensed doctors in the United States begins with applying for certification with the Educational Commission for Foreign Medical Graduates (ECFMG).⁶³ To then obtain an ECFMG certification, an individual must prove their attendance of an accredited medical school, provide other key documents, and then pass steps one and two of the United States Medical Licensing Examinations (USMLE). Once an individual passes these exams and has their documents approved, they then receive the ECFMG certification. The next step is to apply and complete a residency program, even if the individual has already completed one in their home country. Then, one must pass USMLE Exam step three and apply to the state medical board for their license. The process it takes for an individual to prove their skills is careful, as it should

60 *Physician License Renewal*, NORTH CAROLINA MEDICAL BOARD, <https://www.ncmedboard.org/licensure/renewals/physicians>.

61 Sarah Kureshi, Shahla Y. Namak, Fatin Sahhar, Ranit Mishori: *Supporting the Integration of Refugee and Asylum Seeking Physicians Into the US Health Care System*, JOURNAL OF GRADUATE MEDICAL SCHOOL EDUCATION, (August 11, 2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6697272/>.

62 Kureshi, Namak, Sahhar, Mishori, *supra* note 61.

63 *U.S. Medical Licensing Process*, OFFICE OF REFUGEE RESETTLEMENT, (June 18, 2012), <https://www.acf.hhs.gov/ort/policy-guidance/u-s-medical-licensing-process>.

be. However, the process becomes compromised when certain barriers cannot be overcome. For example, “only 56.5% of IMGs participating in the U.S. Match in 2018 were successful in obtaining a first-year residency position (versus 94.3% success rate for U.S. graduates).”⁶⁴ Since the process of becoming reaccredited is already lengthy, it is even more challenging when refugees are denied with higher frequency than an average U.S. Medical School graduate. Clearly, the accreditation process needs to be examined and revised in order to allow further opportunities for refugees to use their skills and specialties gained outside of the United States.

D. Foreign Medical Professionals in the COVID-19 Pandemic

The COVID-19 pandemic produced a unique opportunity for modification of licensure policies for foreign medical professionals. The unprecedented stress on the healthcare system led to a massive labor shortage of healthcare professionals. The stress was so great that individual states began modifying licensing policies to allow more medical professionals to practice. Several states, including Idaho and Florida, allowed physicians in good standing with licenses from other states to practice in their states. On January 28, 2021, the U.S. Department of Health and Human Services added the fifth amendment to the Declaration under the Public Readiness and Emergency Preparedness Act (PREP Act) that authorized “any healthcare provider who is licensed or certified in a state to prescribe, dispense, and/or administer COVID-19 vaccines in any other state or U.S. territory.”⁶⁵

Other states allowed foreign medical professionals to practice in their state, with New York allowing Canadian doctors to practice and New Jersey creating a foreign licensed doctor program. The governor of New Jersey signed Executive Order 112 on February 3, 2020 “authorizing the practice in New Jersey of foreign doctors in

64 Kureshi, Namak, Sahhar, Mishori, *supra* note 61.

65 *HHS Amends PREP Act Declaration to Increase Workforce Authorized to Administer COVID-19 Vaccines*, ASPR PRESS OFFICE, January 28, 2021 <https://www.hhs.gov/about/news/2021/01/28/hhs-amends-prep-act-declaration-increase-workforce-authorized-administer-covid-19-vaccines.html>.

good standing in other jurisdictions.⁶⁶ To qualify for the Temporary Emergency Foreign Physician Licensure Program in New Jersey, medical professionals must:

- 1) Reside in the United States;
- 2) Be a United States citizen, legal permanent resident, or otherwise legally present and authorized to work in the United States;
- 3) Hold a medical license in good standing in a country other than the United States;
- 4) Have practiced clinical medicine under that license for at least five (5) years during their career;
- 5) Have practiced clinical medicine under that license at some point during the last five years; and
- 6) Limit their practice under their temporary emergency license to providing in-person clinical medical services in a facility licensed by the New Jersey Department of Health, including but not limited to field hospitals and long-term care facilities, or another location designated as an emergency health care center by the Commissioner of Health.⁶⁷

Licenses granted were valid until the end of the Public Health Emergency declared by Governor Murphy. The International Rescue Committee (IRC) estimated that at the time the Executive Order was signed, there were approximately 165,000 underutilized health-care refugee and immigration workers that received their healthcare

