IMG SELECTION:

Independent Review of Access to Postgraduate Programs by International Medical Graduates in Ontario

---

VOLUME 2: ANALYSIS AND BACKGROUND

SEPTEMBER 2011

Submitted to the Ontario Ministry of Health and Long-Term Care and the Council of Ontario Universities

by George Thomson and Karen Cohl

CONTENTS

IMG Selection:
Independent Review of Access to Postgraduate Programs by International Medical Graduates in Ontario

Volume 2: Analysis and Background

PART A: INTRODUCTION

1. The IMG Review

Mandate

The Ontario Ministry of Health and Long-Term Care commissioned an independent "IMG Review" to address the following questions:

1. What is the process for international medical graduates (IMGs) seeking access to postgraduate training or assessment in Ontario? How are selection decisions made?
2. What parts of the process are working well? What progress has been made to improve postgraduate access for IMGs?
3. What are the most challenging or demanding parts of the process for IMGs and for the organizations and institutions involved?
4. What is the rationale for policies and practices that may limit postgraduate opportunities for IMGs and to what extent are they justifiable?
5. What changes should be considered?

Scope

The underlying issue in the IMG Review was whether access to the available postgraduate positions is fair. This included looking at ways in which the selection process could be improved and ways to more easily identify the best candidates.

It was not in our mandate to recommend the number of positions that should be available for IMGs or to assess the projected demand for physicians. Our terms of reference acknowledged that financial and other constraints limit the number of training and assessment positions available in the system and also

that some IMGs will not be able to meet the standards for safe practice or for entry to practice in Ontario.

It was also not within the scope of the IMG Review or our competence to comment on the specific content of exams or the clinical definition of a good candidate. Nor did we examine issues touching on Canada's immigration system as it relates to IMGs, apart from thinking about how to better inform IMGs who are considering immigrating or returning to Canada.

We did consider two related issues because of their connection to postgraduate selection and access. The first is success in residency and beyond. If those who are selected do not do well in a residency program or in the national certification exams, it could imply that the selection process is flawed or that there are insufficient supports within the program to prepare IMGs for success. No selection process will be effective if the stages that follow it are inadequate. We therefore considered it important to look at and comment on this issue.

The second related issue is whether it is possible to increase access to residency positions through greater reliance on alternative routes to practice for experienced physicians who are found not to require a full postgraduate program in Ontario. The more some IMGs can take advantage of alternative routes, the more others will have a chance to obtain one of the limited number of postgraduate positions. Specifically, we considered the proposed new national route to practice through assessment and provisional licence. We also briefly considered ways to potentially increase the capacity of the system to take on more positions, for example by reducing the number of "visa trainees" entering first-year residency positions.

GUIDING PRINCIPLES

The IMG Review was grounded in the following principles, which we shared with consultation participants:

Access and Safety ▪ It is in Ontario's best interest, and a matter of fairness, to provide opportunities for qualified, safe, and competent IMGs to obtain the support and training they need to enter the Ontario medical profession.
Innovation and Practicality ▪ Recommended solutions should be innovative, workable, and implementable without causing undue hardship to faculties of medicine or other bodies involved in postgraduate selection and without compromising safety.

Independence and Consultation

- The reviewers will consult with a broad range of organizations and individuals. However, the findings and recommendations will be formulated independent of government and any other body or individual with an interest in the outcome.

METHODOLOGY

PRELIMINARY ISSUES

Instead of beginning the IMG Review with a blank slate, we first prepared a summary of the current process for IMGs seeking entry to medical practice in Ontario through a postgraduate position at an Ontario faculty of medicine. We then created a list of preliminary issues. The summary and list of issues were distributed to stakeholders as a starting point for discussion.

The issues were divided into challenges for IMGs and challenges for the institutions involved.

CHALLENGES FOR IMGS:

- Gaining an accurate and realistic understanding of the system, the opportunities, and their own prospects before coming to Canada and at all stages of the process
- Obtaining transparent information about the interview process, how selection decisions are made, and the criteria for decision-making
- Understanding the roles and responsibilities of the various bodies involved
- Showing competence through various exams and clinical assessments and still not securing a postgraduate position (or understanding the reason for the decision)
- Being treated differently from graduates of Canadian and US medical schools in terms of the interview process, number of spaces, return of service agreements, etc.
- Facing perceptions about their ability to “fit” in the Canadian medical culture and the potential extra work involved in training them
- Finding that there is limited recognition of international postgraduate experience
- Experiencing difficulty in gaining access to bridging programs and other supports
- Bearing the personal and financial cost of pursuing Ontario postgraduate training or assessment
- Wanting to be treated fairly and to be recognized for the knowledge and experience they bring

CHALLENGES FOR INSTITUTIONS:

- Having to make difficult decisions when there are many more qualified candidates than available spaces
- Predicting which IMGs are most qualified and would perform best in the Ontario context
- Knowing that the system lacks the capacity to accommodate all qualified IMGs
- Dealing with the high volume of IMG applicants and the diversity of their medical systems and specialties
- Dealing with the labour-intensive nature of assessment, interviews, and selection decision-making
- Having limited ability to assess and recognize international medical school degrees and postgraduate training
- Dealing with the impact of the Agreement on Internal Trade and other national initiatives
- Operating with a lack of data (vs. anecdote) about the IMG cohort and the system improvements to date
- Having insufficient tools for physician planning, for example to predict the specialty areas where physicians will be most needed
- Having limited capacity to provide constructive feedback to unsuccessful applicants

INITIAL DISCUSSIONS AND CONSULTATION PLANNING

The IMG Review began in October 2010. The first step was to initiate preliminary discussions with several key organizations (listed below) and to plan for the formal consultations. The preliminary discussions took place in November 2010.

Preliminary discussions

- Centre for the Evaluation of Health Professionals Educated Abroad
- College of Physicians and Surgeons of Ontario
- Office of the Fairness Commissioner
- Health Canada
- HealthForceOntario/Access Centre
- Ministry of Health and Long-Term Care
- Ontario Human Rights Commission
- Postgraduate Deans of Ontario's six faculties of medicine

FORMAL CONSULTATIONS

We embarked on an intensive period of consultation from February to April 2011. We visited each of Ontario's six medical schools and met with a wide range of other organizations, individual experts, and IMGs. We also received

and reviewed written submissions and relevant literature and statistics. Over all, we heard from over 200 people.

Most of the consultation meetings took place in a group setting, with individuals brought together by the relevant organization, but we also had several one-on-one meetings. In addition to Ontario organizations, we consulted with national organizations that play a key role in the IMG process. We prepared a generic slide deck to help facilitate the meetings and submitted specific discussion questions in advance.

Organizations Consulted for the IMG Review

Ontario Organizations

- Each of the six Ontario faculties of medicine
- Association of International Physicians and Surgeons of Ontario
- Centre for the Evaluation of Health Professionals Educated Abroad
- College of Physicians and Surgeons of Ontario
- HealthForceOntario Access Centre
- Ontario Ministry of Citizenship and Immigration
- Ontario Ministry of Health and Long-Term Care
- Ontario Physician Human Resources Data Centre
- Professional Association of Internes and Residents of Ontario
- IMG bridging programs

National Organizations

- Canadian Resident Matching Service
- Medical Council of Canada
- College of Family Physicians of Canada
- Royal College of Physicians and Surgeons of Canada
- Citizenship and Immigration Canada
- Federation of Medical Regulatory Authorities of Canada
- Association of Faculties of Medicine of Canada

At each of the faculties of medicine, we held a series of meetings with postgraduate faculty members, including program directors and IMG coordinators, and with IMG residents, both immigrant IMGs and Canadians who had studied medicine abroad.

We also conducted two focus groups with IMGs who had not been successful in obtaining postgraduate positions. One was convened by the HealthForceOntario Access Centre and the other by the Association of International Physicians and Surgeons of Ontario (AIPSO).

Document review

While we did not conduct a comprehensive literature review, we did gather many reports, articles, policies, statistics, and other research material. We focused on the most relevant documents, including summaries of the literature. See **Appendix A** for a list of references.

In-depth look at the 2011 selection process

Following the formal consultation, we took an in-depth look at the 2011 IMG resident selection process in Ontario, focusing on family medicine and two other specialties: internal medicine and pediatrics. For the latter two specialties, we had one-on-one calls with the program directors at the faculties of medicine. For family medicine, we spoke with the coordinator of the joint selection process as well as some of the program directors. We sent summaries of these discussions to the individuals involved to confirm that we had correctly captured what they told us. This process took place mostly during May and June 2011.

In July, we were pleased to receive a specially commissioned series of data tables from the Canadian Resident Matching Service (CaRMS). These tables provided a wealth of information about the 2011 selection results in Ontario for first-year residency positions, including breakdowns as between Canadians who studied medicine abroad (CSAs) and physicians who immigrated to Canada after having obtained medical degrees abroad (immigrant IMGs).

Other provinces

In June and July, to better understand the processes for postgraduate selection and alternative routes to enter practice in other Canadian jurisdictions, we reviewed documentation and contacted key individuals in Quebec, Manitoba, Alberta, and British Columbia. We sent summaries to the contacts from those four provinces to confirm that we had accurately captured their information.

Analysis and report

During the summer of 2011, we analyzed the data from all sources and wrote our report on the IMG Review.

Liaison with the Ministry and the Council of Ontario Universities

The IMG Review was commissioned by the Ontario Ministry of Health and Long-Term Care. The Council of Ontario Universities provided administrative and logistical support. We kept in contact with both organizations to make them aware of our progress on the project, but remained at arm's length to preserve the independence of our findings and recommendations. We submitted the report to both organizations at the end of September 2011.

2. About this report

This report is in two volumes. Volume 1 contains our main findings and recommendations. This volume (Volume 2) contains additional background information and analysis. In both volumes, we refer to many of the ideas and perspectives shared with us during the course of the IMG Review. As promised in the consultations, we have not attributed comments to specific individuals unless they expressly asked us to do so or agreed that we should.

Read Volume 1 of this report to find…

- Observations about the changing climate affecting IMGs in Ontario
- Key findings about the selection process for first-year residency positions, including the use of initial filters, file reviews, interviews and ranking
- Key findings about access by IMGs to advanced postgraduate positions
- Discussion of related issues such as transparent decision-making, success in residency, and ways to increase access to postgraduate positions
- A vision of fairness
- Detailed recommendations and ideas for moving forward

Terminology

This section describes the key terms, definitions, and acronyms used in this report.

International medical graduate (IMG) and Canadian medical graduate (CMG)

For the purpose of the IMG Review, IMGs are individuals who received their medical degree outside of Canada or the United States. CMGs are graduates of accredited medical schools in Canada or the United States. The distinction below is drawn from the registration regulation under the *Medicine Act*.

Table 1

CMG	IMG
Degree is from a Canadian or US medical school accredited by the Committee on Accreditation of Canadian Medical Schools (CACMS) or the US Liaison Committee on Medical Education. (LCME) O. Reg 865/93 s.1(a)	Degree is from an international medical school listed in the World Directory of Medical Schools published by the World Health Organization. O. Reg 865/93 s.1(b)

Immigrant IMGs and CSAs

IMGs include physicians who immigrated to Canada after completing their medical degree (immigrant IMGs) and Canadian citizens or permanent

residents who left Canada to pursue their medical studies abroad (CSAs). Although some CSAs are also immigrants, the distinction is that they immigrated to Canada before becoming physicians.

We recognize that there is debate about the most appropriate terminology. We decided to use these terms knowing that no descriptor is perfect. The term CSA is in common usage. The 2010 report of the Canadian Resident Matching Service on "Canadian Students Studying Medicine Abroad" distinguishes CSAs from immigrant IMGs, so we have chosen to continue on that path for clarity and consistency.

Postgraduate training and assessment positions

The postgraduate positions reserved for IMGs can be distinguished as "training versus assessment" and as "entry-level versus advanced."

Although the six-month practice ready assessment positions available in some specialties are considered to be "assessment" and not "training" positions, we have noted that, in practice, they do and should include a training component.

Table 2

	Training or assessment position	Entry-level or advanced position
Postgraduate Year 1	Training (residency)	Entry-level
Postgraduate Year 2	Training (residency)	Advanced
Practice Ready Assessment	Assessment	Advanced

Residency

A medical residency provides in-depth postgraduate training and practical experience within a specific branch of medicine. Medical residents are persons who have received a medical degree and practise medicine under the supervision of fully licensed physicians, usually in a hospital or clinic. In Ontario, family medicine residency is a two-year program and specialty programs are typically four or five years in duration. Residents receive a salary during the residency period.

Visa trainees

Some IMGs come to Canada under an employment visa that requires them to return to their country when the postgraduate position has been completed. Some come as "visa residents" to complete a full residency. However, the vast majority are "visa fellows," highly qualified specialists who come to complete fellowships in subspecialties. Fellowships are postgraduate positions that occur after residency and are not a requirement for licensure. The IMG Review did

not review access to fellowships or access to residency by visa residents. However, we have commented on how a decreased reliance on visa residents could increase the capacity to absorb more IMGs who plan to practise medicine here.

Acronyms

During the IMG Review, we encountered many new terms and over 60 acronyms. In this report, we have tried to keep the use of acronyms and technical terminology to a minimum. To avoid the repeated use of lengthy terms, however, at times we have used some of the acronyms and short forms listed below. See **Appendix B** for a more extensive list of acronyms.

Table 3

Common Acronyms and Short Forms	
AVP	Assessment Verification Period
CaRMS	Canadian Resident Matching Service
CEHPEA	Centre for the Evaluation of Health Professionals Educated Abroad
CFPC	College of Family Physicians of Canada
CMG	Canadian Medical Graduate
CPSO	College of Physicians and Surgeons of Ontario
CSA	Canadian Studying Abroad
IMG	International Medical Graduate
MCC	Medical Council of Canada
NAC	National Assessment Collaboration
OSCE	Objective Structured Clinical Examination
PGY1 and PGY2	Postgraduate Year 1 and Year 2 (first and second year of residency)
PRA	Practice Ready Assessment
Royal College	Royal College of Physicians and Surgeons of Canada

PART B: ACCESS TO POSTGRADUATE POSITIONS

This Part examines postgraduate selection in Ontario from the perspective of IMG applicants and the faculties of medicine and describes the roles of various institutions. It also includes an in-depth look at the 2011 selection process for first-year residency positions, with a focus on family medicine, internal medicine, and pediatrics.

3. WHAT DOES THE PROCESS LOOK AND FEEL LIKE?

There are two primary participants in the selection process: the IMG applicant and the postgraduate faculty responsible for making selection decisions. For both parties, the experience is challenging and personally difficult. The IMG faces a decision that will have a fundamental impact on his or her future career and life experience. Although the stakes are less personal for faculty members, these individuals are charged with the responsibility of making decisions of great significance to the applicants, the program, and the provision of health care in Ontario. Before considering ways to improve the selection process, it is helpful to understand the selection process from these two vantage points.

THE PROCESS FOR IMGS

For an IMG, obtaining a postgraduate position in Ontario is often the pivotal step along the path to medical practice in this province. Without it, many will never succeed. The tables below summarize the basic steps an IMG takes, compared with CMGs, before and after obtaining an Ontario postgraduate position. In order to highlight the main process components, this summary omits some of the complexities or variations that can apply, especially those that are relatively infrequent exceptions to the standard process.

In this summary, **PGY1** refers to individuals who apply for or enter a first-year residency position. **PGY2+** refers to individuals who apply for or enter a residency position at second year or higher. **PRA** refers to individuals who apply for or enter a six-month practice ready assessment in an Ontario postgraduate program. All three categories are postgraduate positions at Ontario faculties of medicine, but only the first two are considered to be residency programs.

STEP 1: QUALIFY FOR POSTGRADUATE POSITION

TABLE 4

<table>
<tr><th>Graduates of Canadian or US medical schools</th><th colspan="3">International Medical Graduates</th></tr>
<tr><th>PGY1</th><th>PGY1</th><th>PGY2+</th><th>PRA</th></tr>
<tr><td rowspan="4">▪ Complete undergraduate medical degree from an accredited Canadian or US medical school.</td><td colspan="3">▪ Complete undergraduate medical degree from a school listed by the World Health Organization or the Foundation for Advancement of International Medical Education and Research.</td></tr>
<tr><td></td><td>▪ Complete some postgraduate training outside Canada.</td><td>▪ Complete recent practice outside Canada.</td></tr>
<tr><td colspan="3">▪ Submit documents to Physician Credential Registry of Canada for verification.
▪ Pass Medical Council of Canada evaluating exam.</td></tr>
<tr><td colspan="3">▪ Meet provincial criteria for fluency in English or French and possess legal authority to work in Canada (permanent residency or citizenship).</td></tr>
</table>

STEP 2: APPLY FOR POSTGRADUATE POSITION

TABLE 5

<table>
<tr><th>Graduates of Canadian or US medical schools</th><th colspan="3">International Medical Graduates</th></tr>
<tr><th>PGY1</th><th>PGY1</th><th>PGY2+</th><th>PRA</th></tr>
<tr><td>▪ Apply through CaRMS for first-year residency positions reserved for CMGs.</td><td>▪ Apply through CaRMS in a separate stream for designated IMG first-year residency positions.
<u>Optional</u>:
▪ Elect to take entry-level clinical exam administered by CEHPEA.
Note: Until 2011, this was an Ontario exam (CE1) and passing the MCC qualifying exam Part 1 was a prerequisite. Now, it is a national exam (NAC OSCE) and the qualifying exam is not a prerequisite.</td><td colspan="2">▪ Apply directly for designated IMG advanced-level specialty positions.
▪ Pass part 1 of MCC qualifying exam.
▪ Take CEHPEA specialty written exam (SWE) and advanced clinical exam (CE2) in the relevant specialty.
▪ For some specialties, take the entry-level clinical exam (CE1 or NAC OSCE).</td></tr>
</table>

STEP 3: OBTAIN INTERVIEW AND RECEIVE DECISION ON POSTGRADUATE POSITION

TABLE 6

Graduates of Canadian or US medical schools	International Medical Graduates		
PGY1	**PGY1**	**PGY2+**	**PRA**
▪ Attend interviews with individual programs.	▪ Family medicine: If selected for interview, attend one interview with a joint panel on behalf of all faculties of medicine. ▪ Specialties: If selected for interview, attend interviews with individual programs.	▪ Attend interview with a panel of program faculty, if assessed by CEHPEA as eligible. Interviews may be coordinated by CEHPEA if more than one school is participating.	
▪ Rank faculties for the computerized match.	▪ If interviewed, rank faculties for the computerized match.		
▪ If matched, receive offer for postgraduate position.	▪ If matched, receive offer for postgraduate position.	▪ If selected, receive offer for postgraduate position.	
▪ If unsuccessful, apply again to be matched in the 2nd iteration of the CaRMS match. (Positions unfilled after the 1st iteration are blended into a single stream and are open to all eligible medical graduates.)			
▪ If unsuccessful after 2nd iteration, apply to programs directly in informal "scramble" for any positions that remain unfilled.			
	▪ Any offer of a postgraduate position is contingent on signing a return of service agreement with the Ministry of Health and Long-Term Care.		

