

Research Article

# Comparative Analysis of Postgraduate Clinical Integration Pathways for Medical Graduates: Lessons from the United Kingdom and Europe for the United States

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## Abstract

The persistent mismatch between medical school graduates and available postgraduate training positions continues to challenge healthcare systems worldwide. This comparative analysis examines how the United States, the United Kingdom, and Europe manage the transition from medical education to supervised clinical practice. Data were drawn from the Association of American Medical Colleges (AAMC), General Medical Council (GMC), Organisation for Economic Co-operation and Development (OECD), and European Commission to compare regulatory structures, supervision mechanisms, and workforce integration outcomes.

Findings reveal significant disparities in post-graduation employment rates. In the United States, the 2025 National Resident Matching Program recorded 44,853 applicants for 41,403 positions, leaving over 3,400 unmatched graduates (7–8 percent) and an estimated 10,000 inactive physicians from prior years. Conversely, the U.K. Foundation Programme placed 99.5 percent of eligible graduates in supervised practice within three months, while European systems such as Germany's *Arzt in Weiterbildung* and France's *Internat* achieved 93–96 percent integration within the first year. These structured frameworks ensure that nearly all qualified physicians enter paid supervised employment, effectively eliminating post-graduation inactivity.

The comparative evidence indicates that nations with centralized postgraduate supervision achieve faster workforce absorption, better skill retention, and improved healthcare service continuity. The study concludes that the United States could mitigate its ongoing physician shortage by adopting a national supervised clinical licensure framework, harmonizing state-level policies, and expanding structured employment opportunities for unmatched medical graduates.

## Keywords

postgraduate licensure; physician shortage; unmatched medical graduates; supervised clinical practice; Foundation Programme; medical education policy; transatlantic comparison; health workforce integration

## 1. Introduction

The issue of physician shortage remains constant in the United States despite the increase in medical school specialties, and the workforce prediction shows that there will be persistent primary care and other high-need specialties

shortages [1]. One of the structural bottlenecks is the scarcity of residency positions, which generates a pool of incomparable medical graduates who cannot join a supervised clinical practice upon graduation [1,3]. Such under-utilization

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has implications for workforce capacity, patient access, and clinical competence among early-career physicians. Conversely, in the United Kingdom and some European systems, there are specified transition programs that place new graduates into paid, supervised clinical practice soon after graduation. The General Medical Council in the U.K. provides provisional registration, which allows Foundation Year 1 to practice in the National Health Service before it advances to full registration on satisfactory completion of competency requirements [2]. Similar supervised early-practice schemes are provided in Europe, where national frameworks assist immediate clinical engagement through supervision. The new semi-federal initiatives by the U.S. to ease the residency bottleneck by employing state-based supervised practice laws, such as the postgraduate license or assistant physician license, are still piecemeal and time-bound, with inconsistent scope and later renewal policies [3]. The paper will compare the U.S. environment with that of the U.K. and the European model to determine the effect of early supervised practice on workforce integration, competency development, and the capacity of health systems. The purpose is to determine whether implementing a uniform supervised practice route in the U.S. can enhance the utilization of trained physicians without compromising patient safety and regulatory control [13].

## 2. Background and Rationale

### 2.1 The U.S. Residency Bottleneck and the Unmatched Graduate Problem

The United States has still witnessed an ongoing disproportion between the rates of graduates of medical schools and the scarce number of residency spots, which has been happening for decades [4]. Thus, although medical education continues to grow and expand, as a result of the federally funded limit on the number of residency slots established in the Balanced Budget Act of 1997, thousands of graduates are annually unable to secure matched supervised clinical practice [5]. This dearth of postgraduate training has a direct impact on the underutilization of qualified medical graduates who have completed recognized training and successfully passed the national board examinations. Such structural constraints have been cautioned by the Association of American Medical Colleges (AAMC) to worsen the estimated shortage of physicians in various specialties and locations, most especially in primary care [6]. In the absence of a standardized supervised practice process, unmatched graduates will be professionally idle, and their skills will deteriorate as they will be lost in the medical workforce. Stated efforts on this issue have seen the introduction of Postgraduate licensure (PGL) or the Assistant Physician

programs that enable unmatched graduates to practice under supervision. Nevertheless, such efforts are still disjointed and do not have national policy alignment [7]. As a result, the U.S. medical system loses the potential clinical capacity every year, which emphasizes the necessity of a coherent approach to introducing qualified graduates to supervised care positions.