66 New Jersey Exec Order No. 112, (Feb 3, 2020).

67 NEW JERSEY DIVISION OF CONSUMER AFFAIRS, TEMPORARY EMERGENCY LICENSURE OF FOREIGN PHYSICIANS SUPPORTING NEW JERSEY'S COVID-19 RESPONSE, (2020) [HTTPS://WWW.NJCONSUMERAFFAIRS.GOV/COVID19/DOCUMENTS/FAQ-FOREIGN-LICENSED-DOCTOR-PROGRAM.PDF](https://www.njconsumeraffairs.gov/COVID19/DOCUMENTS/FAQ-FOREIGN-LICENSED-DOCTOR-PROGRAM.PDF).

education outside the United States.⁶⁸ The process required for the Temporary Emergency Foreign Physician Licensure Program is significantly more manageable than the non-emergency application process for physicians licensed in other countries. A notable change was no longer requiring foreign medical professionals to complete a residency, which typically requires relocation. Rather, the temporary license only required them to have practiced within the past five years and for at least five years. Unfortunately, logistical challenges and closure of verification services due to the pandemic resulted in only 35 of the 1,100 applicants receiving a license. Despite poor implementation of the Temporary Emergency Foreign Physician Licensure Program, the modifications to the licensure requirement demonstrated the possibility of simplifying the licensure requirements. Remarkably, refugees who did not receive their emergency license were still willing to volunteer and contribute their medical expertise at little to no cost to those benefiting from their service.⁶⁹

The welfare of both refugees and the U.S. medical system could be expanded if licensure requirements for non-emergency foreign physicians were adjusted. The benefit to society of having more access to healthcare surely outweighs the need to heavily retrain already capable foreign doctors.

E. The Undue Burden Standard Applied to Foreign Medical Personnel Licensure

The ease of licensure facilitated during the COVID-19 health emergency stands in stark contrast to the current process for accreditation of foreign medical professionals, especially since refugees are

68 Charlie Ozuturk, *IRC launches online platform for refugees and immigrants in the United States seeking to obtain medical accreditation and join the fight against Coronavirus*, IRC PRESS RELEASE, April 12, 2020. <https://www.rescue.org/press-release/irc-launches-online-platform-refugees-and-immigrants-united-states-seeking-obtain>.

69 Karen Yi, *NJ Asked Foreign Doctors To Help During COVID—But Then Only Licensed 35 Of Them*, GOTHAMIST, July 30, 2021. <https://gothamist.com/news/nj-asked-foreign-doctors-to-help-during-covid-but-then-only-licensed-35-of-them>.

guaranteed “assist[ance] in obtaining the skills which are necessary for economic self-sufficiency, including projects for job training, employment services, day care, professional refresher training, and other recertification services.”⁷⁰ As it currently exists, the accreditation process for foreign medical professionals stands in the way of foreign doctors practicing in the United States. As defined by Justice Stevens, a “burden may be ‘undue’... because [it] is too severe.”⁷¹ The government has an interest in ensuring that doctors are sufficiently qualified to practice safely in the United States, but the current licensure requirements are severe, especially when compared to the requirements for doctors that received their training in the United States and recent modifications for emergency licensure. Thus, the difficulty of acquiring a license as a foreign medical professional was highlighted by the significant modifications made by various state governments that lightened licensure requirements during the public health crisis. In this situation, foreign medical personnel faced a similar standard as recently retired medical personnel who were also granted temporary emergency licenses.

Furthermore, the residency requirement is not cohesive with the resettlement policy for newly arriving refugees. The residency one is accepted into is not guaranteed to be close to where one lives. The setup in itself is problematic as refugees are placed in various host cities around the country without consideration for their professional skill set. Refugees would have to move to an unfamiliar location just months after becoming settled in their initial host city. To comply with the “assistance,” “professional refresher training, and other recertification services,” as mandated by the Refugee Act of 1980,⁷² the Refugee Resettlement process should be amended to ensure refugees with previous professional medical experience are placed in a city that allows them to complete their residency without having to relocate or modify the residency requirement in consideration of past experience.

70 Refugee Act of 1980, Pub. L No. 96-212, 94 Stat. 102. (Codified as 8 U.S.C. §§ 1157-1159 (1980)).

71 *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992).