STEP 4: OBTAIN CERTIFICATE OF REGISTRATION AUTHORIZING POSTGRADUATE EDUCATION

TABLE 7

Graduates of Canadian or US medical schools	International Medical Graduates		
PGY1	**PGY1**	**PGY2+**	**PRA**
▪ Obtain CPSO certificate of registration authorizing postgraduate education.	▪ Obtain provisional CPSO certificate of registration authorizing postgraduate education for purpose of 12-week assessment verification period (AVP).		▪ Obtain CPSO certificate of registration authorizing postgraduate education.
▪ To obtain the certificate, must be accepted into postgraduate program, meet good character criteria, and be authorized to work in Canada.			

Step 5: Complete pre-residency requirements

Table 8

<table>
<tr><th>Graduates of Canadian or US medical schools</th><th colspan="3">International Medical Graduates</th></tr>
<tr><th>PGY1</th><th>PGY1</th><th>PGY2+</th><th>PRA</th></tr>
<tr><td rowspan="2"></td><td>▪ Take pre-residency program (family medicine) or orientation program (specialties) from CEHPEA.</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td colspan="2">▪ Successfully complete first 12 weeks of residency (AVP) in order to continue under CPSO certificate. If AVP is unsuccessful, leave the residency program.</td></tr>
</table>

Step 6: Complete postgraduate program, pass exams, and obtain registration

Table 9

<table>
<tr><th>Graduates of Canadian or US medical schools</th><th colspan="3">International Medical Graduates</th></tr>
<tr><th>PGY1</th><th>PGY1</th><th>PGY2+</th><th>PRA</th></tr>
<tr><td colspan="4">▪ Pass Part 1 of the MCC qualifying exam if not previously completed. Note: CMGs usually complete this written exam in their final year of medical school.</td></tr>
<tr><td colspan="3">▪ Pass Part 2 of the MCC qualifying exam (a clinical exam taken after 12 months of training).</td><td>▪ Pass Part 2 of the MCC qualifying exam.</td></tr>
<tr><td></td><td colspan="3">▪ Enter into a practice location agreement with the Ministry prior to completion of the postgraduate program. The agreement will indicate the Ontario community where the first five years of practice will take place under the return of service agreement. This can be anywhere except the Toronto area or Ottawa.</td></tr>
<tr><td colspan="4">▪ Complete the postgraduate residency or assessment program.</td></tr>
<tr><td colspan="3">▪ Pass the certification exams of the Royal College of Physicians and Surgeons of Canada (for specialty) or the College of Family Physicians of Canada (for family medicine).
▪ Obtain a certificate of independent practice from the College of Physicians and Surgeons of Ontario (or a restricted licence until passing the national exams).</td><td>▪ Obtain restricted certificate from CPSO.
▪ Pass Royal College certification exam (specialty).
▪ Obtain certificate of independent practice.</td></tr>
</table>

Step 7: Enter independent practice

Table 10

<table>
<tr><th>Graduates of Canadian or US medical schools</th><th colspan="3">International Medical Graduates</th></tr>
<tr><th>PGY1</th><th>PGY1</th><th>PGY2+</th><th>PRA</th></tr>
<tr><td>▪ Practise anywhere in Ontario (unless return of service has been specifically required).</td><td colspan="3">▪ Enter practice in an eligible community in accordance with the practice location and return of service agreements.</td></tr>
</table>

IMG PERSPECTIVES

Over the course of this project we met with many IMGs, including those who were successful in obtaining postgraduate positions and those who were not. We spoke with the Association of International Physicians and Surgeons of Ontario (AIPSO) and the Professional Association of Internes and Residents of Ontario (PAIRO), both of whom also provided formal written submissions. We spoke with organizations that support and prepare IMGs for the postgraduate selection process, such as the HealthForceOntario Access Centre and a few organizations that offer IMG bridging programs. We met with IMG coordinators at the faculties of medicine and with other faculty who are IMGs themselves or who take a particular interest in issues facing IMGs during the selection process and residency program. We also read previous reports that describe the IMG experience.

Our consultations underscored the diversity of personal stories, backgrounds, and experiences among the large group of IMG applicants for Ontario postgraduate positions. They include immigrant IMGs (many of whom had practised as physicians in other countries) and Canadians who studied medicine abroad (who typically were more-recent graduates). Each story we heard was unique, and yet there were common themes. We were struck by the relentless, often years-long efforts of so many to join the medical profession in Ontario.

A. IMMIGRANT IMGS

MAKING THE TRANSITION

IMGs who immigrated to Canada after practising medicine in another country often spoke of the difficulties inherent in the transition to a new country. Many deal with financial and family issues and other challenges associated with establishing social and professional networks and supports in a new environment. We were told that these difficulties can persist throughout the postgraduate selection and training periods, affecting the individual's ability to focus on his or her medical training in Canada.

Adaptation can be especially difficult for seasoned professionals who are told that they must return to a first-year postgraduate position, only to discover how difficult it is to obtain one of the positions available. We heard about the impact of the loss of their identity and status as physicians, their fear and frustration as the size of the challenge facing them becomes clearer, their anger and alienation as time passes without success, and their disillusionment if it becomes apparent that they will not be able to practise medicine here. Those who work to support IMGs report how difficult it is for IMGs to consider alternative careers in the health field when so much of their careers, goals, and identities is tied to the practice of medicine.

IMMIGRATION

Some immigrant IMGs have been accepted to Canada as principal applicants under the Federal Skilled Worker Program. Under the current rules for that program, applications will not be processed unless the principal applicant has a valid offer of arranged employment or has had one year of paid work experience in an eligible occupation on the Ministerial Instruction List. "Specialist physicians" and "general practitioners and family physicians" are both on the list and a cap is imposed on the number of applications that will be processed for each occupation. Eligible applications are assessed under a system that assigns points for education, language ability, work experience, age, arranged employment, and adaptability. Other immigrant IMGs may have come to Canada as family members of the principal applicant, as refugees, or under the family reunification program.

Principal applicants can feel betrayed when their education and professional experience help them to immigrate to Canada but their qualifications are not recognized when they get here. Even if warned beforehand that a residency position or a medical licence is far from guaranteed, many immigrant IMGs feel that they will be the ones to succeed on the basis of their past accomplishments, determination, and hard work.

INFORMATION

The summary tables (4-10) above give an indication of the complexity of the process of seeking access to medical practice through the postgraduate route in Ontario. They do not cover access to programs in other provinces or alternative routes to practice for experienced physicians that do not require completion of a Canadian postgraduate program.

Various websites offer information on parts of the process, but there is no consolidated site or portal that provides the comprehensive information IMGs need. And, the processes are constantly undergoing change and refinement. Even when the changes are positive for IMGs, they add to the challenge of understanding the system and making best use of it. There is also frustration when some of the most important information remains hidden, such as the weight given to the various residency selection criteria. Our discussions with both IMGs and faculty brought home the power of the rumour, anecdote, and stories that circulate about the real and alleged experiences of previous applicants.

NAVIGATING THE SYSTEM

Immigrant IMGs lose valuable time trying to navigate the system. They worry that making even one mistake can cause them to lose a year, after they have already lost time during the immigration and settlement process. Every delay means more time away from practice, which hurts their chances of obtaining a postgraduate position. We heard several stories of small misunderstandings

and mistakes (such as taking the wrong language test) that forced individual candidates to wait until the following year to compete for a residency position.

Many immigrant IMGs take every possible exam to improve their chances of obtaining a postgraduate position. This includes the clinical exam, for which Part 1 of the Medical Council of Canada qualifying exam was, until recently, a prerequisite. We heard of and met with others who had also successfully completed Part 2 of the qualifying exam to obtain the MCC Licentiate. Those who had done so felt that this credential proved them more than equivalent to graduates of Canadian medical schools. This added to their frustration when they were nonetheless unsuccessful in gaining access to the profession. Every exam added to the cost and to family pressures.

Limited opportunities

IMGs spoke of the stress of a process in which much more is at stake for them than for graduates of Canadian medical schools, who enter into it with the assurance that a postgraduate position is virtually guaranteed. They also spoke with dismay about the rising number of designated IMG positions going to Canadians who have studied medicine abroad and the reduction in advanced-level specialty positions for experienced IMG physicians. Added to this is the growing worry, fuelled by recent news reports, that physician shortages in Ontario are coming to an end and fewer opportunities will be available for IMGs.

"How can someone decide in 25 to 30 minutes whether I am suitable for a residency position or not?"

–IMG focus group

The selection process

Those who are successful in obtaining an interview worry about the inordinate significance of this relatively brief encounter. Immigrant IMGs, including those with the highest of qualifications and practice experience, often do not know why they did not get an interview or why, if interviewed, they did not get a position. As a result, they feel unable to improve their chances in the next round.

Some immigrant IMGs said that they had declined to participate in the second iteration of the residency match because they believed the chances of success were too low to justify the cost. They felt that their chances were even more remote since they would be competing against graduates of Canadian medical schools, in addition to CSAs, for a much smaller pool of positions. They also said that they find it demoralizing when designated IMG positions remain unfilled after the first iteration and when blended positions remain unfilled after the second iteration.

Perhaps the most difficult moment for immigrant IMGs comes with the realization, at the end of the matching process, that they are facing at least one more year of delay—often with little sense of why they were not selected or what they might do to improve their chances the following year. They do know that another year out of practice is almost sure to weaken their position in the next year's competition, unless they can find a clinical opportunity that is more than just an observership. While a small number of highly skilled specialists are able to obtain clinical fellowships, and a few others secure employment that has some relationship to medicine or clinical practice, most find that there simply are no opportunities in Ontario. Some choose to return for a time to the countries where they are licensed to practise in order to stay active in the profession.

POST-SELECTION ISSUES

IMGs who were successful in obtaining residency positions described the hardship of having to attend the mandatory pre-residency program or specialty orientation in Toronto. Some were discouraged to find that attending this program could result in a late start in the residency program. The 12-week Assessment Verification Period, during which IMGs can be terminated from residency, was reported to be a time of stress and uncertainty. Return of service requirements were also an issue for many IMGs, especially when it meant personal isolation and separation from family, cultural community, and valued collegial support.

B. CANADIANS STUDYING ABROAD

Canadians who study medicine abroad have been obtaining an increasing share of the designated IMG positions in the past several years. They also obtain a higher percentage of positions than their representation in the applicant pool. Nonetheless, their success is far from assured. In 2011 in Ontario, approximately 20% of CSA applicants were matched in the first iteration and 80% were unmatched.

TABLE 11

2011 1st Iteration Matches in Ontario for IMG Designated Positions		
	CSAs	**Immigrant IMGs**
Matched applicants	98 (20.9%)	85 (6%)
Unmatched applicants	371 (79.1%)	1,326 (94%)
Total applicants	469 (100%)	1,411 (100%)

CaRMS Data Tables, 2011 Main Residency Match (R-1)

CSAs told us about several challenges from their perspective. One practical problem many of them face is the large debt they accumulate through

financing their medical education abroad. Another is the difficulty of obtaining an opportunity to complete an elective in Canada during their medical school clerkship. It is well known that such opportunities, where available, can significantly improve their chances of obtaining a residency position in Ontario. However the number of available electives is limited and subject to "blackout" periods when Ontario medical schools will not take international students.

CSAs have also expressed their unhappiness with the mandatory pre-residency training and orientation programs. They believe that much of the curriculum is designed for immigrant IMGs and is not necessary for those who are familiar with North American culture, systems, and terminology. Both CSAs and immigrant IMGs react positively to the on-site component of the family medicine pre-residency program and would prefer an on-site approach for the specialties as well.

There is also bitterness about the return of service obligations, which do not apply to graduates of Canadian medical schools. CSAs make the case that they have saved the taxpayers money by self-funding their undergraduate medical degree and they should not be restricted in where they can practise.

Some CSAs also raised concerns about the limited number of designated positions available for certain specialties. As one said, "We should be able to participate in CaRMS on the same basis as Canadian students, rather than competing for the one position for IMGs in our specialty."

Finally, CSAs are frustrated by the fact that some people seem to assume that they are somewhat less worthy than graduates of Canadian or US medical schools. They counter that Ontario simply does not have enough medical schools to meet the demand for physicians and that there should be no stigma attached to those who have pursued medical studies elsewhere.

Faculty perspectives

"CMGs all get a job somewhere. IMG selection changes people's lives."

–Faculty member

"Comparing IMG candidates is a challenge. It is not as though they are apples and oranges—they are not even the same fruit. It is like comparing an apple with a fire truck with a chocolate bar."

–Faculty member

We met with many program directors, IMG coordinators, and other faculty who are part of the postgraduate selection process. We came away with much respect for the time, effort, and dedication they give to IMG selection. We also came to appreciate how much their role has changed over a short time and the

size of their task. They are the key decision-makers in an intense, deadline-driven exercise to assess a growing number of applicants for a finite number of positions.

For the faculties of medicine, the selection process for first-year residency positions involves the following steps:

- Decide whether the program will designate one or more positions for IMGs, with the ultimate allocation determined centrally by the postgraduate deans.
- Decide in what ways the program's selection criteria and processes for file review, interview, and ranking will be the same as or different from what they use for graduates of Canadian and US medical schools.
- Post information about the process and criteria online.
- Receive applications. If the volume of applications is too high to review each file in detail, determine what filters will be used to reduce the applications to a more manageable number.
- Review files in detail and conduct interviews.
- Determine the program's ranking of interviewed applicants for the CaRMS matching process.
- Ensure that IMGs matched into a position have access to a mentor or IMG coordinator and that the residency program meets their learning needs.
- Assess and document whether IMGs matched to residency positions have successfully completed the 12-week Assessment Verification Period.

CHANGING ENVIRONMENT

The volume and complexity of the work involved in selecting IMGs for first-year residency positions has increased dramatically in light of the changes in the last several years:

TABLE 12

Changes Affecting IMG Selection in Ontario (2004–2009)
In **2004**, the number of designated positions for IMGs more than doubled—from 90 to 200.
In July **2005**, CSAs were allowed to apply for first-year residency positions during their final year of medical school rather than after they completed their medical degree.
In **2005**, IMGs were able to compete for positions left vacant after the first and second iterations of the CaRMS match.
In **2006**, IMGs were able to participate in the second iteration of the CaRMS match.
In **2006**, selection decisions shifted from the IMG-Ontario program in place at the time to the faculties of medicine.
As of **2007**, IMGs were able to apply for first-year residency positions through a dedicated stream in the CaRMS match.
As of **2009**, IMG and CMG vacancies were blended in the second iteration.

WORKLOAD

The Ontario faculties of medicine face an enormous challenge as they try to manage the selection process. It starts in early December, when they receive the applications from CaRMS, and continues to the date in February when they must submit their lists of ranked candidates in the first iteration. Part of the challenge is that the same timelines apply to two streams of applicants: IMGs and CMGs. The growing number of CSA applicants has added to the volume and increased the challenge of selecting among IMG applicants.

Faculties have the added pressure of CSAs requesting elective positions and immigrant IMGs looking for ways to gain North American clinical exposure through observerships or other means. They also field questions from IMGs about the application and selection process and about why their applications have not been successful.

Most programs have a committee to work with the program director on planning and to give advice on the selection process. In many cases, the committee also reviews the results, once the process is over, with a view to making changes for the following year.

Selection criteria

Selection criteria, and how they are weighted, depend on the nature of the medical specialty and the perspective of the person in the role of program director. For example, should there be a preference for younger applicants who, like CMGs, will practise medicine for many years? Or should there be a preference for older, more experienced physicians who will have a shorter career in this country but bring a rich diversity of experience? Programs do not want to discriminate on the basis of age. At the same time, they worry about how well an older individual who has been in practice for some time will adapt to being back in a first-year residency position, at the bottom of the hierarchy and facing many physical demands. Some also wonder whether scarce resources should go to persons who will have a much shorter period of practice here compared with recent graduates. In addition, programs must consider certain skills in deciding on selection criteria, depending on the specialty. Highly developed written skills, for example, are essential in community medicine, laboratory medicine, and pathology. Spoken language skills are paramount in psychiatry, where every nuance matters. Manual dexterity is essential for surgical specialties.

Predicting success

Another major difficulty for the medical faculties is the lack of clear evidence about predictors of success. Some feel instinctively that the best predictor is insight into one's own limitations—to be reflective and therefore a good learner. However, this quality is difficult to ascertain based on the available selection tools.

Faculties are concerned that there is no good way of knowing what the many international medical programs entailed or how they differed in content and scope from North American standards. The same concern applies to the clinical experience IMG applicants have obtained abroad.

Programs are also concerned that some applicants may be so anxious to obtain a position that they apply to multiple specialties rather than the area in which they have the most genuine interest and experience.

Assessment Verification Period

With regard to IMGs who are successful in obtaining a position, faculty members expressed great frustration with the 12-week Assessment Verification Period. They feel that there is a conflict between their role as teacher, mentor, and coach and their role as an assessor whose decision could result in early termination. The requirement to extensively document problem cases and to defend decisions at appeal hearings has meant that they are reluctant to use the process. Many of them worry that 12 weeks is not long enough to determine whether IMGs can ultimately be successful in residency if they have assistance, support, and a chance to get used to the system. The 12 weeks was

described as a high-stakes period for both faculty and the IMGs in the program. Although faculty members welcome the opportunity to observe individuals in a clinical setting before finalizing the selection decision, they would rather have that opportunity much earlier in the process. As one faculty member said, "AVP is the right thing at the wrong time."

Success in residency

The Ontario faculties of medicine have added IMG coordinators in family medicine and in a few specialty areas over the past few years. In addition to participating in the selection process, IMG coordinators provide orientation, mentorship, and learning plans, and they intervene when there are problems. Our sense is that they are performing an important role for both IMGs and faculty.

Conclusion

We are impressed with the time and effort expended by postgraduate faculty and administrators to make the IMG resident selection process work despite all the challenges. Program directors expressed a genuine desire to "get it right" and they worry about missing some of the best candidates because of the limitations of the selection process.

There was openness to ways to improve the process, and this report provides examples of important innovations. At the same time, we saw broad concern that the selection process has become overwhelming, particularly when added to the pressures of teaching and training a significantly larger number of medical students in both primary and distributed locations.

Involvement of other bodies

Ontario government

In consultation with the faculties of medicine, the Ministry of Health and Long-Term Care decides on the target number of designated IMG postgraduate positions to be funded each year. For each IMG who obtains a position, the Ministry pays an "IMG premium" to the faculty and requires a return of service agreement from the IMG. The Ministry also engages in physician planning and policy development.

The Ministry of Citizenship and Immigration supports bridge training programs that help newcomers to Canada become licensed to practise their profession or trade in Ontario.

Council of Ontario Universities / Council of Ontario Faculties of Medicine

Under the auspices of the Council of Ontario Universities and the Council of Ontario Faculties of Medicine, the postgraduate deans meet to discuss education programs (as PGE: COFM) and management issues (as PGM: COFM). These meetings are the forum at which decisions about the allocation of designated positions are made and related issues are discussed at the provincial level.