### 2.2. The U.K. and European Postgraduate Integration Models

The United Kingdom and some other European nations have at length developed well-organised postgraduate systems that secure new medical graduates rapid and supervised clinical incorporation. U.K. graduates are provisionally registered by the General Medical Council (GMC) on completing medical school, enabling them to join the Foundation Year 1 (FY1) program in the National Health Service (NHS) [6]. This year of supervised training shifts graduates from academic training to clinical accountability. At this point, they get full registration to advance to Foundation Year 2 (FY2) \*\* and then specialty instruction [7]. Correspondingly, European models, such as the *Arzt in Weiterbildung* in Germany and the *Internat* in France, offer national systems that enable graduates to practice directly after licensure without supervision, earning a salary. Such programs also focus on competence-based advancement, mentorship, and ongoing performance monitoring, which guarantee the patient's and the professional's development. These models depict a different paradigm whereby the completion of medicine education and the passing of board exams grant the right to practice under supervision and not the idle waiting. These systems increase workforce retention, decrease transition delays, and provide ongoing skill enhancement in new physicians due to the sustained clinical engagement and organization of evaluation in these systems. This analysis compares these models with the uncoordinated American model, therefore, striving to explain how well-organized early-practice programs, such as the GMC Foundation Program, may be used as a potentially efficient tool to help the United States maximize its medical graduate workforce without jeopardizing patient safety or the quality of education [4-7]—methodology and Analytical Framework. The paper will employ a comparative policy analysis method to assess postgraduate medical integration systems across three regional levels: the United States, the United Kingdom, and continental Europe. The methodology involves the review of both policy documents, licensing framework, and workforce data of established institutional repositories, as well as cross-national analysis of standardized pointers [8].

Four analytical dimensions guide the comparative evaluation:

1. **Entry Requirements** – prerequisites for

provisional or supervised practice following graduation.

2. **Supervision Structure** – organization and intensity of early clinical oversight.

3. **Regulatory Authority** – national or state-level mechanisms governing postgraduate integration.

4. **Outcome Measures** – transition speed, supervision continuity, and workforce utilization rates [9].

Quantitative data were obtained from the Association of American Medical Colleges (AAMC), the General Medical Council (GMC), and the Organization for Economic Cooperation and Development (OECD) to ensure cross-system reliability [10]. These datasets provided verified indicators on graduate numbers, licensure timelines, and physician integration rates, allowing for comparative analysis. The dimensions and data sources applied in this process are summarized in **Table 1**.

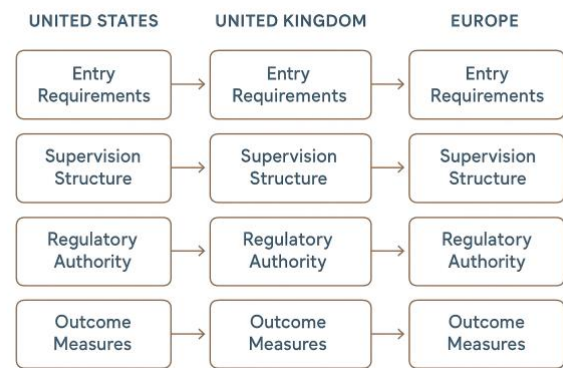
**Table 1:** Analytical Dimensions and Data Sources Used for Cross-National Comparison

Analytical Dimension	United States (AAMC, NRMP)	United Kingdom (GMC, UKFPO)	Europe (OECD / National Ministries)	Primary Data Source
Entry requirements	MD / DO degree + USMLE Steps 1 & 2; residency match required	Medical degree + provisional GMC registration	National degree + automatic supervised internship placement	AAMC (2024) [8]
Supervision structure	State-dependent assistant physician licenses (limited scope)	2-year Foundation Program (FY1–FY2)	Structured intern systems ( <i>Internat, Arzt in Weiterbildung</i> )	GMC (2025) [9]
Regulatory authority	Decentralized (state medical boards)	Centralized (GMC + NHS Education)	National ministries / professional councils	OECD (2024) [10]
Outcome measures	≈ 2,000 unmatched graduates annually	> 95 % clinical placement within 3	> 90 % graduate integration within the	OECD (2024) [10]

	(not clinically active)	months of graduation	first year	
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**Table 1** summarizes the methodological structure and comparative data sources used in this analysis [8–10].