72 Refugee Act of 1980, 8 U.S.C. §§ 1157-1159 (1980)).

Justice Stevens also said that something could be an undue burden if it “lacks a legitimate, rational justification.”⁷³ An analysis of foreign medical professionals currently practicing in the United States showed no significant difference in mortality rates of patients treated by foreign educated medical professionals and medical professionals educated in the United States.⁷⁴ Graduates of international medical schools make up approximately one-quarter of U.S. practicing physicians. Many individuals, especially Americans, feel distrust towards the level of medical training that individuals receive in countries other than their own. As our health and safety is at risk when we interact with medical professionals, these concerns are rational. However, many individuals will be enlightened as they examine different data behind this claim. John J. Norcini, the president and CEO of the Foundation for Advancement of International Medical Education and Research (FAIMER), conducted an elaborate study in 2010 comparing results over a lengthy period of time of patients who were cared for by international versus American medical school graduates. A total of 6,113 physicians were included in the study with 1,497 of such physicians being international graduates. The study focused on the care of patients who had congestive heart failure or acute myocardial infarction. During the study 244,153 patients were hospitalized. 22 percent of these patients were cared for by international medical graduates. The most pressing statistic was the mortality rate among total patients. Non-U.S.-citizen international graduates were associated with a nine percent decrease relative to U.S. graduates. Holding the scales of measurement to be constant, this study proved the capability of many non-U.S.-citizen international graduates. Thus, the current licensure requirements also lack “legitimate rational justification.” While cultural and communicative skills could be a reasonable concern in employability, they are not an indicator of practical medical skills or knowledge.

73 *Id* at 920

74 John J. Norcini, John R. Boulet, W. Dale Dauphinee, Amy Opalek, Ian D. Krantz, and Suzanne T. Anderson, *Evaluating the Quality of Care Provided by Graduates of International Medical Schools*, HEALTH AFFAIRS (August 2010). <https://www.edmonds.edu/welcomeback/documents/Interesting-Articles.pdf>.

The cultural and communicative barriers could be overcome by ensuring that the “professional refresher training” is adequately provided. One example of a cultural shift that is necessary and easily resolved is moving from a “doctor-centered” practice to a “patient-centered” practice. Health systems in Eastern Europe or Asia tend to be “doctor-centered,” meaning that doctors rarely seek patient input in their treatment. The United States’ healthcare system is “patient-centered,” with doctors typically interacting directly with patients and educating them about treatment choices.⁷⁵ By refocusing efforts on improving refugee employability instead of excluding them from the labor market of their chosen career via stringent licensure, the aims of the Refugee Act of 1980 will be realized, and refugee doctors will no longer be subject to an undue burden of excessive licensure requirements.

F. Recent Usage of the Due Process Clause (1791) to Protect Marginalized Groups

Under the Equal Protection Clause (1868) of the 14th Amendment, “nor shall any state... deny to any person within its jurisdiction the equal protection of the laws.”⁷⁶ The Due Process Clause contained within the Fifth Amendment of the Constitution requires the United States government to practice equal protection, while the Equal Protection Clause requires state governments to do the same. Therefore, protection is granted under both federal and state jurisdiction for all “persons born or naturalized in the United States.”⁷⁷ As was stated in the background section, refugees are not included in this wording. However, precedent establishes that they are to be included as protected groups. It is interesting to examine the case of *Trump v. Hawaii* (2018)⁷⁸, as potential challenges to both the Equal Protection and Establishment Clauses.

75 Jeanne Batalova, Michael Fix, *Tapping the Talents of Highly Skilled Immigrants in the United States*, MIGRATION POLICY INSTITUTE (August 2018).

76 U.S. CONST. amend. XIV § 1.

77 *Id.*

78 *Trump v. Hawaii*, 585 U.S. __ (2018).