Canadian Resident Matching Service

CaRMS administers a national resident matching service for CMGs, and in most provinces, IMGs as well. The match for entry-level residency positions takes place in two iterations. The second iteration is a chance for unmatched applicants to apply for positions unfilled after the first iteration. In Ontario, all applicants for first-year residency positions (except positions taken by visa residents) must apply through CaRMS. CaRMS is not involved in the selection of IMGs who apply to enter at a higher year of residency or for a six-month practice ready assessment.

Centre for the Evaluation of Health Professionals Educated Abroad

CEHPEA is funded by the Ontario government to conduct assessments of IMGs seeking postgraduate positions. For IMGs seeking entry to first-year residency positions, CEHPEA administers an optional clinical assessment. Until 2011, CEHPEA administered its own exam (CE1). Now, it administers a national exam (NAC OSCE). For IMGs seeking entry to second-year residency or to a six-month practice ready assessment position, CEHPEA administers specialty-specific written and clinical exams. In addition, it administers pre-residency and orientation programs for IMGs who have been successful in obtaining residency positions.

HealthForceOntario Access Centre

The Access Centre of HealthForceOntario is a provincially funded office that provides counselling, information, and referrals to internationally educated health professionals. Of their registered clients, 75% are IMGs. Through the Access Centre, IMGs can obtain information and personal counselling services to help them to identify the most effective path to professional practice. Services include group orientation sessions, one-on-one counselling, and mock interviews. The Access Centre also offers advice on alternative career options.

Other bridging programs

During the IMG Review, we became aware of several bridging programs that exist specifically to assist IMGs in improving their chances of gaining entry to

the profession. In Ottawa, the *Catholic Immigration Centre* offers a Medical Licence Bridge Program, in partnership with the faculty of medicine at the University of Ottawa, to help prepare IMGs through mock clinical exams and other types of assistance. Their Career Transitions program helps IMGs to find jobs or volunteer positions in the Canadian health sector. In Hamilton, the *Bridge for International Medical Doctors* is a volunteer program for IMGs that includes exam preparation. It has recently started to charge a fee. In Toronto, the *Medical Literacy Course* is an experiential program to improve cultural and professional language skills. This program is currently offered on a user-fee basis at SIM-ONE, an Ontario network that provides services in healthcare simulation. Also in Toronto, the *Ontario IMG School* is a private, fee-based program that offers services to prepare IMGs for exams and residency interviews.

College of Physicians and Surgeons of Ontario

The College of Physicians and Surgeons of Ontario is statutorily responsible for the governance of the medical profession in Ontario and for deciding who can be registered to practise medicine here. The College issues a variety of certificates, including postgraduate education certificates.

Medical Council of Canada

The Medical Council of Canada is responsible for several examinations, some of which apply to all medical graduates. Others apply only to IMGs. The Council plays a leadership role within the National Assessment Collaboration that developed the national clinical exam (NAC OSCE) for IMGs seeking access to postgraduate positions in Canada. The Council also houses the Physician Credential Registry of Canada, which enables IMGs to submit and verify documents only once, even if they are applying to more than one province.

Evaluating exam (MCCEE)

The evaluating exam is the first medical examination that an IMG must take on the path to obtaining a full medical licence in Canada. It is a four-hour, computer-based examination offered at 500 international sites in more than 80 countries, including multiple facilities in Canada and the United States. Neither the Ontario faculties of medicine nor faculties elsewhere in Canada will consider IMGs for a postgraduate position unless they have passed this exam. The evaluating exam is also a prerequisite before an IMG may challenge the qualifying exams.

Qualifying exam (MCCQE1 and MCCQE2)

The Medical Council of Canada administers a two-part qualifying exam. Graduation from a recognized medical school, acceptable postgraduate training, and both parts of the qualifying exam constitute the Licentiate required for registration as a practising physician. IMGs who pass parts 1 and 2

of the exam and either have acceptable postgraduate training or successfully complete a postgraduate program in Ontario will obtain their Licentiate. Graduates of Canadian and US medical schools must fulfill the same criteria. Some eligible Ontario IMGs choose to take one or both parts of the qualifying exam at an earlier stage in order to increase their chances of success in obtaining a postgraduate position.

Part 1 of the qualifying exam (MCCQE1) is a computer-based test comprised of multiple-choice questions and short-answer questions related to medical cases and clinical decision-making. Part 2 of the qualifying exam (MCCQE2) is an objective structured clinical examination (OSCE). The candidates visit stations and perform specific medical tasks with a standardized patient who has been trained to simulate a patient with a health issue or an illness. The minimum postgraduate training before a candidate may attempt Part 2 of the qualifying exam is a full year of postgraduate training, either in Canada or abroad.

National Assessment Collaboration Objective Structured Clinical Examination (NAC OSCE)

This exam assesses IMGs on knowledge, clinical skills, communication, clinical reasoning, and behaviours considered essential for entrance to Canadian first-year residency programs. It is a hands-on examination that simulates typical clinical scenarios at a series of stations and includes a written therapeutic component. Candidates are assessed for language usage and proficiency as well as basic knowledge of the therapeutic management of common complaints. This exam is not currently mandatory in Ontario, but it is mandatory in some of the other provinces.

National certifying bodies

College of Family Physicians of Canada

The College of Family Physicians of Canada is the national certifying body for family medicine. Subject to a few exceptions, family physicians must pass the College's exam before they can be registered for independent practice in Ontario.

Royal College of Physicians and Surgeons of Canada

The Royal College is the national certifying body for medical specialties. Subject to a few exceptions, specialist physicians must pass the relevant Royal College exam before they can be registered for independent practice in Ontario.

Federal government and Federal-Provincial-Territorial Framework

Citizenship and Immigration Canada is responsible for immigration policy. It has offices abroad for individuals wishing to immigrate to Canada. That department, along with Human Resources and Skills Development Canada and

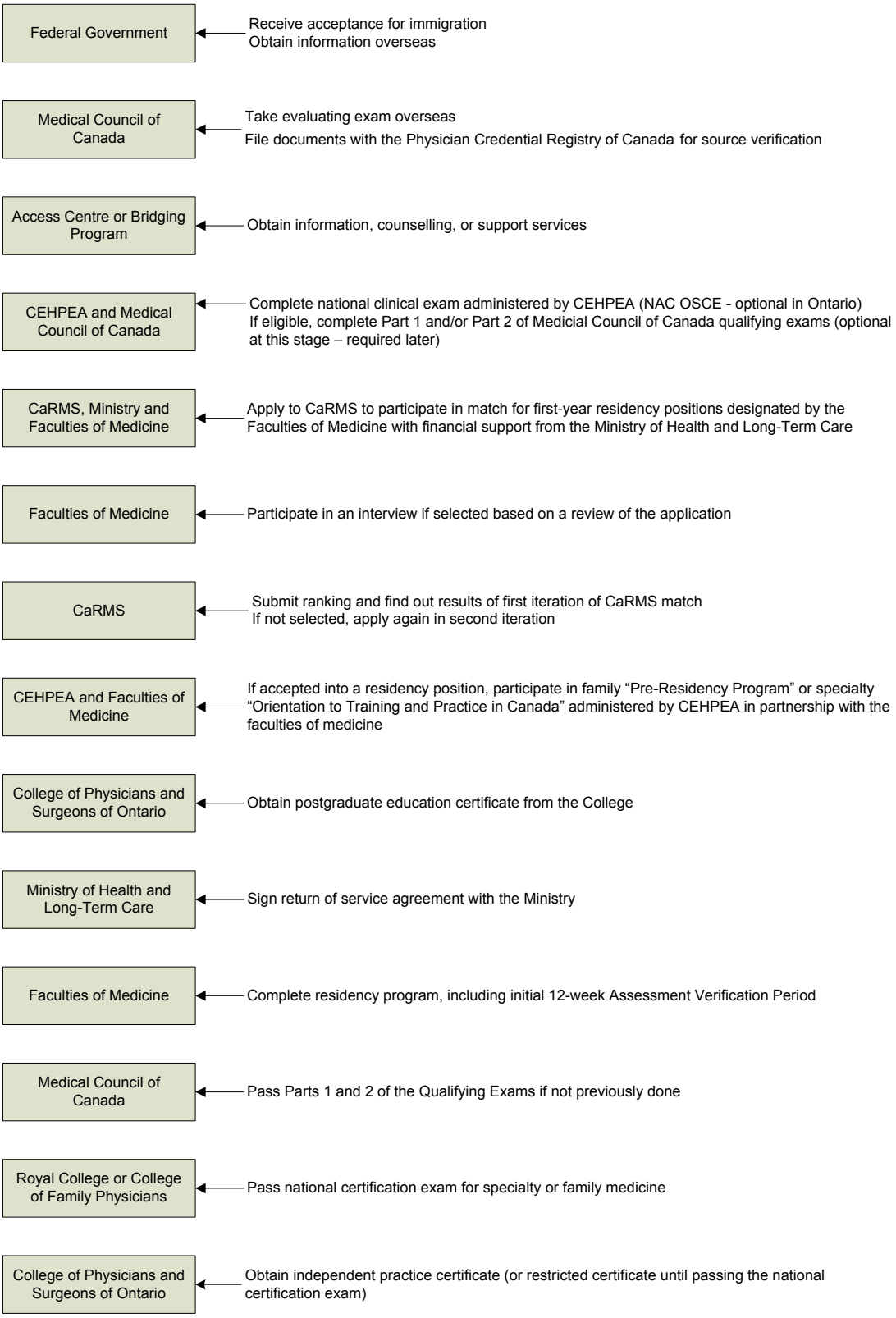
Health Canada, has been working intensively with the provinces and territories to implement the Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications. Physicians are included in the second group of occupations targeted for governments' individual and collective actions in implementing the Framework.

INTERPLAY OF ORGANIZATIONS

The chart on the following page shows how an IMG might encounter or be impacted by various organizations on a typical path before, during, and after completing a postgraduate residency position in Ontario.

FIGURE 1

Interplay of Organizations



4. 2011 SELECTION PORTRAIT

The IMG Review included an in-depth look at the 2011 selection process in three program areas: family medicine, internal medicine, and pediatrics. These programs collectively accounted for 60% of the first-year residency positions designated for IMGs. For family medicine, we reviewed available documentation, had extensive discussions with the coordinator of the joint component of family medicine selection, and followed up with some faculty members who had participated in our general consultation. For the two specialty programs, we had one-on-one telephone calls with each program director and reviewed materials they shared with us. For all three programs, we reviewed online information and asked the individual informants to vet our summaries of the discussions to confirm accuracy. We also reviewed 2011 CaRMS statistical data for additional information.

FIRST-YEAR POSITIONS: FACTS AND FIGURES

The Canadian Resident Matching Service (CaRMS) provided the IMG Review with a special run of data for Ontario 2011. This section looks at what the data can tell us about designated positions, the applicant pool, and the results of the 2011 selection process for first-year residency positions. Other sections of this report have also drawn on the CaRMS data, including the sections relating to family medicine, internal medicine, and pediatrics.

All statistical data in this section are from CaRMS Data Tables, 2011 Main Residency Match (R-1), used with permission.

DESIGNATED POSITIONS

- ***The 191 designated IMG positions represented 17% of all first-year residency positions in Ontario.***
  - In the first iteration, 935 positions (83%) were reserved for graduates of Canadian or US medical schools (CMGs) and 191 positions (17%) were reserved for IMGs.
  - Over 65% of the 191 designated IMG positions were within four program areas.

TABLE 13

IMG Designated Positions, First Iteration Ontario, 2011			
10 or more	**5 to 8**	**1 to 3**	**None**
Family Medicine-80	Anesthesiology-8	Obstetrics & Gynecology-3	Hematological Pathology
Internal Medicine-25	Emergency Medicine-7	Dermatology-2	Medical Biochemistry
Pediatrics-11	Orthopedic Surgery-6	Ophthalmology-2	Neuropathology
Psychiatry-10	Diagnostic Radiology-5	Physical Med & Rehab-2	Otolaryngology
	General Surgery-5	Plastic Surgery-2	
	Laboratory Medicine-5	Radiation Oncology-2	
	Neurology-5	Urology-2	
		Anatomical Pathology-1	
		Cardiac Surgery-1	
		Community Medicine-1	
		General Pathology-1	
		Medical Genetics-1	
		Medical Microbiology-1	
		Neurology – Pediatric-1	
		Neurosurgery-1	
		Nuclear Medicine-1	

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

- ***During the first iteration, 28 designated positions "reverted" to other programs or locations within the same faculty.***

FILLED AND UNFILLED POSITIONS

- ***In the first iteration, 183 IMG positions were filled and eight remained unfilled.***
  - At McMaster University, there were five unfilled positions, one in each of anatomical pathology, community medicine, medical microbiology, orthopedic surgery, and urology.
  - The University of Ottawa had three of the unfilled positions, one in each of cardiac surgery, laboratory medicine, and psychiatry.
- ***After the second iteration, 11 positions remained unfilled at three faculties of medicine.***
  - The unfilled positions were at the University of Ottawa (5), McMaster University (4), and the Northern Ontario School of Medicine (2). Note:

During the second iteration, positions are "blended" and not reserved for either IMGs or Canadian medical graduates.

TABLE 14

IMG Positions Unfilled after Second Iteration Ontario, 2011
Cardiac Surgery (2)
Family Medicine (2)
Laboratory Medicine (2)
Orthopedic Surgery (2)
Psychiatry (2)
Medical Microbiology (1)

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

- ***In the second iteration, 33 IMGs filled positions that had originally been reserved for graduates of Canadian or US medical schools.***
  - IMGs filled positions originally reserved for CMGs at the Northern Ontario School of Medicine (11), the University of Western Ontario (9), McMaster University (7), and Queen's University (6).
  - Only one position that had originally been designated for IMGs was filled by a CMG in the second iteration.

VOLUME OF APPLICATIONS

- ***The Ontario faculties of medicine received more applications from IMGs than from graduates of Canadian or US medical schools.***
  - In the first iteration, IMGs represented just over half of all applicants for first-year residency positions: 1,880 (50.6%) IMG applicants and 1,839 (49.4%) CMG applicants. All schools were close to this ratio except the Northern Ontario School of Medicine, which had 80% IMG applicants and 20% CMG applicants.
  - In the second iteration, IMGs represented 90% of the applicants: 1,320 (89.9%) IMG applicants and 149 (10.1%) CMG applicants.

TABLE 15

Applicants to Ontario Schools, 2011					
	Applicants from Canadian or US medical schools		IMG Applicants		Total Applicants
	#	%	#	%	
1st Iteration	1,839	49.4%	1,880	50.6%	3,719
2nd Iteration	149	10.1	1,320	89.9	1,469

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

- ***Eighty-four IMG applicants withdrew from the first iteration match.***
  - Of the 84 IMGs who withdrew, 55 (65.5%) were CSAs and 29 (34.5%) were immigrant IMGs. A further five applicants who withdrew were CMGs.

APPLICANT BREAKDOWN: IMMIGRANT IMGS AND CSAS

- ***Immigrant IMGS accounted for approximately 75% of the IMG applicant pool and CSAs represented 25%.***
  - In the first iteration, there were 1,411 (75.1%) immigrant IMG applicants and 469 (24.9%) CSA applicants.
  - In the second iteration, the ratio was closer to 80:20 among IMG applicants: 1,037 (78.6%) immigrant IMG applicants and 283 (21.4%) CSA applicants.

Data on Canadians Studying Abroad

The Canadian Resident Matching Service is a leader in data on IMGs because it is able to track the numbers of CSAs among applicants for the computerized residency match across Canada. An IMG counts as a CSA in the database if the person is a Canadian citizen or permanent resident who (a) took undergraduate education in Canada, or (b) graduated from a pre-defined medical school abroad.

During the IMG Review, we found a few instances where CSAs had not been counted because they had gone to a medical school directly from high school (which some European medical schools allow) and their medical school had not yet been added to the predefined list. However, most CSAs who began medical school directly from high school would be captured in the database because CaRMS maintains and updates a comprehensive list of schools with international programs for Canadians.

RESULTS

- ***In the first iteration, 183 IMG applicants were matched; in the second iteration, 38 were matched, for a total of 221.***
- ***There was a 50/50 split between CSAs and immigrant IMGs matched into first-year residency positions.***

TABLE 16

IMGs Matched in Ontario, 2011						
	CSA		Immigrant IMG		Total IMG	
	#	%	#	%	#	%
Matched in 1st iteration	98	53.6	85	46.4	183	100
Matched in 2nd iteration	14	36.8	24	63.2	38	100
TOTAL	112	50.7	109	49.3	221	100

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

- As the above table indicates, the first iteration resulted in a higher percentage of CSAs and the second iteration resulted in a higher percentage of immigrant IMGs.

➢ ***A total of 85 applicants were matched in the second iteration, 47 (55.3%) CMGs and 38 (44.7%) IMGs.***

- The 38 IMGs were matched into 11 programs in five faculties of medicine: McMaster University (11), the Northern Ontario School of Medicine (11), the University of Western Ontario (9), Queen's University (6), and the University of Ottawa (1). None were matched at the University of Toronto.
- The breakdown of CMGs and IMGs matched in the second iteration varied among faculties. For example, the Northern Ontario School of Medicine matched 11 IMGs and one CMG while the University of Toronto matched two CMGs and no IMGs.

APPLICANT CHARACTERISTICS

Notes:

1. In tables 17-20 below, all percentages are of the total that appears at the top of the relevant column.
2. The listed subcategories are examples and do not cover all regions, years of graduation, or age groups.