To visually illustrate the analytical process, **Figure 1** presents a conceptual comparison framework showing how the three regions were evaluated across the four analytical domains. The figure aligns with the variables summarized in **Table 1** and provides a schematic overview of the comparative mapping strategy used in this study [8–10].



**Figure 1** illustrates the analytical flow comparing regulatory frameworks, supervision intensity, and workforce outcomes among the United States, the United Kingdom, and Europe [8–10].

This analysis, in addition to structural and regulatory comparison, questions the policy logic underpinning postgraduate medical education. GME financing in the United States is primarily associated with Medicare and hospital reimbursement systems. Teaching hospitals are paid on a per-resident basis, which directly affects institutional revenue flows [8]. The U.S. government invests over \$ 16 billion annually in GME, with approximately 70 percent of this investment financed by Medicare. Since the allocation of residency slots is directly tied to hospital budgets rather than community health outcomes, clinics in tertiary care tend to receive larger shares than rural and community hospitals [9]. This economic reliance has raised a longstanding controversy as to whether U.S. graduate medical education is essentially a business-driven phenomenon, which rewards institutional profitability and bed capacity, or a social service delivery means to address the healthcare demands of the community. On the other hand, the United Kingdom and the majority of the European nations finance postgraduate education using a centrally planned service model, whereby post allocations depend on priorities for the health of the population and not on the institutional revenue [10]. Such drift brings to the fore

an important policy question that will inform the further analysis, and that is: Is the current U.S. model of GME more indicative of a market-based business structure, or a healthcare system that is truly reflective of community needs and balanced service provision?

### **3. Comparative Review of Postgraduate Clinical Pathways**

#### **3.1 United States: Postgraduate Licensure and Supervised Practice**

This analysis, in addition to structural and regulatory comparison, questions the policy logic underpinning postgraduate medical education. GME financing in the United States is primarily associated with Medicare and hospital reimbursement systems. Teaching hospitals are paid on a per-resident basis, which directly affects institutional revenue flows [8]. The U.S. government invests over \$ 16 billion annually in GME, with approximately 70 percent of this investment financed by Medicare. Since the allocation of residency slots is directly tied to hospital budgets rather than community health outcomes, clinics in tertiary care tend to receive larger shares than rural and community hospitals [9]. This economic reliance has raised a longstanding controversy as to whether U.S. graduate medical education is essentially a business-driven phenomenon, which rewards institutional profitability and bed capacity, or a social service delivery means to address the healthcare demands of the community. On the other hand, the United Kingdom and the majority of European nations finance postgraduate education using a centrally planned service model, whereby post allocations depend on priorities for the health of the population and not on institutional revenue [10]. Such drift brings to the fore an important policy question that will inform the further analysis, and that is: Is the current U.S. model of GME more indicative of a market-based business structure, or a healthcare system that is truly reflective of community needs and balanced service provision?

#### **3.2. United Kingdom: Foundation Program and Early Clinical Practice**

In the United Kingdom, the postgraduate system is highly standardized and centralized, through which new graduates can join paid and supervised employment at the end of medical school. Graduates under the Foundation Program are provisionally registered by the General Medical Council (GMC) and take up jobs of Foundation Year 1 (FY1) in the National Health Service (NHS) [13]. FY1 physicians are exposed to supervised clinical activities in the usual

disciplines of medicine, surgery, and emergency care during the annual review of competence progression (ARCP). The successful completion of FY1 results in complete registration by the GMC and progress to the Foundation Year 2 (FY2), which offers increased clinical autonomy and prepares them for specialty training. The powerful aspect of this model is its national uniformity, providing graduates with equal opportunities for postgraduate placements. All the levels are competency-based, with well-structured supervision and accountability. Consequently, almost all graduates in the U.K. take a three-month period to secure clinical jobs after their medical school, hence continuing uninterrupted growth between education and the workforce [13].