Although the travel ban was never directly stated as a “Muslim ban,” the common belief was that of racial and religious animosity towards this group. In the case of *United States v. Windsor* (2013)⁷⁹, precedent and protection for marginalized groups was established under Justice Anthony Kennedy, who stated, “The Constitution’s guarantee of equality ‘must at the very least mean that a bare congressional desire to harm a politically unpopular group cannot’ justify disparate treatment of that group.”⁸⁰ This judicial ruling reiterates the protections established under the Due Process and Equal Protection clauses. However, the evidence of the claim in *Trump v. Hawaii* (2018) was ultimately predicated on the concern that “the nationals of eight foreign states whose systems for managing and sharing information about their nationals the President deemed inadequate.”⁸¹ In concern with the religious prejudice in question in the decision, the Court ruled that, “many majority-Muslim countries were not subject to restrictions and that some non-majority-Muslim countries were subject to the restrictions... and was based on a sufficient national security justification.”⁸²

In recent decades, tensions surrounding refugees and border control have created a pressing issue in the United States. Precedent has established that equal protection must be given to citizens, naturalized individuals, or refugees within the United States of America. The Constitution therefore allows these individuals the right of life, liberty, and the pursuit of happiness. Both *United States v. Windsor* (2013) and *Trump v. Hawaii* (2018) deal with the role of government in cases of refugees or marginalized groups and their rights. Although no violation was made against the Equal Protection or Establishment Clauses in the case of *Trump v. Hawaii* (2018), it is interesting to consider the statements made by the dissenting opinion from both Justices Sonia Sotomayor and Ruth Bader Ginsburg.

79 U.S. v. Windsor, 570 U.S. __ (2013).

80 *Id.* at 3, (Kennedy, J., opinion).

81 *Trump v. Hawaii*, 585 U.S., 1, (Certiorari) (2018).

82 *Id.* at 32, (Roberts, J., opinion).

Justice Sotomayor “criticized the majority for turning a blind eye to the pain and suffering the Proclamation inflicts upon countless families and individuals, many of whom are United States citizens.”⁸³ As was established in *U.S. v. Windsor* (2013), congressional desires to harm a politically unpopular group cannot justify disparate treatment of this group. As cases and proclamations create a rise in animosity and hard feelings towards specific minority groups, it is crucial that legislation aligns with precedent set in both the Due Process and Equal Protection Clauses and cases such as *United States v. Windsor* (2013). Many refugees belong to these groups and rely on the protections established under the precedents set. For refugees to prosper and have equal access to opportunities in their work, their communities, and their social well-being and health, it is essential to examine ways in which the government can fully protect their rights and opportunities. As we examine the specific benefits of reforms in the accreditation process in the healthcare industry for refugees, we see clear improvements among these refugees’ financial, social, and physical situations. Poverty rates will fall, healthcare opportunities for minority groups will expand, and social inclusion will rise as refugees are better represented and seen as active, important members of communities. Overall, these individuals will be valued, and their skills and training will be utilized to not only better themselves, but better the communities they live in.

IV. CONCLUSION

Clearly, the utilization of foreign-trained medical professional refugees is diminished within the United States due to the undue burden they face in the arduous accreditation process. Thousands of individuals like Layla Sulaiman are limited in their ability to work in the United States using their professional skillset. We view the medical accreditation process to be ineffective in providing equal opportunities on many levels. To begin, refugees face greater difficulty in being accepted into new residency programs upon arrival in comparison to U.S. citizens. If they are inclined to participate in

83 *Id.* at 1, (Sotomayor, J., Ginsburg R. dissenting).

another residency program, one may question why it is even more challenging for them to be accepted. Likewise, in the case of the emergency call in New Jersey for more medical professionals during the COVID-19 pandemic, extensive and disorganized forms of licensure and accreditation resulted in a lack of essential healthcare to society. Additionally, international medical graduates have proven their medical training and skills in many instances to be similar if not better than many U.S. medical graduates. Thus, it is evident that the accreditation process is both severe and lacks legitimate rational justification, constituting an undue burden. We reiterate that precedent surrounding the Due Process Clause guarantees refugees equal protection under the law.

The attention of legislators around the United States should therefore be directed towards mitigating this undue burden that foreign-educated refugees face. Policy changes should be enacted in a holistic sense, however one proposal is to adjust the current residency requirements. They are both lengthy in nature and an additional difficult adjustment for refugees to undertake as they must move to another new city. An improved system of accreditation for foreign medical refugees in the United States provides key benefits to society as a whole. Healthcare for other refugees will improve as those from similar backgrounds and cultures can more effectively communicate and treat refugees in need. Economic prosperity will be a realistic future for refugees as medical professionals are generally compensated far above wages of those living in poverty. Increasing medical professionals will provide greater accessibility to healthcare for all members of society.