TABLE 17

First Iteration: Canadians Studying Abroad Ontario, 2011				
		Applicants	**Matched Applicants**	**Unmatched Applicants**
Total		**469**	**98 (20.9%)**	**371 (79.1%)**
Region of graduation	Central America/ Caribbean	59.1% (277)	45.9% (45)	62.5% (232)
	Europe	27.9% (131)	35.7% (35)	25.9% (96)
	Oceania/Pacific Islands	8.7% (41)	14.3% (14)	7.3% (27)
Year of graduation	2011, 2010, or 2009	86.1% (404)	97% (95)	83.3% (309)
	2004 or earlier	2.3% (11)	0	2.9% (11)
Age	Between 25 and 34	85.2% (400)	88.8% (87)	84.4% (313)
	Between 35 and 49	8.6% (40)	4.1% (4)	9.7% (36)
Gender	Male	57.4% (269)	46.9% (46)	60.1% (223)
	Female	42.6% (200)	53.1% (52)	39.9% (148)

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

TABLE 18

First Iteration: Immigrant IMGs Ontario, 2011				
		Applicants	**Matched Applicants**	**Unmatched Applicants**
Total		**1,411**	**85 (6%)**	**1,326 (94%)**
Region of graduation	Asia	34.9% (493)	24.7% (21)	35.6% (472)
	Middle East	23.2% (327)	23.5% (20)	23.2% (307)
	Africa	18.6% (262)	11.8% (10)	19% (252)
	Europe	16.7% (236)	25.9% (22)	16.1% (214)
Year of graduation	2011, 2010, or 2009	5.3% (75)	17.6% (15)	4.6% (60)
	2004 or earlier	78.8 (1111)	61.2% (52)	79.8 (1059)
Age	Between 25 and 34	34.1% (482)	51.8% (44)	33% (438)
	Between 35 and 49	56.7% (800)	43.5% (37)	57.5% (763)
Gender	Male	49.1% (693)	32.9% (28)	50.2% (665)
	Female	50.9% (718)	67.1% (57)	49.8% (661)

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

TABLE 19

Second Iteration: Canadians Studying Abroad Ontario, 2011				
		Applicants	**Matched Applicants**	**Unmatched Applicants**
Total		**283**	**14 (5%)**	**269 (95%)**
Region of graduation	Central America/ Caribbean	56.9% (161)	64.3% (9)	56.5% (152)
	Europe	29.7% (84)	21.4% (3)	30.1% (81)
	Oceania/ Pacific Islands	7.8% (22)	14.3%(2)	7.4% (20)
Year of graduation	2011, 2010, or 2009	76.7% (217)	85.7% (12)	76.3% (205)
	2004 or earlier	4.6% (13)	0	4.8% (13)
Age	Between 25 and 34	79.2% (224)	92.8% (13)	78.5% (211)
	Between 35 and 49	14.2% (40)	0	14.8% (40)
Gender	Male	59.4% (168)	50% (7)	59.9% (161)
	Female	40.6 (115)	50% (7)	40.1% (108)

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

TABLE 20

Second Iteration: Immigrant IMGs Ontario, 2011				
		Applicants	**Matched Applicants**	**Unmatched Applicants**
Total		**1,037**	**24 (2.3%)**	**1,013 (97.7%)**
Region of graduation	Asia	35.6% (369)	58.3% (14)	35% (355)
	Middle East	24.0% (249)	8.3% (2)	24.4% (247)
	Africa	17.6% (183)	8.3% (2)	17.9% (181)
	Europe	17.3% (179)	20.8% (5)	17.2% (174)
Year of graduation	2011, 2010, or 2009	5% (52)	12.5% (3)	4.9% (49)
	2004 or earlier	80.7% (837)	66.7% (16)	81.1% (821)
Age	Between 25 and 34	31.9% (331)	62.5% (15)	31.2% (316)
	Between 35 and 49	58% (601)	37.5% (9)	58.5% (592)
Gender	Male	50% (519)	62.5% (15)	49.8% (504)
	Female	50% (518)	37.5% (9)	50.2% (509)

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

Region of Graduation

- ***With the exception of Europe (which had a relatively high number of matches for both CSAs and immigrant IMGs), matched CSAs and matched immigrant IMGs tended to have graduated from medical schools in different world regions.***

  - Of the CSAs matched in the first iteration, 96% had graduated from medical schools in three world regions (Central America/Caribbean, Europe, and Oceana/Pacific Islands).
  - Of the immigrant IMGs matched in the first iteration, 86% had graduated from medical schools in four world regions (Europe, Asia, Middle East, and Africa).
  - In the first iteration, Europe was the top region for matched IMGs, with relatively high numbers of both CSAs and immigrant IMGs. Central America/Caribbean was second, and with almost exclusively CSAs.

Figure 2

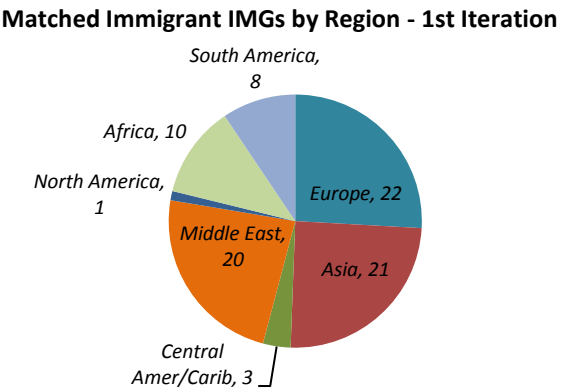
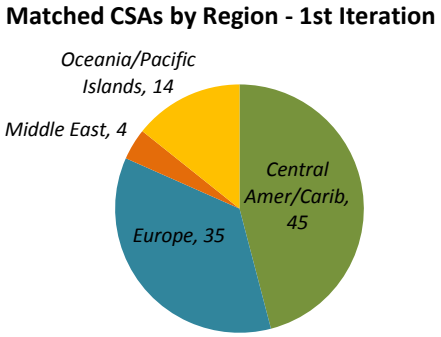


Figure 3



  - In the second iteration, Asia was the top region for matched IMGs, and all 14 were immigrant IMGs. Central America/Caribbean was second, and nine of the 10 matched IMGs were CSAs.

Year of graduation

- ***Most CSAs were recent graduates and most immigrant IMGs were not.***
  - In the first iteration, 97% (95) of matched CSAs and 17.6% (15) of matched immigrant IMGs were recent graduates (2011, 2010, 2009).
  - Of the CSAs matched in the first iteration, 69.4% (68) had graduated in 2011 (and would have applied in their final year of medical school). None of the matched immigrant IMGs had graduated in 2011.
  - Of the matched immigrant IMGs, 61.2% (52) graduated in 2004 or earlier. None of the matched CSAs graduated in 2004 or earlier. This indicates that, although recency of graduation is preferred by many programs, experienced applicants are still able to obtain a portion of the designated positions.

Age

- ***As a group, CSAs were younger than immigrant IMGs.***
  - In the first iteration, 89% (87) of matched CSAs and 52% (44) of immigrant IMGs were between the ages of 25 and 34.
  - In the first iteration, 43.5% (37) of matched immigrant IMGs and 4.1% (4) of matched CSAs were between the ages of 35 and 49.

Gender

- ***More females than males were matched, especially in the immigrant IMG group.***
  - In the first iteration, immigrant IMG applicants were approximately 50% men and 50% women. However, women represented a higher percentage (67%) of the matched applicants than men did (33%).

Unmatched applicants

- ***High percentages of both CSA and immigrant IMG applicants remained unmatched.***
  - In the first iteration, 80% (371) of CSA applicants and 94% (1,326) of immigrant IMG applicants remained unmatched.
  - In the second iteration, over 95% remained unmatched in both categories.

FAMILY MEDICINE

Family medicine accounts for the largest single group of postgraduate trainees in Ontario. In 2011, 80 (42%) of the 191 designated first-year residency positions for IMGs were in family medicine. All of the 80 designated positions in family medicine were filled by IMGs in the first iteration. An additional 13 IMGs were matched to non-designated family medicine positions in the second iteration.

A JOINT PROCESS

Representatives from all six family medicine programs in Ontario sit on a provincial steering committee to guide and oversee the selection process for admission to first-year positions in family medicine. In the first iteration, the initial filtering of applications, file reviews, and interviews are conducted jointly on behalf of the six faculties. After these steps, it is up to the individual program directors to rank applicants for the match. The Ministry of Health and Long-Term Care provides approximately $160,000 per year to support the joint process.

During our consultations, many participants identified the joint family selection process as a positive development. It is a good example of programs working collaboratively on a common approach. With each faculty typically receiving over 1,000 applications in family medicine, many from the same individuals, a joint process can save much time.

Dr. Marcus Law, the Residency Recruitment Coordinator for family medicine at the University of Toronto, has coordinated the joint selection process, from its inception, on behalf of the program directors. The six program directors also meet regularly as a group to discuss issues, including those affecting IMGs.

After the first year of the joint process for IMG selection in family medicine in 2006/07, the program directors retained researchers from the Ontario Institute for Studies in Education to conduct an evaluation of the process. This commitment to learning and evaluation is another positive feature of the joint approach adopted by the family medicine program directors at Ontario's six faculties of medicine.

VOLUME OF APPLICANTS

For the selection of first-year residents in 2011, family medicine received a total of 1,407 eligible applications from IMGs during the first iteration, with many of them applying to multiple faculties.

TABLE 21

IMG Applications to Family Medicine, 2011				
	1st Iteration		2nd Iteration	
	Applications	Matched	Applications	Matched
Ottawa	1,150	13	0	0
Queen's	1,094	11	867	3
Toronto	1,224	24	487	0
McMaster	1,186	12	799	1
Northern	856	2	664	4
Western	1,203	18	876	5
TOTAL		**80**		**13**

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

TWO GROUPS OF APPLICANTS

A defining feature of the joint process for family medicine is that it divides eligible applicants into two groups for determining who gets a file review and interview. Recent graduates are screened on the basis of their scores on the written Medical Council of Canada evaluating exam that all IMG applicants must take in order to be eligible to apply. Less-recent graduates are screened on their scores in the clinical exam, which is an optional assessment for IMG applicants. Recently, the Ontario clinical exam (CE1) has been incorporated into a national exam (NAC OSCE).

Although the family medicine programs see the clinical exam as a better screening tool, they did not expect very recent graduates (less than one year) to have taken it. This is because it would not have been feasible to have completed the clinical exam (and the prerequisite qualifying exam in place at the time) during the final year of medical school in time to meet the application deadline. The following summarizes how the first iteration played out in 2011 for the two groups of applicants:

- ***Total Eligible Applicants:***
  - A total of 1,407 IMG applicants for family medicine met the basic eligibility requirements.
- ***Applicants who graduated after January 1, 2010:***
  - This group represented 21.7% (305) of the 1,407 eligible applicants.
  - 126 (41.3%) received a file review and interview on the basis of their scores on the evaluating exam.

- Applicants from this group obtained 44 (55%) of the 80 positions available.
- 14.4% of applicants (44 out of 305) and 34.9% of interviewed applicants (44 of 126) obtained a position.

➢ ***Applicants who graduated before December 31, 2009:***

- This group represented 78.3% (1,102) of the 1,407 eligible applicants.
- 708 (64.2%) did not submit clinical exam scores and were therefore not considered for a file review or interview.
- 394 (35.8%) submitted clinical exam scores.
- 158 received a file review and interview on the basis of their scores. They represented 14% of applicants and 40% of those who submitted clinical exam scores.
- Applicants from this group obtained 36 (45%) of the 80 positions available.
- 3.3% of applicants (36 out of 1,102) and 22.8% of interviewed applicants (36 of 158) obtained a position.

As shown in the table below, the more-recent graduates represented 21.7% of the applicant pool and obtained 55% of the positions.

TABLE 22

Family Medicine 2011 1st Iteration IMG Percentages		
	Date of Graduation	
	after Jan 1/10	before Dec 31/09
Applicants	21.7 %	78.3 %
Interviewed	44.4 %	55.6 %
Matched	55.0 %	45.0 %

Source: Coordinator, joint family medicine selection process

APPLICATION PROCESS

The family medicine programs' website (www.ontariofmp.ca) provides information for IMG applicants seeking first-year residency positions. It sets out key dates in the selection process, documents that must be submitted with the application, and criteria for obtaining an interview and for ranking in the CaRMS match. The website also notes the pre-residency program and Assessment Verification Period that successful applicants must undertake. Each faculty of medicine also provides information about the family medicine selection process in their individual sections of the CaRMS website.

MANDATORY REQUIREMENTS

Information on the family medicine website indicates that IMG applicants must include the following documentation with their application:

- ***Medical school transcript***
- ***Reference letters***
  - Applicants must provide three reference letters, at least one of which is from a family physician. Referees are expected to provide an assessment of the applicant's medical knowledge and clinical skills, interpersonal skills, ability to engage and communicate effectively with patients, attitudes toward learning, and commitment to family medicine. The letters must date within the past two years, even if the experience with the referee occurred at an earlier time.
- ***Personal letter***
  - Applicants must provide a personal letter of less than 500 words. The letters should describe how their background and experience led to an interest in and commitment to a career in family medicine, as well as their understanding of the role of family physicians in the Canadian health care system.
- ***Proof of Canadian citizenship or permanent resident status***
- ***Curriculum vitae***
  - The applicant's curriculum vitae must list the level of responsibility for each clinical experience, such as observer, student, resident, other trainee status, or independent practice.
- ***Language proficiency***
  - Applicants must provide proof of language proficiency as listed under "Provincial Restrictions/Ontario" on the CaRMS website.

All IMG applicants are also required to submit their evaluating exam scores.

OPTIONAL ITEMS

For 2011, the family medicine sections of the CaRMS website listed "Assessment" under the heading "Optional – Will Be Reviewed." The clinical exam, which at the time was the CE1, appeared in the optional category under the "Assessment" heading. Most faculties also listed Part 1 of the Medical Council of Canada's qualifying exam as optional.

Faculties used the following common text regarding the CE1:

For individuals who have completed their MD program at the time of application, **preference** will be given to those who have undergone an assessment by the Centre for the Evaluation of Health Professionals Educated Abroad (CEHPEA) which should be submitted with the supporting documents to CaRMS. Information can be found on the CEHPEA website.

CEHPEA CE-1 results for exams written prior to December 31, 2007 will not be accepted. CEHPEA CE-1 scores < 450 will not be accepted.

[Emphasis added.]

Two faculties of medicine (Ottawa, Northern) elaborated, as follows, when describing the selection criteria for IMGs on the CaRMS website:

Preference will be given to the following applicants for interviews:

1. Medical students or graduates who have been assessed by Centre for Evaluation of Health Professionals Educated Abroad (CEHPEA, previously IMG-Ontario) or other Canadian provincial IMG assessment programs, and can provide the CE-1 score or equivalent in Family Medicine, and/or;

2. Applicants with full time clinical experience (clinical clerkship during medical school or residency or independent practice, observership is excluded) within the past 4 years, and/or

3. Applicants who have participated in a training program in Family Medicine or broad based clinical practice experience.

Although CE-1 (CEHPEA) exam is optional, we **strongly advise** those who have completed medical school to take the examination and provide us with the scores. For those who have not yet completed medical school training, solid training record/transcript and MCCEE results are highly preferred.

[Emphasis added.]

The other four faculties (Queen's, McMaster, Toronto, Western) were more specific about the expectations that depended on date of graduation:

Preference will be given to the following applicants for interviews:

1. Applicants with full time clinical experience (clinical clerkship during medical school or residency or independent practice) within the past 4 years are preferred. Observership is NOT considered clinical experience.

2. Applicants who have participated in a training program in Family Medicine or broad based clinical practice experience are preferred.

3. For IMG applicants who graduated from medical school **before Dec 31, 2009**, **preference** will be given to those who have undergone the provincial assessment program (CEHPEA CE-1)

   a. CEHPEA CE-1 results for exams written prior to Dec 31, 2007 will not be accepted.

   b. CEHPEA CE-1 scores < 450 will not be accepted.

   c. Historically, the applicants in this group invited for interviews have a minimum CEHPEA CE-1 score of 537. This number varies from year to year, and should not be used to predict the minimum CE-1 score for the current match. A CE-1 score of 537 or higher does NOT guarantee an interview.

4. IMG applicants who graduated from medical school **after Jan 1, 2010** are not expected to have taken the MCCQE1 or CEHPEA CE-1 examinations. **Preference** for this group will be given to those who have a solid training record/transcript and MCCEE results.

   a. MCCEE scores below mean (271) will not be accepted.

   b. Historically, the applicants in this group invited for interviews have a minimum MCCEE score of 318. This number varies from year to year, and should not be used to predict the minimum MCCEE score for the current match. An MCCEE score of 318 or higher does NOT guarantee an interview

[Emphasis added.]

Based on these extracts, IMG applicants who had graduated from medical school less than a year before would have had a clear understanding that they

needed to submit evaluating exam scores (as did all applicants). If they read the second extract, they would also have known that, historically, applicants who obtained an interview had a minimum score of 318. This is clear and helpful information.

On the other hand, IMG applicants who had graduated more than a year before would have had less-clear information. They would have known that they needed to submit evaluating exam scores (as did all applicants). And they would have known that the clinical exam was "preferred" and "strongly advised." If they read the second extract, they would also have known that clinical exam results from prior to December 31, 2007 would not be accepted, scores of less than 450 would not be accepted, and that, historically, applicants who obtained an interview had a minimum score of 537.

This information is helpful to a point, but it misses a salient fact that we learned from those involved in the 2011 joint family medicine selection process. The fact is that IMG applicants who had graduated before December 31, 2009 were simply not considered for a file review and interview unless they had submitted clinical exam scores.

We recommend that those responsible for the content of the CaRMS website and the family medicine website take care to clarify what requirements are to be considered mandatory. It is not our intent to single out the joint family medicine program in this regard. All programs that use filtering on the basis of date of graduation, for example, should be transparent about that fact.

We note that as of August 2011, three faculties of medicine had updated their family medicine descriptions for the 2012 selection process on the CaRMS site. The requirement for less-recent graduates to take a clinical exam still appears under the heading "Optional – Will be Reviewed." Under "selection criteria," applicants are simply directed to the family medicine website. This is helpful, because the 2012 family medicine website makes it clear that clinical exam scores are required for less-recent graduates:

Ontario Family Medicine Website, Updated for 2012 Admission:

You are eligible to apply if you can submit all of the following documents on www.CaRMS.ca before November 25, 2012….

8. Assessment scores:

If you graduate from medical school before Dec 31, 2010 - proof of a passing score in the 2011 National Assessment Collaboration (NAC) OSCE Exam, or proof of score over 500 in the 2009 or 2010 Ontario IMG Assessment exam (CEHPEA CE-1).

If you graduate from medical school after Jan 1, 2011 - proof of score over 300 in the 2010 or 2011 MCC Evaluating Exam (MCCEE).

Source: http://www.ontariofmp.ca/appinfo2012.html

TIMELINE

The following timeline was published on the family medicine website for 2011:

TABLE 23

Timeline for 2011 CaRMS Match, Family Medicine	
Nov 26/10	Deadline to submit an application to CaRMS match
Dec 11/10	First round of interview invitations are sent out
Dec 17/10	Deadline to submit interview location ranking (by invitation only)
Dec 28/10	Interview locations announced to candidates
Jan 19/11	IMG Information Session in Toronto (not mandatory, by invitation only)
Jan 21/11	IMG interviews
Feb 22/11	Deadline to submit rank order to CaRMS
March 7/11	CaRMS 2011 first iteration Match Day
March 21/11	Pre-Residency Program Phase 1 begins for successfully matched applicants
April 5/11	If there are positions available after 1st iteration, deadline to submit 2nd iteration rank order to CaRMS
April 13/11	CaRMS 2011 second iteration Match Day

Note: Based on this timing, some IMGs, including those selected in the second iteration, were not able to take the pre-residency program beginning in March and had to take it at a later time. That meant they were unable to begin residency at the same time as everyone else.

SELECTION AND MATCHING PROCESS

STEP 1: INITIAL FILTERS

In 2011, initial filters were used to reduce the 1,407 applications to the approximately 300 invited to an interview. As described above, the applications of very recent graduates (less than a year) were filtered based on evaluating exam scores. Less-recent graduates (more than a year) were filtered based on clinical exam scores. Over 700 applicants were eliminated off the top because they were less-recent graduates who had not submitted clinical examination scores.

TABLE 24

2011 – 1st Iteration Family Medicine Joint Process Breakdown by Date of Graduation			
	Graduated after Jan 1/10	Graduated before Dec 31/09	TOTAL
Eligible applicants	305	1,102	1,407
Interview: invited	141	170	311
Interview: accepted	126	158	284
Matched, 1st iteration	44	36	80

Source: Coordinator, joint family medicine selection process

Filtering is a straightforward process. It can be done electronically, through the CaRMS website, using date of graduation and exam scores. However, the coordinator for the joint family selection process indicated that consolidating the applications for each program and merging them into a single spreadsheet can be time-consuming. This is because there are six universities, with more than one program location per faculty.