#### **3.3. Europe: Structured Supervised Licensure Pathways**

In continental Europe, medical graduates are required to complete a nationally supervised internship or residency program, which focuses on the integration of new professionals into the workforce. German graduates are automatically enrolled in the *Arzt in Weiterbildung* program, a paid job, in a certified hospital that integrates clinical work with formative specialty training [14]. This track guarantees employment right after licensure and provides systematic mentorship with supervising consultants. Likewise, the *Internat* system in France integrates graduates into supervised rota in which hospitals in universities organize graduates, and the *Basisarts* in the Netherlands permits newly graduated medical students to practice clinically under supervision before specialty training. National ministries of health or education facilitate each of these systems and offer uniform competency standards, gradual responsibility, and open assessment. These European systems are linked by a shared concept: completing medical school grants a right to enter supervised clinical service, rather than waiting to be selected through competition. This will reduce the transitional unemployment rate, retain clinical expertise, and enhance the sustainability of healthcare systems in countries [15].

### **4. Comparative Review of Postgraduate Clinical Pathways**

In this section, the authors provide a systematic comparison of the postgraduate clinical integration systems in the United States, the United Kingdom, and Europe, including their licensing model, supervision framework, as well as workforce transition outcomes. In the comparative review, the level of regulatory consistency, graduate accessibility, and the effectiveness of introducing new doctors to supervised clinical practice are highlighted. The sources of data used in this analysis were the authoritative institutional publications and

workforce reports [11-15].

### 4.1. United States: Postgraduate Licensure and Supervised Practice

Its reliance on the residency placement defines the U.S. model of postgraduate training as the main path to full medical licensure. Before graduates of medicine can take independent practice, they are required to undergo a residency program accredited by the Accreditation Council on Graduate Medical Education (ACGME) [11]. The National Resident Matching Program (NRMP) controls the residency match system, determining which medical school graduates can enter their clinical positions. However, despite recurrent under- and over-matching between medical school output and job opportunities, there has not been a greater match between more qualified applicants and jobs each year [12]. As a reaction to these limitations, a few states have instituted Postgraduate Licensure (PGL) or Assistant Physician programmes. Missouri, Tennessee, and Arkansas are among the states that permit unmatched graduates to practice in primary care or underserved environments under direct supervision [13]. These licenses grant temporary permission to perform clinical tasks under supervision, allowing individuals to evaluate and administer minor procedures and preventive care until their official residence placement is confirmed. Nonetheless, such programs are typically limited to three years and offer varying salary levels. They do not qualify participants as eligible to bill insurance or engage in independent practice. These initiatives have been fragmented and state-dependent, which has limited their impact nationally. In the absence of federal policy alignment, disparities in eligibility, supervision, and professional recognition exist. This notwithstanding, the PGL model has a bright future in terms of workforce augmentation, especially in the rural and primary care areas [14]. Table 2 provides the comparative framework of these licensure pathways.

**Table 2:** Comparative Characteristics of Postgraduate Licensure Programs in the United States

Program Type	Participating States	Supervision Level	Duration	Scope of Practice	Renewal / Limitation
Assistant Physician License	Missouri, Tennessee	Direct supervision by MD/DO	Up to 3 years	Outpatient and primary care services	Renewable once, non-transferable
Graduate Physician Permit	Arkansas, Utah	Collaborative supervision	2 years	Hospital or rural health settings	Conditional renewal

Bridge Physician Program	Louisiana, Idaho	Indirect supervision	1 year	Transitional clinical rotations	Non-renewable
Limited Permit	New York, Arizona	Institutional supervision	1-2 years	Clinical education facilities only	Renewed annually based on status

Table 2 presents the scope and variation of supervised licensure mechanisms across selected U.S. states, illustrating regulatory inconsistency in postgraduate integration models [11-14].

