International medical graduates

Past, present, and future

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Historically, international medical graduates (IMGs) have played an important role in maintaining Canada's medical work force. Approximately 25% of Ontario doctors are IMGs.[1] In some provinces, such as Saskatchewan and Manitoba, the numbers are higher.[1] However, the contribution of foreign-trained doctors to the net increase in practising doctors from 2000 to 2007 was a modest 8% in Canada, compared with 55% in the United States and 92% in Ireland (**Figure 1**).[1,2]

In 2012, Canada had 2.44 physicians per 1000 people, well below the Organisation for Economic Co-operation and Development (OECD) average of 3.4.[2] In 2007, Canada had 6.2 medical graduates per 100 000 people, well below the OECD average of 9.9 (**Figure 2**).[1]

In the past, IMGs typically immigrated to Canada under the Federal Skilled Worker Program. Recently, the federal government has closed this door by removing physicians from the list of eligible professions.[3] While this will shift the future medical landscape in Ontario by virtually eliminating newcomer physicians from the immigration mix, there still exists a substantial backlog of immigrant IMGs in Canada who have not been able to achieve licensure.

In most cases, IMGs must complete a postgraduate training program to be licensed in Ontario. Some provinces, such as Saskatchewan, Manitoba, Nova Scotia, and Newfoundland and Labrador, allow some IMGs to start practising with limited licensure without going through a postgraduate program. The shortage of training positions has meant that many IMGs have been unable to retrain. Ontario more than doubled training positions for IMGs from 90 positions in 2003 to 200 positions in 2004.[4] George Smitherman, the Minister of Health and Long-Term Care at the time, announced:

> This is a win-win for this province .... Foreign-trained doctors will be able to practice in their new home, as they want and are trained to do. And Ontario patients will have better access to doctors in their own communities.[5]

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The situation now is dramatically different. While these 200 positions still exist, the latest data available from the Canadian Resident Matching Service indicate that only 6% of immigrant IMG applicants were successful in obtaining one of these sought-after training positions compared with 23% in 2008.[6]

There are now new players in the game. More than 4000 Canadian citizens are studying undergraduate medicine abroad.[7] These Canadians studying abroad (CSAs) are studying in various medical institutions. These are mostly Caribbean-based schools without affiliated clerkship or residency positions or opportunity to practise in the country where the school is situated. Even European and Australian medical schools do not provide CSAs with opportunities for postgraduate training. It appears that the mandate of most of these schools is to profit from largely North American trainees. They do not absorb these students into their own hospitals; instead, they send them mostly to the United States or the students' countries of origin for clerkship and residency.

More than 90% of CSAs intend to return to Canada to pursue postgraduate medical training and more than 87% intend to practise medicine in Canada.[7] The current policies have these CSAs competing in the same pool as the immigrant IMGs, and the CSAs are gaining ground. In 2011, CSAs represented approximately 25% of the IMG applicants and obtained more than 50% of the first-year IMG residency positions in Ontario.[6]

Selection process

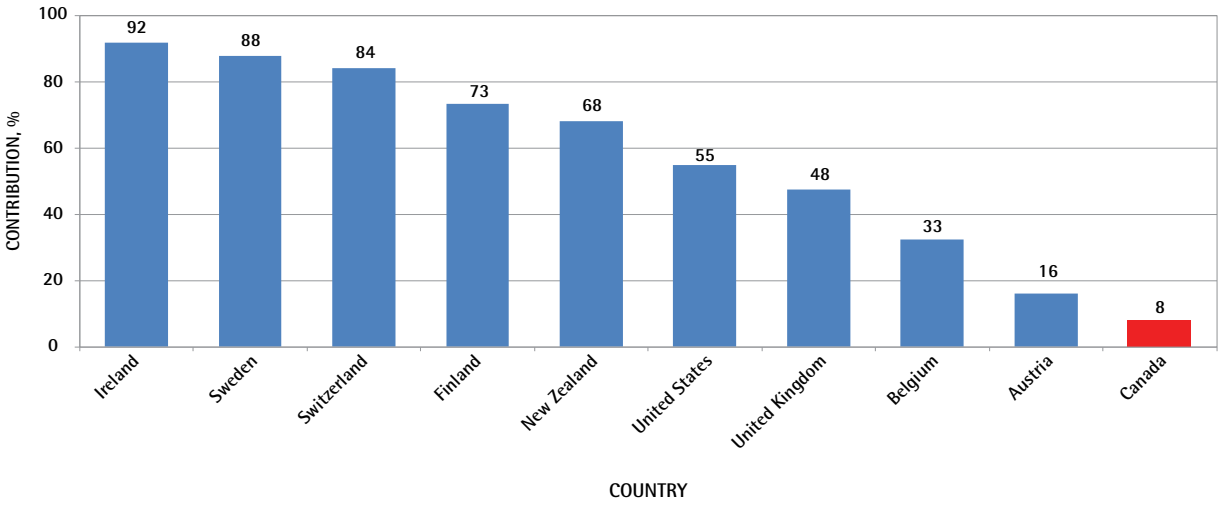
The IMG selection process is expensive and onerous. Based on an unpublished literature search we completed, the process of selecting residents includes file review; completing short structured interviews; completing standardized tests such as the United States Medical Licensing Examination and objective structured clinical examinations; and providing letters of recommendation and personal statements. Nevertheless, there is little or no evidence that any of these selection modalities, alone or in combination, are able to identify the best candidates. Despite this onerous selection process, IMG candidates have a substantial and consistently higher failure rate on the College of Family Physicians of Canada Certification Examination in Family Medicine than residents from Canadian medical schools.[8]