Another problem has been that scores from the written evaluating exam were sent directly from the Medical Council of Canada to CaRMS, but applicants had to enter their results for the clinical exam on line and mail a hard copy to CaRMS for scanning. The joint family coordinator's office had to verify every clinical exam result on line, and several errors were detected where the applicants had entered the data incorrectly. We have been advised that the results of the new clinical exam (NAC OSCE) will be electronically transferred from the Medical Council of Canada to CaRMS, so this should not be a problem in the future.

STEP 2: RATIO

Since there were two groups of applicants, filtered on two different exams, the family medicine program directors agreed on a ratio for the high scorers from each group who would be invited to an interview. In 2011, they agreed on a 50:50 ratio, so that approximately the same number of interviews were offered to applicants screened on their evaluating exam scores and applicants filtered on their clinical exam scores. Over the history of the joint program, the program directors have increased the percentage assigned to recent graduates. The coordinator advised us that this is a topic for discussion each year, and that the program directors recognize that the division is somewhat arbitrary—more of an educated guess based on their experience than a decision based on research or policy analysis.

After applying the filter and the ratio, the coordinator created a master spreadsheet of the 311 applicants who were offered an interview.

Step 3: Invitations for interviews

Since there is only one interview per person in the joint family medicine selection process, regardless of the number of faculties or locations to which an applicant applies, applicants invited for an interview were asked to indicate their three preferred locations out of the five possibilities (any of the universities except the Northern Ontario School of Medicine). The coordinator's office then chose interview locations for the applicants, making an effort to accommodate their preferences. The University of Ottawa was the only location that offered interviews in French.

In 2011, not all of the 311 interview invitations were accepted. This brought the number of applications down to 284.

Step 4: Pre-interview file review

After the interview locations were determined, the coordinator sent the applicants' files to the schools at which they were to be interviewed. Before the interviews, each file was reviewed by one of a cadre of experienced faculty members at the interview location. They used a standardized file review form, similar to the one used for graduates of Canadian or US medical schools.

The file reviewers did not assign a numerical score. They assigned one of the non-numerical ratings for each item and the coordinator's office translated the ratings into numerical scores. Personal and reference letters, for example, were rated not acceptable, acceptable, or exemplary, depending in part on the credibility of the source. For applicants who had graduated before December 31, 2009, the reviewers noted whether they had completed a postgraduate program. For all applicants, the reviewers noted the date of their most recent family medicine elective or observership. At the bottom of the form, there was a place for the reviewers to make comments to flag for the interviewers.

As the online information for applicants noted, the programs' preference was for full-time clinical experience within the past four years, or participation in a training program in family medicine, or broad-based clinical practice experience. Clinical experience could consist of a clinical clerkship during medical school, a residency, or independent practice, but not an observership.

Currently, the family medicine IMG coordinator at each site is responsible for training the file reviewers and interviewers. There is a plan in place for the future use of sample files to help in the training and to ensure consistency.

Step 5: Family medicine information session

A few days before the interviews, an information session took place in Toronto. All applicants selected for an interview were invited, divided into two groups to make the event manageable. All six program directors, some IMG residents from each school, and the family medicine IMG coordinators attended the

session. After the program directors gave presentations about their schools, the applicants had the opportunity to circulate and ask questions.

These sessions help to compensate for the fact that the family medicine IMG applicants have only one interview and would not otherwise have a chance to meet people from all locations to which they have applied.

Step 6: Interviews

There was no joint process for preparing the interview teams, other than providing a set of interview questions and a brief interview guide and rating sheet. The goal of these materials was to standardize the interviews so that all six family medicine programs could use the scores in deciding how to rank candidates.

The set of interview questions included mandatory questions, along with optional follow-up or probing questions to ask if needed to elicit more information related to each mandatory question. The interviewers were also free to ask applicants to clarify items flagged in the file review, provided that they stayed within the areas covered by the mandatory questions. The mandatory questions were designed to assess the applicant's interest in and exposure to family medicine, self-reflection, self-assessment, and approach to problem-solving, professionalism, and collaboration and interpersonal skills. At the interview, applicants were asked to sign a non-disclosure clause agreeing not to reveal the interview questions.

The interview guide specified that the interviewers should not change the pre-interview file review score. It also advised the interviewers about questions that would be inappropriate due to human rights legislation (age, ethnic background, sexual orientation, religion, etc.) or because they relate to the applicant's interest in other programs or how they are planning to rank the faculties.

The interview panel consisted of one faculty member and one resident. Often, the person who conducted the file review was also part of the interview panel. The interview was limited to 30 minutes. The process was synchronized so that each of the five sites held the interviews on the same day.

The interviewers rated the candidates on each of the mandatory questions using the interview rating sheet. They also noted whether they had any difficulty understanding the applicants or whether the applicants had difficulty understanding them. At the bottom of the sheet, the interviewers rated their overall impression of the applicants: not acceptable, marginally acceptable, acceptable, highly acceptable, or outstanding. There was also a place for the interviewers to provide comments.

The rating sheet noted that before the end of the interview, the interviewer should inform the applicant of the following: "The residency program requires

you to be able to drive or be driven between different sites on a day to day basis as part of your rotation requirements as well as driving to rotations in communities outside of your home base. Do you foresee any problems with this requirement?" The form then stated that the interviewer must notify the program director if an applicant had concerns with that requirement.

Each interviewer on the panel arrived at a score independently. The final score was the average of the two interviewers' scores.

Step 7: Ranking

The coordinator prepared a spreadsheet showing the totals of the file review scores and interview scores for the interviewed applicants and sent it to the family medicine program directors. The spreadsheet ranked the candidates according to their scores. The program directors also had access to the rating sheets, including the comments section. At this point, the joint process ended. It was up to the individual programs to decide how to use the scores in ranking candidates, how many to rank, and the order in which to rank them.

One family medicine program indicated that it chose to give more weight to the interview score than to the file review score. Another approach was to decide on a cutoff line, excluding from ranking all applicants falling below that line. Some applicants falling above the line could also be eliminated from ranking on the basis of considerations of particular importance to the program or "red flags" indicated on the forms. Sometimes, programs chose to move candidates up the list if they had a connection to the community in which the school was located or to the region as a whole, as in the case of the Northern Ontario School of Medicine. Their sense was that people with family or other connections in the community or region tended to do better and to be more committed to that location. Apart from these considerations, most program directors said that their ranking of the applicants rarely differed much from where the file review and interview scores would place them.

We do not know how many of the interviewed applicants were ranked. However, we can assume that a sufficient number were ranked, since all the designated positions were filled in the first iteration.

Step 8: Match

In 2011, as indicated above, all of the 80 designated IMG positions in family medicine were filled in the first iteration of the CaRMS matching process. This was also the case in previous years, with the exception of 2010 when one faculty of medicine had not filled four designated positions in the first iteration. However, that faculty ended up matching additional IMGs in family medicine in the second iteration.

All of these steps reduced the IMG family medicine applications from 1,407 to the 80 who were matched into first-year residency positions in the first iteration.

FIGURE 4

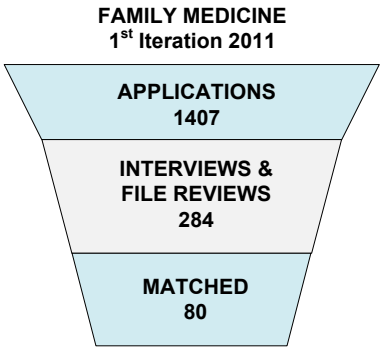


Table 25, below, shows matched IMGs divided into the two categories used by the joint family selection process—applicants who graduated after January 1, 2010 and applicants who graduated before December 31, 2009. Table 26 divides them by CSAs and immigrant IMGs (using CaRMS data). For three faculties (McMaster, Northern, Ottawa), the breakdown of individuals matched is identical in both tables. For the three others (Queen's, Toronto, Western), the numbers are very close, just one apart. This is an indication that the recent graduates filtered on their evaluating exam scores were almost all CSAs and that the less-recent graduates filtered on their clinical exam scores were primarily immigrant IMGs.

TABLE 25

Family Medicine 2011 1st Iteration IMG Match by Faculty: Graduated Before Dec 31/09 vs. After Jan 1/10													Total	
	McMaster		Northern		Ottawa		Queen's		Toronto		Western			
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Graduated after Jan 1/10	8	66.7	1	50	7	53.8	3	27.3	19	79.2	6	33.3	**44**	**55**
Graduated before Dec 31/09	4	33.3	1	50	6	46.2	8	72.7	5	20.8	12	66.7	**36**	**45**
TOTAL	12	100	2	100	13	100	11	100	24	100	18	100	**80**	**100**

Source: Joint family selection coordinator

TABLE 26

Family Medicine 2011 1st Iteration IMG Match by Faculty: Canadian Studying Abroad vs. Immigrant IMG	McMaster		Northern		Ottawa		Queen's		Toronto		Western		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Canadians studying abroad	8	66.7	1	50	7	53.8	4	36.4	18	75.0	5	27.8	**43**	**53.75**
Immigrant IMGs	4	33.3	1	50	6	46.2	7	63.6	6	25.0	13	72.2	**37**	**46.25**
TOTAL	12	100	2	100	13	100	11	100	24	100	18	100	**80**	**100**

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

SECOND ITERATION

There is no joint or coordinated process for family medicine selection in the second iteration. Due to time pressures, interviews may be conducted by telephone ("You have eight days and March break is in the middle of it"). Some faculty also expressed a worry about the "epiphany crowd," who try for family medicine when they are not matched in their preferred specialty.

In 2011, all of the designated IMG positions in family medicine were filled after the first iteration of the CaRMS match. In the Canadian medical graduate (CMG) pool, 52 positions remained unfilled. Unmatched CMGs and IMGs competed for the unfilled position in the blended second iteration. During the second iteration, 13 IMGs obtained family medicine positions. Two family medicine positions (originally CMG positions) remained unfilled after the second iteration, both of them at the Northern Ontario School of Medicine.

TABLE 27

Family Medicine 2011 2nd Iteration Volume, by CaRMS Categories	CMG positions unfilled after 1st iteration	CMG		CSA		Immigrant IMG		Total IMG	
		Applicants	Matched	Applicants	Matched	Applicants	Matched	Applicants	Matched
Ottawa	0	0	0	0	0	0	0	0	0
Queen's	16	83	14	229	2	638	1	867	3
Toronto	2	52	2	117	0	370	0	487	0
McMaster	10	78	9	232	0	567	1	799	1
Northern	7	36	1	187	1	477	3	664	4
Western	17	79	12	233	3	643	2	876	5
TOTAL	**52**		**38**		**6**		**7**		**13**

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

Observations: Family medicine selection 2011

The joint family medicine process represents an impressive effort to make the selection process as fair and as reliable as possible in the face of a massive number of applications to consider within a short time. It is the only selection process conducted on behalf of all faculties of medicine. This innovative approach avoids duplication in reviewing files and interviewing candidates, yet enables the program directors to make their own decisions about ranking the interviewed applicants. We are impressed with how the programs work closely together, and with their commitment to learning from results—for example by having commissioned and responded to a formal evaluation.

One of the positive features of the family selection process is the use of exam results as an objective filter to determine who will obtain an interview and file review. Another is the use of structured file reviews and interviews. The overall process is managed by a highly committed coordinator who is eager to make it even better.

We are concerned, however, that the information the programs posted on the CaRMS website for 2011 understated or failed to disclose a crucial element in the family medicine selection process: those who had graduated more than one year earlier and who had not written the clinical exam would immediately be eliminated from the process. It is hard to believe that the over 700 persons who fell into that category would have applied to multiple family medicine programs and paid the required fees had they known that their files would never be considered. Revisions to the CaRMS and family medicine websites will improve this situation.

In our view, the decision the programs make on the percentage of applicants to take from each of the two categories of applicants is an extremely important one. In essence, it determines the extent to which recency of graduation will be a major advantage. The decision to take 50% from each category in 2011 led to the relatively close number of candidates ultimately matched from each category.

It may be true, as we were told, that the ratio decision is in some respects arbitrary. However, it also seems to reflect at least some unstated assumptions about the applicant pool, or to represent perspectives that have developed over the five years the joint program has been in place. For example, does a 50:50 ratio, in the face of an approximately 80%/20% split in applicants, represent a policy decision about recent graduation as a predictor of success? Is it based on the program directors' views about the calibre of residents selected in the past? Or is it simply a reflection of the numbers still eligible after elimination of all the less-recent graduates who had not done the clinical exam?

There would be value in attempting to articulate the rationale more clearly so that it could be tested over time in future evaluations of the family medicine selection process. Even more helpful would be a decision to ensure that all IMG applicants are able to submit clinical exam scores, as we have recommended (for all programs) in Volume 1 of this report. The NAC OSCE, which does not require Part 1 of the Medical Council of Canada qualifying exam as a prerequisite, should make this more viable.

Some IMGs consider it unfair that everything rests on a single interview performance ("I only get one shot to prove myself in an interview, even though I applied to five or six medical schools"). They would prefer to obtain interviews at all of the schools they are interested in attending, which is the case for CMGs. They find it somewhat impersonal that they cannot go to their preferred site and meet the people there ("I'm interviewed at UofT even though I want to go to Mac"). At the same time, we heard that some CMGs would prefer a single interview to travelling across the province for multiple interviews. One faculty member suggested that the family medicine interviews should all be done at one location, with mixed faculty on the panels.

We believe that the single-interview approach for IMGs represents a reasonable decision in light of the desire to maximize the number of applicants who will be interviewed rather than inviting a smaller number to attend multiple interviews. This gives more IMGs a chance to demonstrate their suitability and gives the programs a larger pool when determining their rankings.

The family medicine program directors have thought about moving to Multiple Mini-Interviews, but there are no plans to move in that direction at present. They are concerned about the logistical challenges of setting up multiple interview stations for a large group of applicants. They also worry about whether this approach would necessitate reducing the number of applicants who could go through the interview and ranking process. We believe there would be merit in supporting the joint family medicine program in piloting Multiple Mini-Interviews. This would be an opportunity to assess the potential of this selection tool to achieve the documented benefits in a large program, as discussed in Volume 1 of this report.

In Volume 1 we have also recommended that the ranking process, as distinct from ranking decisions, should be more transparent and structured. In family medicine, a more structured ranking process would be more consistent with the carefully constructed process that precedes it.

INTERNAL MEDICINE

In 2011, 25 (13%) of the 191 designated IMG first-year residency positions were designated for internal medicine. This was the second-highest number of designated positions, after family medicine. Five of the six faculties of medicine had designated positions in this specialty program. All of the designated IMG positions in internal medicine were filled in the first iteration.

The Northern Ontario School of Medicine had no positions designated for IMGs in any program other than family medicine. However, its six internal medicine positions reserved for graduates of Canadian medical schools remained unfilled after the first iteration. In the second iteration, the Northern Ontario School of Medicine filled all of these unfilled positions with IMGs. Queen's University also had an unfilled CMG internal medicine position after the first iteration, but did not invite applications for that program during the second iteration.

TABLE 28

IMG Applications to Internal Medicine, 2011				
	1st Iteration		2nd Iteration	
	Applications	Matched	Applications	Matched
Ottawa	584	4	0	0
Queen's	518	4	0	0
Toronto	603	8	0	0
McMaster	539	3	0	0
Northern	0	0	402	6
Western	521	6	0	0
TOTAL		**25**		**6**

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

On average, each of the five programs with designated IMG positions received 169 (30.6%) applications from CSAs and 384 (69.4%) from immigrant IMGs.

TABLE 29

2011 – 1st Iteration IMG Applications to Internal Medicine, by Category					
	CSA applicants		Immigrant IMG applicants		Total IMG applicants
	#	%	#	%	#
Ottawa	171	29.3	413	70.7	584
Queen's	166	32	352	68	518
Toronto	182	30.2	421	69.8	603
McMaster	158	29.3	381	70.7	539
Western	168	32.2	353	67.8	521
AVERAGE	**169**	**30.6**	**384**	**69.4**	**553**

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

In the first iteration, the number of applications from IMGs for the designated IMG positions exceeded the number of applications from CMGs for non-designated positions. On average, the internal medicine programs received 322 (37%) applications from CMGs and 553 (63%) from IMGs, for an average total of 875 applications over all.

TABLE 30

2011 – 1st Iteration Volume of CMG and IMG Applications in Internal Medicine					
	CMG		IMG		TOTAL
	Applications from graduates of Canadian or US medical schools		Applications from IMGs (CSAs + immigrant IMGs)		CMG + IMG
	#	%	#	%	#
Ottawa	375	39.1	584	60.9	959
Queen's	272	34.4	518	65.6	790
Toronto	375	38.3	603	61.7	978
McMaster	292	35.1	539	64.9	831
Western	294	36.1	521	63.9	815
AVERAGE	**321.6**	**36.8**	**553.0**	**63.3**	**874.6**

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

APPLICATION PROCESS

The internal medicine programs at each faculty of medicine posted information about the selection process and criteria for first-year residency positions on their individual sections of the CaRMS website. They also indicated specific

provisions relating to IMGs. The following are highlights from the online information for 2011 pertaining to IMG applicants for first-year residency positions.

Provincial restrictions

The Ontario faculties of medicine and the Ontario Ministry of Health and Long-Term Care had agreed on policies for the first-year residency match. All five internal medicine programs provided a link to a listing of those policies. The policies included IMG eligibility requirements regarding proof of legal status, proof of MD degree and transcripts, language proficiency, and successful completion of the evaluating exam. They also included details about return of service contracts, pre-residency orientation programs, and the Assessment Verification Period.

Documentation to submit with the application

The five internal medicine programs were consistent in stating that IMG applicants were required to submit the following items:

- Medical school transcript
- Medical school performance record
- Reference letters
- Personal letter
- Proof of status as citizen or permanent resident
- Results of Medical Council of Canada evaluating exam

There were differences, however, in the specifics regarding reference letters and personal letters. There were also differences in whether other types of documentation were mandatory, optional, or “preferred.” We are not suggesting that it is wrong for programs to differ in their requirements. However, it can be a burden on applicants when there is too much variation or when it is difficult to readily ascertain the similarities and differences.