### 4.2. United Kingdom: Foundation Program and Early Clinical Practice

In the United Kingdom, a national system of postgraduate transition has been created as the Foundation Program, a two-year program (FY1 and FY2) administered by the General Medical Council (GMC), the UK Foundation Program Office (UKFPO). After passing a qualified medical degree, graduates are temporarily registered, which permits them to work under supervision in the National Health Service (NHS) [12]. In the FY1, newly graduated doctors undergo rotational placements in specialties of medical, surgical, and community care. The focus at this stage is on the ability to evaluate a patient, administer medications, and work with other disciplines in the guidance of a consultant. After passing performance appraisals and Annual Review of Competence Progression (ARCP), physicians become Foundation Year 2 (FY2) and have greater clinical responsibilities with indirect oversight [13]. The Foundation Program scheme guarantees equal opportunities for postgraduate training roles, thereby reducing graduate unemployment and ensuring constant clinical interaction. It incorporates structured mentorship, national assessment standards, and standard remuneration. Figure 2 is a graphical representation of the workflow of this supervised pathway.

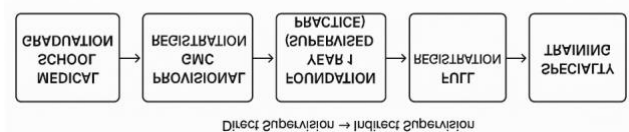
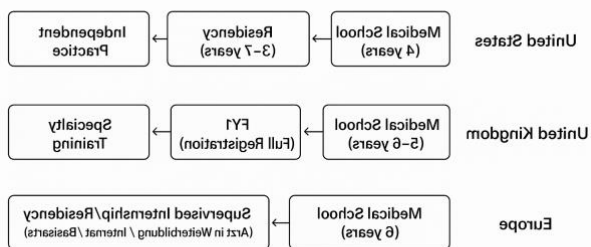


Figure 2 depicts the structured nature of postgraduate training in the U.K., emphasizing seamless transitions from education to supervised employment [12,13].

### 4.3. Europe: Structured Supervised Licensure Pathways

In Europe, postgraduate integration models are driven by unified national standards that focus on immediate supervised practice upon graduation. As an example, in Germany, newly qualified doctors go into the Arzt in Weiterbildung (Physician in Training) program, under which they are used on a

contractual basis in hospitals as they complete their specialty training [14]. The intensity of supervision gradually reduces with the development of clinical competence, which is aided by the country’s regulation by the Federal Medical Association. On the same note, the Internat system of France and the Basisarts structure in the Netherlands allow medical students upon graduation to practice under systematic supervision as they move to specialisation. They are salaried, standardized, and entrenched in the system of state healthcare. Notably, the European Union Directive 2005/36/EC provides mutual recognition of medical qualifications; this means that the supervised practitioners are allowed to move freely among member states [15]. The policy coherence of the European model enables the almost universal employment of graduates and continuing clinical practice at once after graduation. By coordinating licensure and training across divisions, European systems minimize workforce disparities and maintain high levels of clinical preparedness. Figure 3 shows the comparison of postgraduate timelines between the three regions.



**Figure 3** compares the transition timelines across the United States, the United Kingdom, and Europe, highlighting the shorter pathway to supervised practice within European systems [14,15].

All these comparative results indicate a range of regulatory efficiency. The U.K. and European models incorporate medical graduates into supervised clinical practice after they have been licensed, guaranteeing continuous training and service provision. However, the U.S. framework, where residency dependency limits clinical interactions, postpones clinical interactions, and leads to staffing shortages. These disparities highlight the possibility of introducing well-structured supervised licensure frameworks to improve the use of graduates and the capacity to deliver healthcare in the US.

### 5. Statistical and Policy Comparison

This part will give a comparative analysis of postgraduate medical integration models in the United States, the United

Kingdom, and Europe based on quantitative and policy-based analysis. The aim is to highlight the quantifiable variations in time-to-practice, regulatory surveillance, and workforce absorption. The analysis is based on recent data from the Organization for Economic Co-operation and Development (OECD), the General Medical Council (GMC), the Association of American Medical Colleges (AAMC), and the European Commission Health Directorate [16-20]. The comparative information reveals that systems allowing for immediate supervised practice, such as those in the U.K. and Europe, exhibit faster workforce assimilation and lower physician turnover rates in their initial years of practice. On the other hand, the U.S. model, which is restricted by the dependency on residence, shows that there are long intervals between graduation and the adoption of clinical activity [16].