A recent independent review of the IMG selection process in Ontario suggests,

> Comprehensive research to support an evidence-based approach should lead to a reexamination of many current techniques [of IMG selection]—or at least reconsideration of the weight to be attached to them.[6]

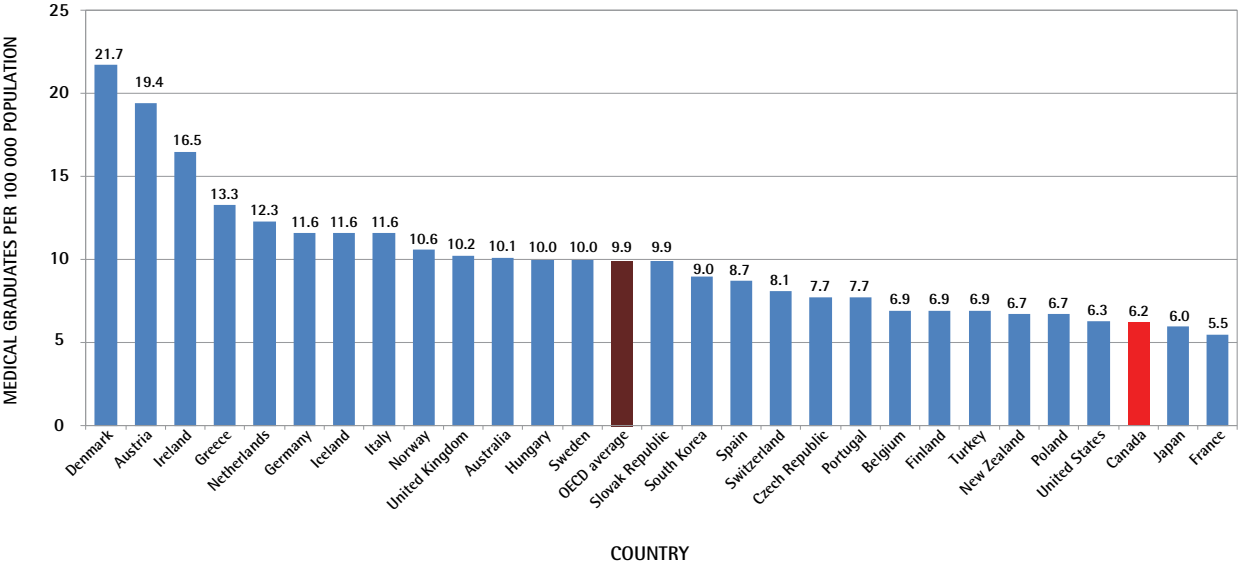
Our unpublished literature review suggests the same. We argue that the selection criteria in Ontario strongly favour

Figure 1. Contribution of foreign-trained doctors to the net increase in practising doctors in selected OECD countries from 2000 to 2007



OECD—Organisation for Economic Co-operation and Development.
Data from the OECD.[1]

Figure 2. Medical graduates per 100 000 population in 2007



OECD—Organisation for Economic Co-operation and Development.
Data from the OECD.[1]

CSAs over immigrant IMGs. Many program directors use recency of graduation and medical practice as the main predictors of success during residency. Overall, 78.8% of immigrant IMG applicants versus 2.3% of CSA applicants graduated in 2004 or earlier.[6] This is a distinct disadvantage for the IMGs, who might not have been able to practise for some time while they settled in Canada and wrote the necessary examinations. It can also be argued that the current process, with its emphasis on examination scores, favours examination and memory skills perhaps more easily accessed by younger and more recent graduates. Finally, the only evaluation of interpersonal skills is in a North American–style job interview. Without training in cross-cultural interviewing skills, interviewers are more likely to choose the CSAs, who more closely resemble them culturally.[9,10] Perhaps some weight should be given to the diversity and experience that IMGs bring to the Canadian health care system. Perhaps we should show some compassion toward our colleagues who are often here escaping war and persecution.