TABLE 31

2011 Selection Process for First-Year Internal Medicine Residency Positions Highlights of Information for IMGs on Program Sections of CaRMS Website	
Reference letters	▪ Toronto required a minimum of three and a maximum of five reference letters. The other four programs each required three letters. ▪ Ottawa stated that a resident who wrote a reference letter must be year two or higher; Queen's said that the resident must be a senior or chief resident; McMaster said that it would not accept letters from residents. ▪ Western said that two of the letters must be from certified specialists in internal medicine and that letters from research mentors or from observerships would not be considered. ▪ McMaster said that two of the letters must be from physicians who could comment on the applicant's clinical performance and interpersonal skills. ▪ Toronto articulated criteria for a good choice of referee and encouraged letters from Canadian referees if available.
Personal letter	▪ Programs specified the following maximum number of words in a personal letter: 600 words (Western); 700 words (Ottawa, Queen's, McMaster); 1,000 words (Toronto). ▪ Programs described in various ways the content they wanted in the personal letter, such as achievements, extracurricular activities, and personal goals (Ottawa and Queen's); reasons for selecting internal medicine and the university (Western); unique attributes (Toronto); comparison of doctor-patient relationship in North America and the applicant's country of medical education or practice (McMaster).
Evaluating exam scores	▪ Western indicated a strong preference for an evaluating exam score above the mean. ▪ Toronto said that a high global mark on the evaluating exam was important for candidates who had not taken an IMG assessment examination.
Recency of graduation and experience	▪ Ottawa said that serious consideration would be given to recent graduates from medical school or an advanced training program. ▪ Western said strong preference would be given to applicants who had graduated from medical school in the last five years or had residency training or clinical experience in internal medicine in the last five years. ▪ Toronto said that recency of graduation and recency of clinical contact were important selection criteria. ▪ Queen's said that consideration would be given to recency of graduation and relevance of clinical experience. ▪ Toronto and Western indicated that observerships were not considered to be clinical contact or experience.
Qualifying exam scores	▪ Toronto indicated that results from Part 1 or Part 2 of the qualifying exam would be considered if available. ▪ Western and Queen's said that results of Part 1 of the qualifying exam were required, except for candidates who had graduated within the past two years.
Prior experience	▪ McMaster and Western requested details on prior postgraduate training or medical practice experience. ▪ Western said it was looking for a demonstrated interest in internal medicine by clinical experience such as electives.
Curriculum vitae	▪ Three programs said that a curriculum vitae must be submitted with the application. The other two listed curriculum vitae as an optional document that would be reviewed if provided.
Provincial assessment	▪ A provincial assessment was "strongly recommended" (Queen's), "strongly encouraged" (Ottawa and Toronto), and a "strong preference" (Western). ▪ Proof of assessment results was mandatory if available (Toronto, McMaster).
Canadian health care system	▪ Ottawa said it would give serious consideration to demonstrated interest in and knowledge of the Canadian health care system.
Other	▪ Western and Toronto said they were looking for academic excellence, excellent interpersonal and communication skills, and a real interest in community internal medicine as a career. ▪ Queen's said it valued academic excellence, strong communication skills, ability to interact well with others, and a clear interest in internal medicine. ▪ Ottawa said it would give serious consideration to demonstrated academic achievement. ▪ Three of the five programs required applicants to provide a photograph for use as a memory aid.

SELECTION AND MATCHING PROCESS

STEP 1: INITIAL FILTERS

"We should be able to search on CaRMS for the candidate's latest true clinical work."

–Program director

Four of the five schools used year of graduation as an initial filter for internal medicine, but each did it differently. Two schools used three years from graduation and a score of over 300 (McMaster) or 325 (Queen's) on the evaluating exam. The University of Ottawa used three years from graduation as the first filter, and then manually reviewed files to add 20 applications back in on the basis of high internal medicine subscores on exams or significant experience and training. The University of Toronto used five years from graduation as the first filter and evaluating exam scores as a second filter. A preliminary manual review of the files then added a few applicants back in on the basis of clear evidence of recent, active engagement in internal medicine.

The University of Western Ontario did not use year of graduation as an initial filter. Instead, they filtered on the basis of evaluating exam scores.

None of the programs used scores from the clinical exam available at the time (CE1) as an initial filter, although some looked at the results during the manual review they undertook as part of the initial filtering process. The clinical exam scores of many less-recent graduates were never seen, no matter how high, because the graduation date filter eliminated them at this initial stage.

STEP 2: DETAILED FILE REVIEW

After the initial filtering, the University of Western Ontario, McMaster University, the University of Ottawa, and Queen's University each conducted a detailed review of all of their remaining files. The purpose was to identify a manageable number of applicants for interviews. At the University of Toronto, the program director conducted a file review to determine who would get an interview. On the day of the interview, the team of two faculty members assigned to conduct a candidate's interview also conducted a detailed review of that person's file. With the exception of McMaster University, the programs assigned numerical scores to the detailed file reviews.

Interviews with program directors and a review of available rating sheets indicate that the following factors were considered during the file review:

- Clinical experience in internal medicine through postgraduate training or employment
- Electives or other Canadian experience
- References, especially Canadian or North American

- Examination scores
- Personal letter
- Transcript, academic performance
- Extracurricular activities
- Unexplained gaps in education or medical practice

The extent to which these factors were considered and the weight given to each varied among the schools, but reference letters, in particular, appeared to carry a lot of weight. One rating sheet allocated a maximum of nine points for references (three points for each reference) out of a total maximum of 20 points for the file review. Programs also looked at clinical exam scores, but most found it difficult to use them as a comparator given that many applicants had not taken the exam.

Step 3: Interviews

All five schools used the traditional interview format. None used Multiple Mini-Interviews. There was a general belief that Multiple Mini-Interviews would be too labour-intensive for the numbers involved in internal medicine.

In four schools, the interview panel had access to information from the file. At Queen's University, the panel had the file but not the file review score. At the University of Ottawa, the panel had some background information but not the entire file. The McMaster University panel members had their notes from reading the file. At the University of Toronto, the panel had full access to the file. At the University of Western Ontario, the interview panel did not have access to the file because, in their view, this helped to ensure that applicants were scored on their interview performance and not on elements that had already been scored during the file review.

Four of the five programs used standardized interview questions, with one of them indicating that they changed the ethical scenario on each day of interviewing. In the fifth program (Queen's University), interviewers had flexibility about which questions to ask and how to phrase them. They were also free to construct their own questions.

Questions were generally analogous to those asked of graduates from Canadian medical schools, but as one program indicated, "with more emphasis on the transition to a new system." All schools but McMaster University assigned numerical scores to the interview.

All programs provided some orientation and a tour for the interviewees. Some also offered a social event.

Step 4: Ranking

At four of the schools, the interviewers met as a group to discuss the ranking. The exception was Queen's University, where the program director did the

ranking using the total scores from the interviews and file reviews and taking into account any red flags.

At the University of Western Ontario, the ranking was primarily based on the scores: 40% for the file review and 60% for the interview. Panel members discussed elements of the ranking, for example to decide how to rank two individuals who had received the same score. Care was taken to ensure that there had been no error in entering the numbers.

At McMaster University, because there were no numerical scores assigned to the file review or interview, the interviewers ranked applicants based on a combination of evaluating exam scores, clinical experience, reference letters, and interview performance.

At the University of Toronto, the file review and interview scores were given equal weight. Because some interview teams could be harder markers than others, each team identified its top two candidates for each half-day of interviews to ensure that all top candidates were ranked.

At the University of Ottawa, the main criterion for ranking was a combined score from the interview and file review, with consideration of general comments noted by the interview panel. Some people were moved up the list if they had done internal medicine in Ottawa, had family and supports in Ottawa, or had strong Canadian experience.

Step 5: Match

All five schools filled all of their designated internal medicine positions in the first iteration of the CaRMS match. Based on information provided by the program directors, 21 (84%) of the positions were filled by Canadians who studied abroad and four (16%) by immigrant IMGs.

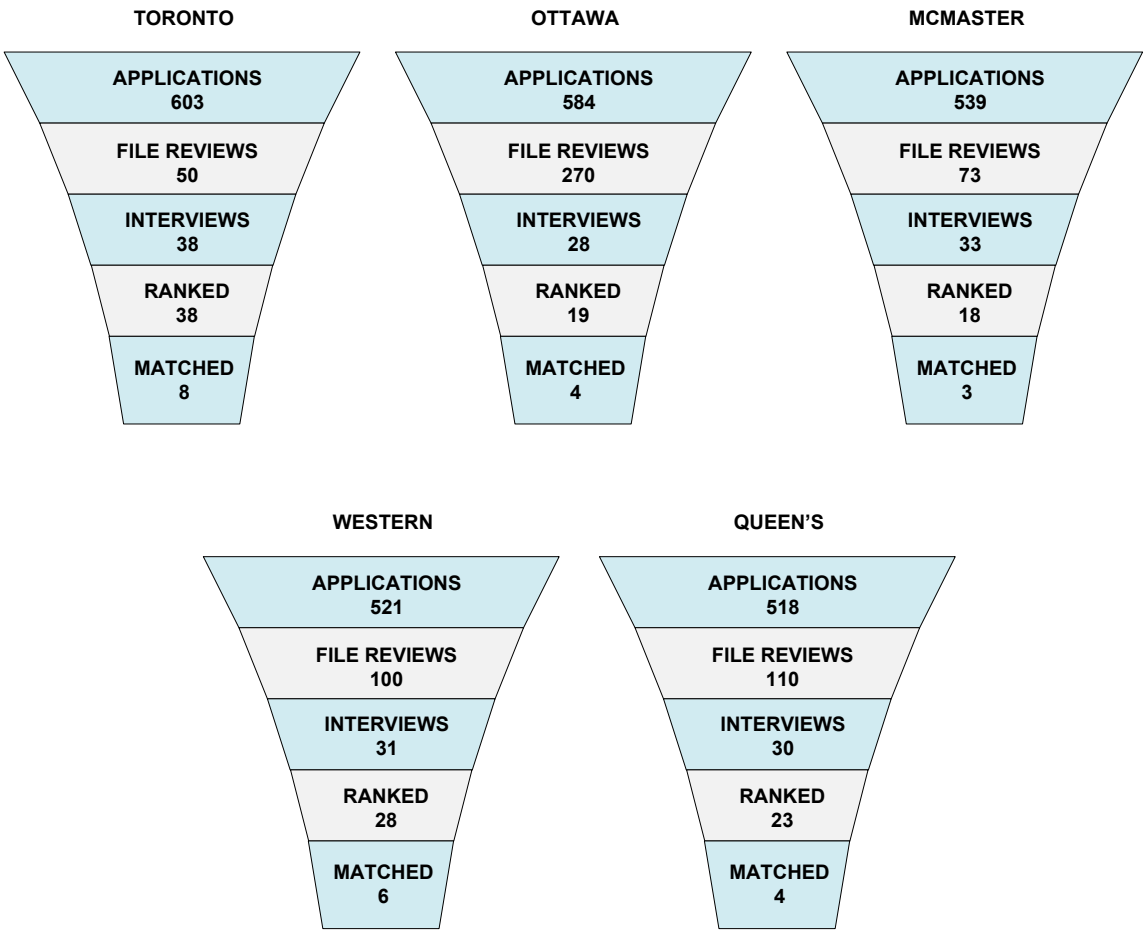
Table 32

2011 Internal Medicine Positions Matched by Category 1st Iteration					
	CSAs		Immigrant IMGs		TOTAL
	#	%	#	%	#
Western	6	100	0	0	6
Queen's	3	75	1	25	4
McMaster	2	67	1	33	3
Ottawa	4	100	0	0	4
Toronto	6	75	2	25	8
TOTAL	21	84	4	16	25

Source: Interviews with program directors

FIGURE 5

Internal Medicine 2011 – 1st Iteration



Source: CaRMS data (re application volume) and interviews with program directors

SECOND ITERATION

The Northern Ontario School of Medicine participated in the second iteration to fill its six non-designated internal medicine positions, which had remained unfilled after the first iteration.

TABLE 33

2011 2nd Iteration – Internal Medicine: Northern Ontario School of Medicine

33.1 Breakdown of CMG and IMG Applicants				
CMG		IMG		TOTAL
#	%	#	%	#
22	5.2	402	94.8	424

33.2 Breakdown of IMG Applicants by Category				
CSA		Immigrant IMG		TOTAL
#	%	#	%	#
129	32.1	273	67.9	402

33.3 Breakdown of Matched Applicants by Category						
CMG		CSA		Immigrant IMG		TOTAL
#	%	#	%	#	%	#
0	0	3	50	3	50	6

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

STEP 1: FILTER

In the second iteration, the internal medicine program of the Northern Ontario School of medicine applied a date of graduation filter of three years. This step reduced the volume of applications by approximately one-half.

STEP 2: FILE REVIEW

Ten faculty members divided up the 200 files that remained after the filtering and reviewed them using a two-page rating sheet. Criteria included scholastic achievement, exam scores, personal letters, and references. The personal letters helped to show why the applicants wanted to come to the Northern Ontario School of Medicine and their interest in a more community-based type of internal medicine program. Where they did their electives and the source of their reference letters were also important factors. Each reviewer rated the approximately 20 files they reviewed, but did not assign a numerical score. The program director took the top three or four from each reviewer to identify a list of 37 people to be interviewed.

STEP 3: INTERVIEWS

The interviews were conducted by two teams of three. Candidates were offered the choice of being interviewed on site or by video conference, and a few candidates opted for the video option. The program has found that videoconferencing is better than teleconferencing for getting a sense of the candidates.

Both teams of interviewers used the same standard questions, but they had latitude in how they worded those questions. Scores were awarded for training, interest in the program, suitability for the north, and clinical

approaches. Because the second iteration pool consisted mostly of IMGs, there was more emphasis on clinical training, experience, and approaches than there had been in the first iteration (which had involved solely CMGs).

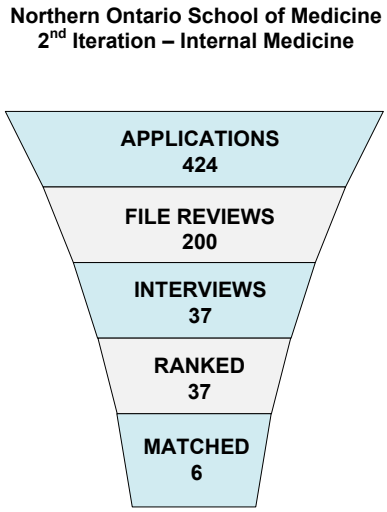
Step 4: Ranking

The two interview teams met to discuss each person interviewed. Ranking decisions were made primarily on the basis of interview scores. The program ranked all candidates who had been interviewed.

Step 5: Match

All six positions were filled by IMGs. Based on CaRMS data, the positions were split 50/50 between CSAs and immigrant IMGs.

Figure 6



Observations: Internal Medicine Selection 2011

"Over the past five years Canadians who studied abroad obtained more positions, mainly due to a reliance on recency of graduation as a filter. An elective and a reference letter from someone in Canada also favour CSAs."

–Program director

We were impressed by the dedication of the program directors as they deal with a high volume of applications and the enormous demands placed upon them. Some regretted the need to use date of graduation as a filter and worried about those left out at this stage. At the same time, they knew that there would be little opportunity to examine the files to find promising applicants who should be brought back in. Yet at least two program directors somehow found time in the busy month of December to do just that. There

was broad recognition that date of graduation was used, in large measure, because it is an easily obtained proxy for recent clinical practice. Some expressed frustration with the lack of a reliable filter, on the CaRMS website, to provide meaningful information on recent practice in internal medicine.

As a whole, the internal medicine program matched a higher percentage of CSAs in the first iteration than the other specialty program we examined. It is difficult to draw firm conclusions about the reasons for this. The initial filtering by year of graduation likely played a significant role. However, the one school that used exam scores as its filter ended up filling all of its designated positions with CSAs. Another important factor appears to be the weight given to North American experience, electives, and references during the file review stage. In some cases, applying factors such as connection to the community at the ranking stage seemed also to have worked to the advantage of CSAs.

Program directors have made adjustments to their selection processes and seemed willing to try new things if they are not too resource-intensive. As an example, the McMaster University program has signed up to pilot the Computer-based Assessment for Sampling Personal characteristics (CASPer) as an assessment tool. However, there seemed to be little interest in moving to the Multiple Mini-Interview, which program directors saw as impractical for a high-volume specialty program.

The volume of applications in internal medicine suggests that there may be real value in exploring opportunities for greater collaboration among the faculties of medicine—especially in light of the positive experience in family medicine, the one program larger than this one. The internal medicine programs do coordinate to avoid holding interviews on the same day, but there is potential to do more on a collaborative basis that would be efficient for the programs and helpful to the applicants.

At a minimum, there is a need to discuss how to create more uniformity in the application requirements and other information contained on the CaRMS website. The confusing mix of requirements from program to program must be challenging for IMGs applying to multiple programs. IMGs who graduated earlier than the date of graduation the programs use as an initial filter would probably decide not to go to the trouble and expense of applying if they were aware of the impact of that one factor. It should be possible to make the criteria more standard and transparent without compromising the right of each program to obtain the information that they feel they need from applicants.

PEDIATRICS

In 2011, 11 (5.7%) of the 191 designated IMG first-year residency positions were in pediatrics. This was the third-highest number of designated positions, after family medicine and internal medicine. Five of the six faculties of

medicine had at least one designated position in pediatrics. The Northern Ontario School of Medicine was the exception in that it had no designated positions in this program.

As a result of a "reversion," the University of Toronto began with three designated positions in pediatrics and ended up filling four. A reversion occurs where a program foresees difficulty in filling one of its positions. That position then "reverts" to another program within the same faculty of medicine. Therefore, although 11 pediatric positions were initially designated for 2011, 12 (6.3% of the 191) were filled in the first iteration of the CaRMS match.

Table 34 shows the number of IMG applications for pediatrics in the first iteration.

TABLE 34

IMG Applicants to Pediatrics 2011 1st Iteration		
	Applications	**Matched**
Ottawa	209	2
Queen's	234	1
Toronto	251	4
McMaster	267	3
Northern	0	0
Western	215	2
TOTAL		**12**

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

All pediatrics positions were filled in the first iteration, in both the IMG and CMG streams. Therefore, there was no second iteration selection activity for this specialty.

On average, each of the five pediatrics programs with designated IMG positions received 65.6 (28%) applications from CSAs and 169.6 (72%) from immigrant IMGs. This percentage breakdown was similar to the one for internal medicine.

TABLE 35

2011 1st Iteration Breakdown of IMG Applications in Pediatrics, by Category					
	CSA applicants		Immigrant IMG applicants		Total IMG applicants
	#	%	#	%	#
Ottawa	60	28.7	149	71.3	209
Queen's	69	29.5	165	70.5	234
Toronto	71	28.3	180	71.7	251
McMaster	72	27.0	195	73.0	267
Western	56	26.0	159	74.0	215
AVERAGE	**65.6**	**27.9**	**169.6**	**72.1**	**235.2**

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

As in internal medicine, the number of applications from IMGs for the designated pediatrics positions exceeded the number of applications from CMG applicants for the non-designated positions in the first iteration. On average, the pediatric programs received 145 (38%) applications from CMGs and 235 (62%) from IMG applicants, for an average total of 380 applications over all.

TABLE 36

2011 1st Iteration Volume of CMG and IMG Applications in Pediatrics					
	CMG		IMG		TOTAL
	Applications from graduates of Canadian or US medical schools		Applications from international medical graduates (CSAs + immigrant IMGs)		CMG + IMG
	#	%	#	%	#
Ottawa	174	45.4	209	54.6	383
Queen's	118	33.5	234	66.5	352
Toronto	167	40.0	251	60.0	418
McMaster	137	33.9	267	66.1	404
Western	128	37.3	215	62.7	343
AVERAGE	**144.8**	**38.1**	**235.2**	**61.9**	**380**

Source: CaRMS Data Tables, 2011 Main Residency Match (R-1)

APPLICATION PROCESS

The pediatrics program at each faculty of medicine posted information on the selection process and criteria for first-year residency positions on their individual sections of the CaRMS website, and also indicated specific provisions

relating to IMGs. The following are highlights from the online information for 2011 pertaining to IMG applicants for first-year residency positions.