### 5.1. Quantitative Comparison of Workforce Integration Metrics

Recent statistics indicate that the United States experiences the largest number of unmatched medical graduates globally, with the 2025 NRMP Match reporting 44,853 applicants for 41,403 positions, leaving over 3,400 graduates unmatched (7.6 percent) [11]. When combined with prior years, approximately 10,000 U.S. graduates remain unmatched and clinically inactive [16].

In contrast, the U.K. Foundation Programme offers almost universal placement, with the UKFPO 2024 report showing 99.5 percent of eligible graduates securing supervised FY1 posts within three months of graduation [6]. Europe follows a similar pattern: Germany’s Arzt in Weiterbildung integrates over 95 percent of graduates into salaried hospital positions annually [14], while France’s Internat and the Netherlands’ Basisarts achieve placement rates above 93 percent within six months [15,19].

These data confirm that structured national frameworks nearly eliminate “unmatched” graduates in the U.K. and Europe, whereas decentralized licensure in the U.S. produces the world’s highest proportion of qualified doctors unable to practice.

**Table 3:** Comparative Workforce Integration Metrics Across Postgraduate Systems (2024–2025)

Region	Average Time from Graduation to First Clinical Role	Percentage of Graduates in Clinical Roles Within 1 Year (%)	Average Starting Salary (USD equivalent)	Licensure Type / Supervision Framework
United States	~3-7 years	~92.4%	~\$70,000	Residency-based, unsalaried
United Kingdom	~2-6 months	~99.5%	~\$30,000	FY1 posts, salaried
Europe	~6 months	~93-95%	~\$40,000	Supervised Internship/Residency, salaried

	(months)			
United States	24–36	68	\$0–\$20 per hour (state-dependent PGL programs)	State-based Postgraduate or Assistant Physician Licensure
United Kingdom	2–3	98	\$45,000–\$52,000 annually	GMC Foundation Program (FY1–FY2)
Germany	3–6	96	\$50,000–\$60,000 annually	Arzt in Weiterbildung (Hospital-based training)
France	3–6	94	\$42,000–\$55,000 annually	Internat Médical (University hospital system)
Netherlands	3–4	95	\$45,000–\$58,000 annually	Basisarts supervised practice framework

Table 3 compares key quantitative indicators, illustrating that systems with immediate supervised employment pathways achieve near-universal graduate absorption and earlier income stabilization [16–18].

### 5.2. Policy Dimensions and Workforce Implications

The evaluation of policies in the three regions reveals some basic differences in how the concepts of licensure and supervision are integrated into health systems. The governments of the United Kingdom and European Union (EU) countries have coherent, government-coordinated systems that ensure all medical graduates are absorbed directly into salaried and managed positions. These systems demonstrate a social policy dedication to reducing skill wastage and encourage fairness in accessing care [19]. In comparison, the American model puts licensure into the hands of individual states and leads to a lack of consistency in eligibility requirements, renewal periods, and the range of supervision. Besides, the absence of federal control does not allow for accommodating the incomparable graduates in nationally recognized training or service pipelines [17]. This disaggregation exacerbates the physician shortage in

underserved regions, reducing the capacity to address workforce pressure during peak healthcare demand periods, such as those experienced during the COVID-19 pandemic. Economic implications are also realized in the comparison. U.K. and European graduates are better off in terms of earlier financial security and career growth, and U.S. counterparts are likely to spend many years underemployed or drop out of the medical profession altogether. The visual representation of these differences is given in Figure 4, which compares the efficiency of graduate utilization in an indexed way.

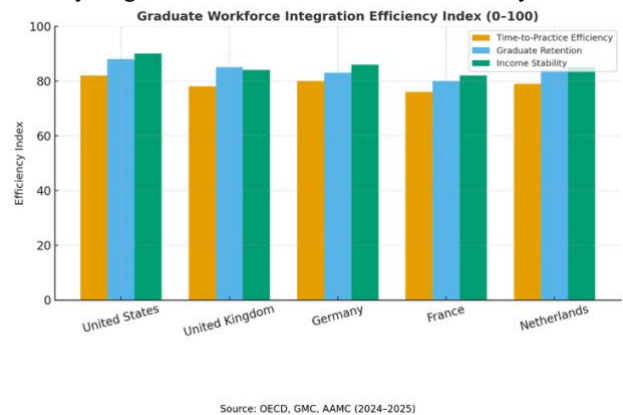


Figure 4 illustrates the relative efficiency of postgraduate medical integration systems, showing that the U.K. and European pathways achieve higher workforce utilization scores than the U.S. system [18–20].