If the CanMEDS roles (medical expert, communicator, collaborator, manager, health advocate, scholar, and professional) are the criteria we currently use to define a good physician,[11] then the selection process should reflect these criteria. Currently the process is heavily weighted to the medical expert role.

Access to medical education

The increasing number of CSAs in Ontario residency positions has implications for residency programs and the size of the physician work force. At first glance, outsourcing undergraduate medical education might appear cost efficient, but it relinquishes control of medical education to enterprises that are not accredited to Canadian standards and have no stake in the Canadian health care system. If we continue to rely on immigrant IMGs, with their different education and cultural backgrounds, perhaps selection criteria based on CanMEDS roles could improve their success rate. This will be a challenge for those who train immigrant IMGs, as they might require more resources for selection and integration.

We can also increase the capacity of our own medical schools to the current OECD standard but this requires more financial and human resource investment. Why not create an accredited Canadian for-profit medical school?

Perhaps the main question is not primarily financial but more about our Canadian values: Who should have access to medical education? Not all Canadians have the substantial financial resources CSAs require to fund their own undergraduate medical education abroad. Does this disadvantage Canadians who cannot afford the, on average, $175 000 to $200 000 in tuition for one of the offshore medical schools?[7]

At the moment, we have immigrant IMGs with the legitimate desire to practise medicine who cannot access postgraduate training positions and CSAs who cannot access undergraduate medical education in Canada. They return to Canada to compete for training positions originally intended for immigrant IMGs, and offshore medical schools profit from this dynamic. We also have a third group of Canadian medical graduates who believe the current reserved IMG residency positions are opportunities taken away from them.

Both CSAs and immigrant IMGs might not have been fully informed as to their true chances of gaining a training position and licensure in Canada. The previous federal immigration policy encouraged applications from physicians from other countries, which led immigrant IMGs to expect to practise their profession when they arrived. The disconnect between the federal immigration policies that enticed physicians and the provincial licensing policies they faced once they arrived has been addressed by removing physicians from the list of desirable professions; yet, the backlog from previous policy still exists.

Canadians studying abroad have also been lured by advertising from foreign medical schools, which do not alert potential students to the shortage of Canadian residency positions. This situation has created unanticipated consequences for both CSAs and immigrant IMGs, and possibly for the size of the physician work force in the near future.

We believe that action is needed, and that we need to consider whether it is time to invest in educating our own country's future physicians.

Questions about the future

As a country of immigrants, do we have obligations to physicians who have already immigrated to Canada in terms of access to training?

We invite the readers to reflect on these issues.

Does Canada want to improve its physician-to-population ratio and increase the number of medical student positions to the OECD average? If so, how do we best achieve this? Should we create new Canadian medical schools or enlarge existing ones? Could this provide a more equitable chance for Canadian candidates to become doctors, and also to ensure high-quality training?

If we want to increase the medical work force without increasing our training capacity, do we want to rely on immigrant IMGs? If so, do we value the diversity and experience that immigrant IMGs bring to our health care system? If we do, should we maintain the residency positions originally created for immigrant IMGs? If we should, how do we make sure we are not depleting developing countries of their physician resources and how do we make sure every qualified immigrant physician has a fair chance to practise medicine?

If the answer to increasing the physician work force is to use CSAs, how can we provide an equitable chance for all to practise in their native country? Should we provide them opportunities to reintegrate sooner at the clerkship level or provide more postgraduate positions?

If the answer is to have both immigrant IMGs and CSAs, we should have a residency selection process that reflects the values of fairness and transparency while ensuring high-quality care for the population. We then need to establish an effective, evidence-based selection process that reflects all the CanMEDS roles. It might require rigorous research to identify the predictors of success.

Conclusion

The system we have now seems cumbersome and unfair. We must seek a solution to improve it for students, immigrant IMGs, the medical system, and—most important—patients.

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Competing interests
Dr Monavvari received academic stipends from the Department of Family and Community Medicine at the University of Toronto while holding a position as IMG Coordinator at the time of writing.

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