Provincial restrictions

All five pediatrics programs provided a link to a listing of policies agreed to by the Ontario Faculties of Medicine and the Ontario Ministry of Health and Long-Term Care for the 2011 first-year residency match. The policies included IMG eligibility requirements regarding proof of legal status, proof of MD degree and transcripts, language proficiency, and successful completion of the evaluating exam. They also included details about return of service contracts, pre-residency orientation programs, and the Assessment Verification Period.

Documentation to submit with the application

The five pediatrics programs were consistent in stating that IMG applicants were required to submit the following items:

- Medical school transcript
- Medical school performance record
- Reference letters
- Personal letter
- Proof of status as citizen or permanent resident
- Results of Medical Council of Canada evaluating exam

There were differences, however, in the specifics regarding reference letters and personal letters. There were also differences as to whether other types of documentation were mandatory, optional, or “preferred.” Again, we are not suggesting that it is necessarily wrong for programs to differ in their requirements. However, it can be a burden on applicants when there is too much variation or it is difficult to readily ascertain the similarities and differences.

TABLE 37

2011 Selection Process for First Year Pediatric Residency Positions Highlights of Information for IMGs on Program Sections of CaRMS Website	
Reference letters	▪ Western required three letters and said it would not review more than three. The other four programs said they would accept three to five letters. ▪ Toronto, Western, and McMaster said the letters must be dated within the last two years, although the information appeared in different sections of their program descriptions. ▪ McMaster articulated criteria for a good choice of referee and encouraged letters from Canadian referees if available. ▪ Toronto said that one letter should be from a pediatrician and that letters from residents or fellows would not be accepted. ▪ Ottawa said that letters should be from attending staff and that letters from pediatric specialists were encouraged.
Personal letter	▪ Programs differed in their specifics for the length of the personal letter: approximately 600 words (Ottawa); maximum two pages single spaced (Western); maximum 750 words (Toronto and McMaster); no maximum (Queen's). ▪ Programs also differed in the desired content of the personal letter. Some requested applicants to state their reasons for choosing pediatrics as a career or that university in particular.
Evaluating exam scores	▪ Toronto said preference would be given to candidates with good marks over all and above-average marks on the pediatrics portion. ▪ Ottawa required a minimum score of 300 for those writing after 2007. ▪ Western required minimum scores of 300 over all and 325 in pediatrics (and scores of 400 and 450 if written before 2007).
Recency of graduation or experience	▪ Toronto, Western, and McMaster said preference would be given to candidates who graduated from medical school within the past three years OR who graduated within the past eight years and had active medical practice within the past three years. ▪ Ottawa said preference would be given to applicants who graduated from medical school within the past three years OR graduated after 2007 and were in active medical practice within the past three years.
Qualifying Exams	▪ Ottawa said preference would be given to candidates who passed Part 1 of the Medical Council of Canada qualifying exam and who scored high on the problem-solving component. Additional preference would be given to those who had passed Part 2 of the qualifying exam. ▪ Toronto, Western, and McMaster said they would give preference to successful completion of Part 1 and/or 2 of the qualifying exam.
Prior experience	▪ McMaster indicated that documentation of prior postgraduate training and medical practice experience would be reviewed, if applicable. ▪ Ottawa asked applicants to let them know if they had any postgraduate training in pediatrics or family medicine. ▪ Toronto and McMaster said they would give preference to those with documented successful pediatric experience beyond the regular medical school program. ▪ Most noted that research experience in Canada and clinical observerships are an asset but considered less valuable than training or work experience.
Curriculum vitae	▪ Some programs said that curriculum vitae must be submitted with the application. Queen's specified that the c.v. be abbreviated (a maximum of three pages).
Provincial assessment	▪ Ottawa, Western, McMaster, and Toronto said preference would be given to candidates who submitted results from a provincial assessment.
Canadian health care system	▪ Toronto, Ottawa, Western, and McMaster said preference would be given to candidates who could demonstrate familiarity with the Canadian or North American health care system.
Other	▪ Toronto said preference would be given to candidates who had participated in scholarly activities. ▪ Two programs required applicants to provide a photograph for use as a memory aid.

Selection process

Step 1: Initial filters

Four of the five schools used year of graduation as an initial filter, but each did it differently. Queen's University used three years from graduation as its filter. The University of Ottawa also used three years from graduation, but applicants with high scores in the evaluating exam or Part 1 of the qualifying exam stayed in the running even if they had graduated more than three years earlier. The Queen's University applications were further reduced by a manual review based on recent clinical work experience and clinical exam results. The University of Toronto used 10 years from graduation as a filter and then reviewed files manually to bring some applicants back in if they had high exam scores and experience. McMaster University chose to filter by manually reviewing the files to identify applicants who were within 10 years of graduation or who had recent clinical experience. McMaster University also looked at exam results. The University of Western Ontario did not use year of graduation as an initial filter. Instead they used pediatrics subscores from the evaluating exam.

As was the case with internal medicine, none of the programs used scores from the clinical exam (CE1) as an initial filter, although some looked at the results during the manual review they undertook to complement the filtering process. It is likely that that some applicants were filtered out by date of graduation without any chance for the clinical exam score to potentially change that result.

Step 2: Detailed file review

All five programs conducted detailed file reviews for applicants remaining after the initial filtering process in order to identify a manageable number for interviews. Two schools (Western and Ottawa) assigned numerical scores to their file reviews. Three schools (Queen's, Toronto, McMaster) did not assign numerical scores.

Interviews with program directors and a review of available rating sheets indicate that the following were factors considered during the file review:

- Recency of graduation or clinical exposure
- Pediatric elective, postgraduate training and experience (especially local elective)
- References (especially Canadian references)
- Scholarly experience, research
- Leadership and community service; commitment to a career in child health
- Personal letter and reasons for choosing the program
- Exam scores and pediatric subscores
- Medical school, academic record and awards

The extent to which these factors were considered and the weight given to each varied among the schools.

Step 3: Interviews

Three faculties of medicine (McMaster, Western, Ottawa) used Multiple Mini-Interviews for residency selection, both for IMGs and for graduates of Canadian and US medical schools. Except for the "personal interview" station, faculty at the interview stations did not have access to the applicants' files.

The other two faculties (Queen's and Toronto) used a traditional interview format. At Queen's University, the faculty member who conducted the file review for an applicant also conducted that person's interview, along with a senior resident, but the interviewers did not have access to the application file during the interview. After the interview, the applicant met for approximately 20 minutes with the program director. At the University of Toronto, the same four-member team interviewed everyone, and the team had access to the files.

Four of the five pediatric programs used standardized questions and assigned numerical scores in the interviews. Queen's University took a less structured approach.

All schools provided orientation and a hospital tour to the applicants who were interviewed. Some also held a social event.

Step 4: Ranking

In all five pediatrics programs, a team of faculty (generally those who had conducted the interviews) met to discuss the ranking. In one program, residents who had interacted with applicants during the hospital tour were invited to provide input as well.

The University of Western Ontario, the University of Toronto, and McMaster University indicated that the ranking of applicants was primarily based on the interview scores. The University of Ottawa based its ranking on interview scores (80%) and file review scores (20%). Flags on the rating sheets affected the ranking in some cases. Queen's University considered all components of the file and interview when deciding how to rank applicants, since it had not assigned numerical scores. The University of Western Ontario program director described the steps they took to ensure that no errors were made in the ranking, for example due to an error in inputting the interview scores.

Step 5: Match

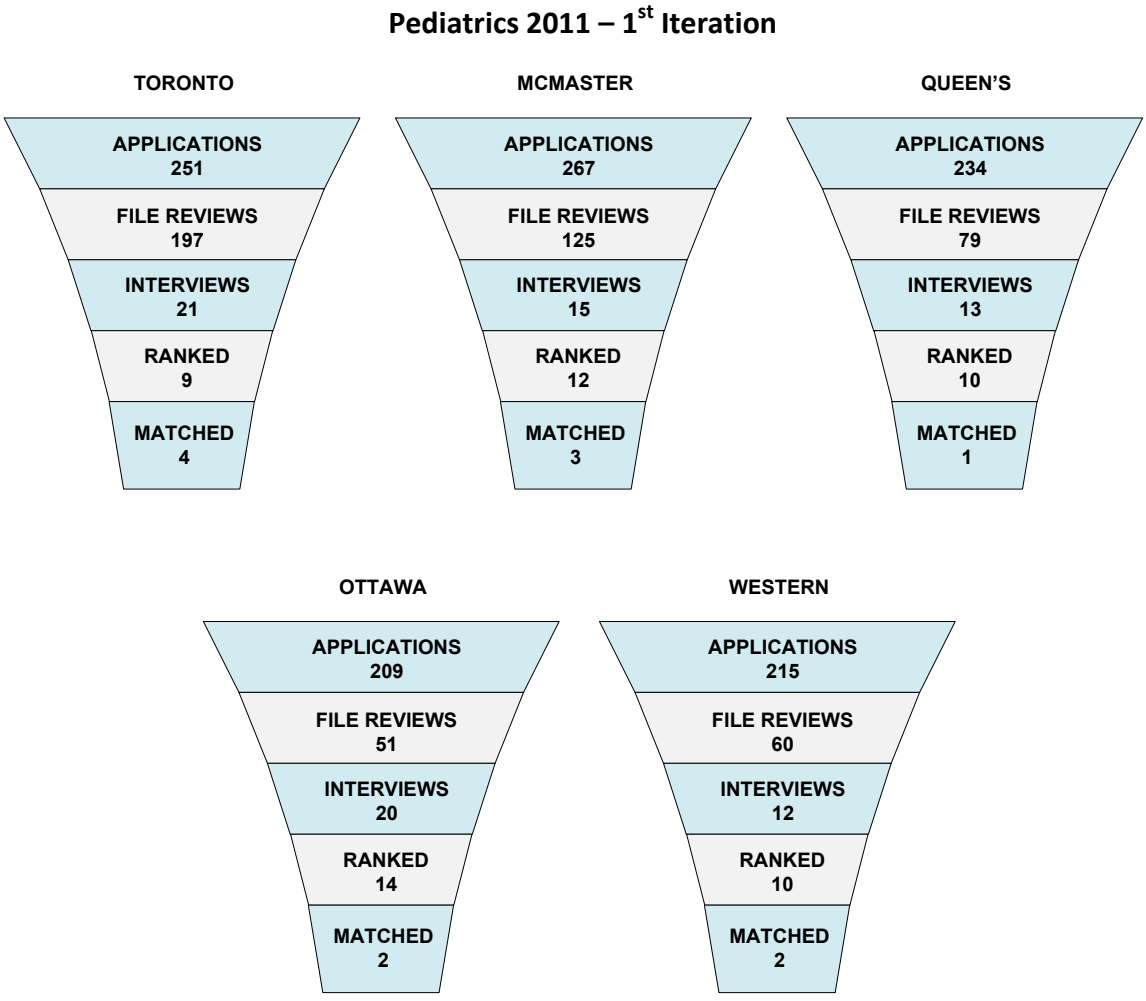
All five schools filled their designated pediatrics positions in the first iteration of the CaRMS match. Based on information provided by the program directors, six (50%) of the positions were filled with Canadians who studied abroad and six (50%) with immigrant IMGs.

TABLE 38

2011 Pediatrics Positions Filled by Category 1st Iteration					
	CSA		Immigrant IMG		TOTAL
	#	%	#	%	#
Western	0	0	2	100	2
Queen's	1	100	0	0	1
McMaster	0	0	3	100	3
Ottawa	2	100	0	0	2
Toronto	3	75	1	25	4
TOTAL	6	50	6	50	12

Source: Interviews with program directors

FIGURE 7



Source: CaRMS data (re application volume) and interviews with program directors

Observations: Pediatrics selection 2011

Pediatrics program directors demonstrated a strong commitment to making the selection process work as effectively as possible. It is noteworthy that some reviewed the files in addition to applying a graduation date filter. This may have helped to identify candidates with strong, recent clinical experience and could help explain the significant number of immigrant IMGs who were ultimately selected. This brings home the potential value of a filter that would provide a more reliable way to identify recent clinical experience, at least for the purpose of identifying candidates who should be looked at more carefully.

The pediatrics programs, as a whole, matched a higher percentage of immigrant IMGs than the other specialty program we examined. It is difficult to draw firm conclusions about why this was the case. However, it appears that the use of Multiple Mini-Interviews by three universities, incorporating exam scores into the initial filtering (as opposed to strict adherence to year of graduation), and the decision of some programs to review all of the files may all have contributed to the match results.

Program directors who used Multiple Mini-Interviews were satisfied with the process and the results, commenting that they found this interview format to be more fair, objective, and consistent. They did not believe the process was more onerous than traditional interviews. Others indicated that they were not planning to move to the Multiple Mini-Interviews. Some saw them as an impersonal way to obtain multiple sampling, but expressed a genuine interest in finding ways to do things better.

Here too, we see value in joint efforts to see if collaboration across the faculties of medicine would be possible. The pediatrics program directors expressed interest in exploring approaches that could improve the selection process, including the sharing of best practices, and we encourage them to do so. More uniformity in the application requirements and greater clarity about how selection decisions are made could be a valuable example of collaboration that benefits the programs and the IMG applicants.

Other programs

During the consultations, we heard from many other programs in addition to the three we examined in detail. Although we did not study the other programs in depth, the information, feedback, and perspectives have informed the findings and recommendations we present in Volume 1 of this report. To supplement our knowledge of the other programs, we reviewed each program's sections on the CaRMS website in August 2011. At that point, some programs had posted their approved text for 2012, others showed 2012 text pending approval, and some still showed text from 2011.

Our conclusion from the review of information on the CaRMS website is that programs are making efforts to ensure that their selection processes and criteria are more transparent. A wide variety of approaches remains, however, and more could be done in this area. We offer a few observations below, including examples of communications that demonstrate progress in becoming more transparent to potential applicants.

Clinical exam

Many programs refer to the clinical exam (whether the new NAC OSCE or the former CE1) as strongly encouraged, recommended, strongly preferred, or mandatory "if available." We did not see any program indicating that the clinical exam was required for all applicants. A few programs appeared to include the clinical exam in their list of mandatory requirements, but they also referred to it elsewhere as being strongly encouraged or preferred. This could lead candidates to be unsure about whether the exam is mandatory and about the consequences of not taking it.

University of Toronto General Surgery is an example of a program that is clear and precise about who is required to take the clinical exam and for whom that requirement will be waived. That program's section of the CaRMS website for 2012 (pending approval) states the following:

- IMGs who graduated from medical school prior to January 2010 (ie: greater than 2 years since graduation), are required to complete the CEHPEA NAC OSCE examination.
- Those who have already written the CEHPEA CE1 (the CEHPEA exam which predates NAC OSCE) need not write the NAC OSCE.
- A minimum score of 70 on NAC OSCE or 550 on CEHPEA CE1 is required. Candidates with scores below this threshold are advised to retake the NAC OSCE and apply in a subsequent year.
- The CEHPEA NAC OSCE score must be available at the time file review opens and should therefore be received by CaRMS by November 24, 2011.
- The CEHPEA NAC OSCE is waived for applicants who graduated after January 2010 (ie: within 2-years of graduation).

Recency

Some programs take care to signal what they are looking for in terms of clinical experience and how they define recency. For example, McMaster Anesthesiology states, in its approved text for 2012, that "[e]vidence and documentation of clinical experience/activity within the previous three years is particularly important." McMaster Urology describes its approach to recency as follows: "Preference will be given to candidates who have graduated from medical school within the past 3 years OR graduation from medical school in

the past 8 years AND active medical practice within the past 3 years. Please note, clinical observerships are not recognized as active medical practice."

Interviews and Ranking

University of Toronto General Surgery says that "interviews are generally offered to the top 15% of applicants." It also states that "[c]andidates are assigned a composite score comprised equally of the file and interview scores. The CaRMS Selection Committee will generate a preliminary rank list on the basis of these scores."

PART C: ADDITIONAL CONTEXT

5. CONCEPTS OF FAIRNESS

"It's our country. We are here to contribute. We came here as knowledge workers."

–Immigrant medical doctor

"We want to be fair and to get the right people."

–Faculty of medicine

"There will always be fewer spots than demand. The issue is a fair process."

–Senior official, Ontario Human Rights Commission

Fairness lies at the heart of the IMG Review. High standards of fairness should be expected from a process that is supported and funded by government and that involves making a fundamentally important decision affecting the lives of those involved.

One way to think about fairness is to articulate and consider policy questions arising out of the specific context of IMGs seeking access to postgraduate positions at Ontario faculties of medicine. Another is to think about fairness from a legal perspective. What standards of fairness have courts and tribunals articulated in cases under the Human Rights Code and the *Charter of Rights and Freedoms*?

This section begins with our sense of the policy questions to keep in mind when assessing potential barriers that affect access to postgraduate positions. We then provide an overview of the how courts and administrative law tribunals have considered claims of discrimination.

POLICY CONSIDERATIONS

In the early stages of the IMG Review, we developed a set of questions to guide us in considering whether the process for IMG selection for postgraduate positions is fair:

- How well does the selection process meet articulated government policy objectives in creating and funding IMG positions? Are the policy objectives transparent?
- Can IMG applicants easily ascertain how to apply for a position, the process that will be used to assess their application, the criteria that will be applied, and the relative weight given to each criterion?
- To what extent are potential applicants able to ascertain the likelihood of success?
- Does the selection process favour or disadvantage any group of applicants within the IMG pool of candidates? If so, is there a clear and well-founded rationale?
- To what extent are selection decisions based on objective, measurable criteria? What efforts are made to structure decisions that involve the exercise of discretion? What measures are in place to ensure like treatment of like cases?
- Has sufficient consideration been given to any special measures that may be necessary to ensure equality of treatment for different groups of applicants?
- How well are those who make selection decisions prepared for this decision-making? Is there sufficient training to prepare them for the unique challenges associated with decisions affecting IMGs? How knowledgeable are decision-makers about how to interpret exam scores and other data in the application?
- To what extent does the selection process take into account the research on effective selection tools and predictors of success?
- Do applicants understand the rationale for negative decisions?
- Are there active efforts to review the results of previous decision-making? Are changes made based on results, best practices, and research? Is there a commitment to continuous learning about the process and what works best?
- What support is available for applicants to assist them with the process, to strengthen their application, or to explore alternate careers?

Another way to look at fairness is to consider the rationale for distinctions between groups. The following are five distinctions between IMGs and graduates of accredited Canadian or US medical schools (CMGs):

- IMGs are ineligible to apply for the larger number and greater variety of first-year residency positions reserved for CMGs in the first iteration of the CaRMS matching process.
- IMGs must take the Medical Council of Canada evaluating exam before they can apply for a postgraduate position.