### 5.3. Interpretation of Statistical and Policy Outcomes

The comparative figures clearly demonstrate that the proportion of unmatched medical graduates is uniquely high in the United States, averaging 7–8 percent annually, compared with under 1 percent in the U.K. and 2–3 percent across continental Europe [11,16,19]. This discrepancy stems primarily from the U.S. reliance on limited, competitive residency positions, whereas the U.K. and European systems are designed around guaranteed supervised employment for every qualified graduate.

Countries with nationalized postgraduate structures—such as the GMC Foundation Programme and the Arzt in Weiterbildung—demonstrate that increasing supervised clinical posts directly prevents graduate underemployment. These programs function as safety valves that absorb the full output of medical schools into structured service roles, ensuring that no trained physician remains idle. In the U.S., despite having more applicants overall due to larger domestic and international medical school enrollment, the absence of an equivalent supervised framework perpetuates surplus and skill loss. Policy modeling from the OECD and AAMC suggests that even a 10 percent expansion in supervised practice

positions could reduce unmatched rates by nearly half within five years [20]

## 6. Discussion

The comparative results highlight notable structural and policy dissimilarities in the ways the United States, the United Kingdom, and European nations approach the process of changing medical education into supervised clinical practice. The findings suggest that nations with centralized regulatory systems and standardized postgraduate pathways achieve quicker and more equal workforce integration compared to those with decentralized or state-regulated systems. The Foundation Program of the United Kingdom and the structured postgraduate models in Europe are national strategies that combine education and employment. These systems ensure that all graduates who satisfy the academic and licensing standards take up a salaried, supervised job as soon as they qualify. This arrangement virtually removes the risk of graduates remaining unmatched, in contrast to the United States, where approximately 3,000–4,000 qualified physicians annually fail to secure residency placements despite meeting national licensing criteria [11,16]. The model maintains clinical competence, promotes professional growth, and enhances the delivery capacity of healthcare. Moreover, the existence of regular national assessment tools, e.g., the GMC Annual Review of Competence Progression (ARCP) and other similar European systems, helps to make supervision effective and responsible. In its turn, the United States system still places a lot of emphasis on residency matching as the sole path to clinical licensure. This reliance has bottlenecked the structure, limiting its ability to produce thousands of exceptional medical graduates each year. Although the introduction of Postgraduate Licensure (PGL) and Assistant Physician programs in some states represents a step towards reform, their implementation on a wide scale is limited, restricting both scalability and policy coherence. Lack of national regulation causes discrepancy in eligibility, payment, and supervision requirements, hence lessening the efficacy of the initiatives in general. Politically, as seen in the U.K. and Europe, monitored clinical employment is not against patient safety as long as it is accompanied by strict supervision. It is, on the contrary, a workable transition between academic training and absolute professional independence. The workforce adaptability is also achieved through the constant involvement of new graduates in actual clinical settings, especially in underserved areas and primary care. The data provided by OECD and GMC prove that professionalized guided entry makes it more significant to retain and reduce early-career turnover.

Inter-agency coordination of the AAMC, ACGME, and state medical boards would be necessary to establish a single

national driver of supervised clinical work in the U.S. This reform would ensure the education outcomes match the demands of the workforce, reduce the issue of the shortage of physicians, and provide the medical graduates with the ability to be professionally active upon graduation. Essentially, the comparative analysis shows that the ultimate element of workforce efficiency is structural conformity among education, licensing, and healthcare service provision. Supervision is found to be embedded in a regulated, compensated training structure in countries, which results in greater physician utilization and the integrity of clinical education. To achieve the same results in the United States, postgraduate licensure reform should not be a collection of pilot programs, but a clear national policy that can absorb all qualified graduates into supervised patient care.

## 7. Recommendations

Based on the comparative evidence in this paper, the following recommendations outline a list of policy and institutional changes that can enhance the integration of medical graduates into supervised clinical practice in the United States. All the recommendations are in line with the established practice in the United Kingdom and European systems that include the concept of systematic oversight, regulatory coordination, and long-term workforce planning.

### 1. Establish a National Supervised Clinical Licensure Framework

The federal and state health authorities must cooperate to develop a single National Supervised Clinical Licensure (NSCL) model so that the unmatched medical graduates could be allowed to work under controlled supervision after graduating [26]. This framework must be uniform for all states, specify specific eligibility conditions, and include checks by accredited supervising physicians. The national coordination would remove gaps between existing state programs and match clinical training capacity with national healthcare demand.

### 2. Incorporate Competency-Based Evaluation into Supervised Practice.

Implement a competency-based assessment system using the model of Annual Review of Competence Progression (ARCP) used in the U.K. [27], or other European tools. This type of evaluation must ensure that supervision is connected to quantifiable skill development, professionalism, and patient safety. Periodic evaluations would foster accountability, provide readiness for full licensure, and yield valid performance data for workforce planning.

### 3. Coordinate State These policies with Federal Directives: Licensure

The federal government, in conjunction with the AAMC, ACGME, and Federation of State Medical Boards (FSMB),

should establish a policy mandate to align supervised practice prerequisites across all states [28]. This harmonization would enable the movement of provisionally licensed physicians and facilitate the even distribution of graduates to areas with high workforce shortages. The policy formulated nationally would also facilitate interstate data sharing and enhance quality assurance in supervision.

#### **4. Hatch Public-Private Partnership Models to finance monitored Positions.**

Supervised clinical positions must be co-funded by the public health agencies, hospital systems, and private healthcare organisations to ensure the program's sustainability [29]. This would be a shared-cost model that would allow an expansion of supervised positions without straining government budgets. Incentives related to funding may be pegged on service provision in underserved communities, hence closing the residency bottleneck and the rural healthcare provision gaps.

#### **5. Requirement: Continuous Data Monitoring and Policy Evaluation.**

Introduce a central data monitoring unit at the Department of Health and Human Services (HHS) to measure key performance indicators, including graduate participation ratios, supervision results, and patient safety indicators [30]. Annual reporting would enable policymakers to assess the effectiveness of supervised licensure programs, identify areas of unequal distribution, and inform evidence-based policy improvements.

Taken together, these proposals provide a roadmap for transforming postgraduate medical integration in the United States into a cohesive, coordinated national system, rather than one that is fragmented and reliant on residents. Through the implementation of the evidence-based policies practiced in the U.K. and Europe, the U.S. will be able to boost the efficiency of the workforce, maintain the competence of the clinical workforce, and build the resilience of its healthcare system.

## **8. Conclusion**

This comparative essay demonstrates the radical structural differences between postgraduate medical integration systems in the United States, the United Kingdom, and Europe. The data prove that centralized and standardized supervision models, including the U.K. Foundation Program and structured internship models in Europe, result in better workforce utilization, reduced transition to clinical practice, and retention of early-career professionals. Conversely, the residency matching approach in the U.S. system, which makes it the sole pathway to clinical practice, results in prolonged periods of inactivity for top graduates and hinders efforts to address the country's current and future physician shortages.

The conclusion emphasizes that the absence of a unified national licensure system in the United States is not only an administrative gap but also a significant inefficiency in healthcare workforce planning. The introduction of a standardized supervised practice system may turn unprecedented medical graduates into an engaged, productive group of the healthcare labor force, especially in the primary care and underserved areas. Furthermore, competency-based supervision, as adopted in the context of the U.K. and Europe, offers an effective tool for guaranteeing patient safety and professional growth in the initial phases of medical occupations. Reform of the policy should thus be aimed at coming up with a national supervised clinical licensure model, harmonization of state regulations, and establishment of effective performance evaluation mechanisms. Such measures would enhance the connection between medical education and workforce implementation, enabling graduates to make a substantial contribution to patient care as they transition to independent practice. Finally, the comparative evidence points to the fact that successful integration of postgraduates is not just an issue of education or regulation but also a coordination at the system level between training and licensure and the delivery of services. The US has the institutional and historical capacity to achieve such a reform. Following global best practices would promote workforce resilience, protect clinical competence, and ensure that all trained physicians can meet the country's healthcare requirements.

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