- IMGs who obtain a residency position must complete a pre-residency or orientation program.
- An IMG is not considered to be a resident until successfully completing the first 12 weeks of the residency period (the Assessment Verification Period).
- A five-year return of service obligation is imposed on IMGs as a condition for acceptance into a postgraduate position.

Not all of these distinctions give rise to fairness concerns. We see no problem with reserving a sufficient number of positions to ensure that CMGs can move to the concluding stages of their medical education. For graduates of medical schools that have not been subject to the North American accreditation process, the evaluating exam is an objective method of determining eligibility to apply. The concept of a pre-residency program is valid, provided that it focuses on training and orientation that will assist IMGs to succeed in residency.

Having a probationary (Assessment Verification) period only for IMGs does raise a concern, since Canadian or US graduates who exhibit problems early on are not subject to swift dismissal from the residency program. A differently structured Assessment Verification Period might be possible, but as we discuss in Volume 1, the effort and resources required to make it work would, we believe, outweigh the benefits.

The rationale for imposing a return of service obligation only on IMGs seems to be based on a "quid pro quo"; in return for getting a residency position, the IMG agrees to practise in an underserviced area. Yet graduates of Ontario medical schools are not asked to "give back" through return of service, nor are CMGs who come to Ontario after graduating from other provinces or the United States. This is a difficult distinction to justify, especially since the same five-year period of return of service is required whether the residency is two years, five years, or more. As we suggest in Volume 1, there is a need to be clearer about the rationale for a return of service requirement, to assess the current requirement against that rationale, and to make changes if necessary.

In theory, the selection process makes no distinction between CSAs and immigrant IMGs, but it is important to look at the impact and outcome of seemingly neutral criteria and processes. This analysis is described in Volume 1, where we look at the impact of an optional clinical exam, the application of initial filters such as date of graduation, and the absence of opportunities for many IMGs to show their competence in a North American clinical setting.

Legal considerations

During our consultations, faculty members spoke about their desire to select IMGs based on legitimate predictors of success and their wish to avoid potential legal challenges. Some IMGs felt that the selection process

discriminated against them, either in relation to graduates of Canadian medical schools or, in the case of immigrant IMGs, in relation to Canadians who had studied medicine abroad. For example, in a focus group with immigrant IMGs, individuals said that they believed the system to discriminate against them on the basis of age. This was based on a perceived preference for CSAs, who, as a group, tend to be younger than immigrant IMG applicants.

A review of reported legal decisions revealed various cases brought by IMGs. Such cases must be viewed with care, since they often involve policies and processes that no longer exist, arose in other provinces with different systems, were decided on legal doctrines that have since been refined or replaced, or do not relate to the issues at stake in the IMG Review. It is probably most instructive to look at how Canadian courts and tribunals consider claims of discrimination under the Canadian *Charter of Rights and Freedoms* and provincial human right laws.

This section of the report looks at the following questions:

1. How do Canadian courts and tribunals define discrimination?
2. What is the legal test to determine if unequal treatment is justifiable?
3. What principles have been applied in cases involving foreign-trained professionals?
4. What legal challenges have been brought by IMGs?

We also refer to an investigation initiated by the human rights commission in Quebec to look at IMG access to postgraduate positions under policies in place in that province, and to two decisions of the Ontario Human Rights Tribunal that relate to other professions.

Note re legal considerations…

We did not conduct a thorough review of all applicable legal decisions, nor should our analysis be relied upon in assessing legal risk or potential legal action.

How do courts and tribunals define discrimination?

Courts and tribunals are often called upon to consider claims of unfair distinctions based on membership in a group or as between one group and another. However, not all distinctions or claims of unfairness amount to discrimination in the legal sense. A review of leading cases under the Canadian

Charter of Rights and Freedoms (the *Charter*) and human right laws[1] reveals legal principles for determining when a distinction amounts to discrimination and when reliance on certain criteria for selecting one person over another is discriminatory.

Section 15 of the *Charter* states that everyone has the right to equal protection and equal benefit of the law without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability. Other similar or "analogous" grounds of discrimination have been recognized, such as sexual orientation,[2] marital status,[3] and citizenship.[4] The *Charter* applies to government, including government policies, programs, and laws.

In addition, human rights statutes such as Ontario's *Human Rights Code* state that everyone has the right to equal treatment with respect to services and facilities (which includes educational services), employment, contracts, and membership in trade unions and self-governing professions, without discrimination based on listed grounds. In Ontario, the relevant prohibited grounds of discrimination are race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status, disability, record of offences (only in regard to discrimination in employment), and receipt of public assistance (only in regard to discrimination in housing). The *Human Rights Code* applies not only to government, but also to the broader public sector (e.g., universities and hospitals) and private entities.

Not every distinction is considered discriminatory under the law. The Supreme Court of Canada has established a two-part test for assessing an equality rights claim under the *Charter*: (1) does the law create a distinction, whether intentional or not, on an enumerated or analogous ground and (2) does the distinction create a disadvantage by perpetuating prejudice or stereotyping?[5] To establish this, the person making the claim must first show that he or she has been denied a benefit that has been given to others or carries a burden that others do not, by reason of a personal characteristic that falls under a prohibited ground of discrimination. If the person is able to show this, then at

---

[1] The focus of this section is on discrimination; however, there have also been legal challenges by foreign-trained physicians citing unfairness or unreasonableness in the decision-making process by the relevant authority (e.g., a College of Physicians and Surgeons). These decisions turn on their own facts, but those reviewed suggest that courts will be highly deferential to the decision-making of expert licensing bodies.

[2] *Vriend v. Alberta*, [1998] 1 S.C.R. 493.

[3] *Miron v. Trudel*, [1995] 2 S.C.R. 418.

[4] *Andrews v. Law Society of British Columbia,* [1989] 1 S.C.R. 143.

[5] Although this test originates from *Andrews*, it has been confirmed by the Supreme Court in decisions such as *R. v. Kapp*, [2008] 2 S.C.R. 283, *Ermineskin Indian Band and Nation v. Canada*, [2009] 1 S.C.R. 222 and most recently in *Withler v. Canada (Attorney General)*, [2011] 1 S.C.R. 396.

the second part of the test the question is whether the distinction between the person making the claim and others discriminates by perpetuating disadvantage or prejudice or by stereotyping in a way that does not correspond to actual characteristics or circumstances.

The Ontario Court of Appeal has said that this same two-step approach to discrimination under the *Charter* applies to claims of discrimination under the *Human Rights Code*.[6] However, the Court also noted that in most human rights cases, if the claimant shows a distinction based on a prohibited ground that creates a disadvantage, it is not necessary to have independent evidence of stereotyping or the perpetuation of prejudice. As a result, in the human rights context, where a claimant demonstrates a "distinction causing disadvantage," this is generally enough to establish a "*prima facie* case." The respondent must then bring itself within a defence under the *Code* to avoid a finding of discrimination.

The courts have emphasized the importance of substantive equality. Substantive equality is concerned with the impact of laws, policies, or actions on disadvantaged groups. It recognizes that inequality can result not only from distinctions that, on their face, treat people unequally. Inequality can also result from neutral rules, requirements, or treatment that do not directly draw distinctions based on prohibited grounds but nevertheless have an adverse impact on particular individuals or groups because of their personal characteristics. Substantive equality also recognizes that different treatment of individuals based on their actual needs and circumstances may not be discrimination.[7]

For example, in *Eldridge v. British Columbia (Attorney General),*[8] the Supreme Court applied a substantive equality approach and ruled that discrimination may result from a failure to take positive steps to ensure that disadvantaged groups are able to benefit equally from services offered to the public. In particular, in order to have equal access to medical services, substantive equality required the government to provide sign-language interpretation to hearing impaired hospital patients, where necessary for effective communication.

The Supreme Court recognized that discrimination can arise on a system-wide or institutional level; *CN v. Canada (Canadian Human Rights Commission).*[9] This

---

[6] *Ontario (Disability Support Program) v. Tranchemontagne*, 2010 ONCA 593 (CanLII) at para. 90.

[7] See *Withler,* note 5.

[8] [1997] 3 S.C.R. 624.

[9] [1987] 1 S.C.R. 1114.

type of "systemic discrimination"[10] is discrimination, often unintentional, that results from procedures or attitudes that that have the effect of limiting access to opportunities. Often, these are established procedures or systems that create barriers that result in the underrepresentation of certain groups, typically in employment. In the CN case, the systemic discrimination in recruitment, hiring, and promotion resulted in very low levels of women in certain "blue-collar" positions. The Court noted that the hiring and promotion policies of CN amounted to the systematic denial of women's equal employment opportunities.

What is the legal test to determine if unequal treatment is justifiable?

In cases that arise under the *Charter*, if a s. 15 violation is found, the government may be able to establish, pursuant to s. 1, that the limit on equality is nevertheless a reasonable limit in a free and democratic society. For example, in *Lavoie v. Canada*[11] the majority of judges of the Supreme Court found that giving preference to Canadian citizens when hiring for the federal public service did breach s. 15 equality rights, but also concluded that this was a reasonable limit on equality rights under s. 1 of the *Charter*. Canada's policy objectives, including enhancing the value of Canadian citizenship and encouraging naturalization, were sufficiently important to justify the discrimination.

Under the *Human Rights Code*, where discrimination is found, the organization or institution against which the claim is made may establish a defence to the discrimination by showing that the policy, rule, or requirement that resulted in unequal treatment is a legitimate standard, or a *bona fide* requirement. In the *Meiorin*[12] decision, the Supreme Court of Canada set out a three-part test to determine whether a standard that results in discrimination can be justified as a reasonable and *bona fide* one. The organization or institution must establish on a balance of probabilities that the standard, factor, requirement, or rule

---

[10] The Ontario Human Rights Commission's *Policy and Guidelines on Racism and Racial Discrimination* (June 9, 2005) adopts the following definition for systemic discrimination:

> Systemic or institutional discrimination consists of patterns of behaviour, policies or practices that are part of the social or administrative structures of an organization, and which create or perpetuate a position of relative disadvantage for racialized persons. These appear neutral on the surface but, nevertheless, have an exclusionary impact on racialized persons. However, systemic discrimination can overlap with other types of discrimination that are not neutral. For example, a discriminatory policy can be compounded by the discriminatory attitudes of the person who is administering it.

[11] [2002] 1 S.C.R. 769.

[12] *British Columbia (Public Service Employee Relations Commission) v. BCGSEU*, [1999] 3 S.C.R. 3.

1. was adopted for a purpose or goal that is rationally connected to the function being performed;
2. was adopted in good faith, in the belief that it is necessary for the fulfillment of the purpose or goal; and
3. is reasonably necessary to accomplish its purpose or goal, in the sense that it is impossible to accommodate the claimant without undue hardship.

The ultimate issue is whether accommodation has been incorporated into the standard up to the point of undue hardship. In this analysis, the procedure used to assess and achieve accommodation is as important as the substantive content of the accommodation.

WHAT PRINCIPLES HAVE BEEN APPLIED IN CASES INVOLVING FOREIGN-TRAINED PROFESSIONALS?

To date, there has been little willingness on the part of courts or tribunals to strike down policies, requirements, or decisions related to foreign-trained persons. However, in one British Columbia decision,[13] a distinction that favoured graduates from countries with an "Anglo-Saxon" tradition was found to be based on assumptions about the merits of the British education system and therefore discriminatory on the basis of place of origin.

Many of the decisions to date have dealt with policies no longer in place or with issues unrelated to those being considered in the IMG Review. Nonetheless, they provide some insight into potential claims that could be made and how these challenges might be handled by Ontario courts or tribunals. It should be noted that the cases are very fact-driven; the evidence marshalled in support of the particular claim is significant in determining its outcome. As well, many of the early decisions failed to apply a substantive equality approach as required by the Supreme Court of Canada. A different approach to the analysis may well have resulted in a different outcome.

As explained above, one of the first considerations in any legal challenge is whether a distinction is based in a prohibited ground of discrimination. If a link to a ground is not established, no discrimination will be made out. Therefore, many of the decisions discuss whether there is a link between place of education and a prohibited ground of discrimination such as place of origin. With regard to persons who originate from Canada but who receive their medical education abroad, decision-makers have found that there does not appear to be a sufficient link to a human rights ground.[14] For persons who

---

[13] *Bitonti v. College of Physicians and Surgeons of British Columbia*, [1999] B.C.H.R.T.D. No. 60.

[14] See for example, *Iqbal v. Ontario (Health and Long-Term Care)*, 2010 HRTO 2351 (CanLII) and *Ramlall v. Ontario,* (11 February 2005), (Ont.S.C.J.), aff'd [2005] O.J. No. 2836 (C.A.). This may also be true of a person born in one foreign country and who

receive their education in their country of origin, there appears to be some willingness to accept that place of education may serve as a "proxy" for place of origin, since there will often be a strong correlation between place of education and where someone comes from.[15] However, this is not always the case, with some decision-makers refusing to make the link between place of education, even when correlated with country of origin, and a prohibited ground of discrimination.[16]

Even if a prohibited ground of discrimination is found to be engaged, to date, decision-makers have been willing to accept that there are differences between IMGs and other graduates that allow for legitimate distinctions to be made between them. Courts and tribunals have tended to defer to the expertise of the regulating body in determining what is required for IMGs or other foreign-trained professionals to qualify to practise in Canada, provided the determination is not based on assumptions about the merits of a particular education system.[17]

Decision-makers have noted the wide variation in the medical and other professional programs around the world and the challenges in evaluating the competence of their graduates. However, there is still an expectation that some individualized assessment of the actual training received or the equivalency of the qualification will be conducted. Where there are additional costs associated with assessing foreign credentials, at least one case has found that charging higher application fees to foreign graduates is not discriminatory.[18]

---

obtains his or her medical training in another foreign country that is unconnected to the place of his or her birth.

[15] See *Bitonti*, note 13, and *White v. National Committee on Accreditation*, 2010 HRTO 1888 (CanLII).

[16] For example *Safai-Naini v. Quebec (Attorney General)*, [2002] Q.J. No. 1392. (Que. Sup. Ct.) and *Durakovic v. Canadian Architectural Certification Board*, 2011 HRTO 333 (CanLII). In both decisions, the decision-maker noted that Canadians who graduate from foreign schools would be in exactly the same position as the foreign-born individual.

[17] There have also been cases where foreign-trained doctors have challenged decisions on the basis of unreasonableness rather than discrimination. For example, in *Devlin v. College of Physicians and Surgeons of British Columbia,* [2002] B.C.J. No 1612., a psychiatrist who graduated from University of Dublin medical school and who had failed the licensing exam seven times filed an application for judicial review seeking a court order compelling the College to register him on its special register. The Court found the College's decision not to register Dr. Devlin reasonable. The evaluation of his credentials, the weight to be given to the opinion of his peers, and his repeated failures were matters within the College's expertise, with which "courts must be very hesitant to interfere."

[18] *Durakovic v. Canadian Architectural Certification Board*, note 16.

In short, courts and tribunals have not found discrimination if (a) the assessment of foreign credentials or the process that foreign graduates are required to go through to obtain a licence is not based on assumptions about the quality of programs in other jurisdictions, and (b) there is some individualized assessment of the actual training received or the equivalency of the qualification. However, this may not always be the case if a requirement that has an adverse effect on IMGs cannot be shown to be related to legitimate difficulties in evaluating programs from around the world or actual differences between IMGs and Canadian graduates. For example, the *Bitonti* Tribunal did note that issues such as the heavy reliance on reference letters from known Canadian doctors raise the potential for unfairness.[19]

In two cases involving applications for certification by foreign-trained teachers, the College's insistence on original records from their country of origin was found to discriminate against them, as they were unable to obtain these documents because they had fled from their countries and come to Canada as Convention refugees. The College was unable to demonstrate that it could not accommodate these applicants without undue hardship.[20]

It is therefore important to consider whether requirements that adversely impact IMGs can be shown to be legitimate and necessary, including whether there has been accommodation to the point of undue hardship. In this analysis, the approach in other Canadian provinces may be relevant. Discrepancies in the effects on Canadian-born and foreign-born IMGs may also be highly relevant. If Canadian-born IMGs are more successful, this could be indicative of discriminatory biases in the system that are unrelated to place of education.

In some instances, IMGs have failed to be selected for or to succeed in a program, or to pass an exam, and have argued that this either reflects systemic discrimination against foreign-trained individuals or biases based on human rights grounds. Courts have tended to dismiss such claims. Although these cases turn on their own facts, the decision-makers in the cases reviewed all concluded that these failures were due to the shortcomings of the individual and not problems with the program or evaluator bias.[21] The fact that other foreign-trained persons have been successful with regard to the same program

---

[19] In a similar vein, in the housing context, the Human Rights Tribunal of Ontario (HRTO) has found that a landlord's policy of rejecting prospective tenants who lack rental, employment, or credit history in Canada disadvantaged newcomers. As the landlord had not shown that these practices were legitimate and *bona fide*, discrimination was found; *Ahmed v. 177061 Canada Ltd (Shelter Canadian Properties Ltd.)*, 2002 CanLII 46504 (ON HRT).

[20] *Siadat v. Ontario College of Teachers,* 2007 CanLII 253 (ON SDC); *Nemati v. Ontario College of Teachers*, 2010 HRTO 1808 (CanLII).

[21] See *Neiznanski v. University of Toronto* (1995), 24 C.H.R.R. D/187 (Ont. Bd.Of Inquiry) and *Zhang v. Queen's University*, 2010 HRTO 2488 (CanLII).

or exam has been cited in support of the finding that the individual was assessed on his or her own merits but did not meet legitimate requirements. As well, objective and documentary evidence that demonstrates deficits in knowledge or clinical skills has been an important consideration for courts and tribunals in concluding that the individual who filed the claim did not experience discrimination.[22]

It is worth noting, however, that the outcome could be different in a case with evidence of highly subjective and culturally biased decision-making criteria. For example, a Tribunal found discrimination in employment when a Pakistani Canadian man was not given a high school teaching job because a White woman was perceived to be more "enthusiastic" and therefore to have greater potential to motivate students. The Pakistani Canadian candidate was enthusiastic, but simply demonstrated this in a different manner. The Tribunal found discrimination because of the employer's failure to take into account cultural differences in communication styles and interpersonal skills.[23]

It may also be different if the challenges in succeeding in the program or on the exam could be shown to be systemic; i.e., affecting not just the individual in question. For a discussion of systemic discrimination, see the Ontario Human Rights Commission's *Policy and Guidelines on Racism and Racial* Discrimination at www.ohrc.on.ca.

There have been decisions that have considered challenges by foreign-trained doctors who seek to be exempted from a commitment to practise medicine in an underserviced area. In both cases, one from Quebec (*Forghani c. Québec (Procureur général))* and another from Saskatchewan (*Kirsten v. College of Physicians and Surgeons of Saskatchewan)*, the commitment was made through a "special program" which required candidates to agree to practise medicine in an underserviced area for a number of years in exchange for access to certain benefits. In both cases, the court refused the request to be exempted from the requirement. Both courts rejected the argument that the physician's *Charter* rights were violated.[24] In each decision, the court noted that the physician freely entered into the agreement and accepted its conditions in exchange for

---

[22] For example, in one case the Tribunal heard specific examples from one of the program evaluators, who described how the applicant's examination of a newborn was observed to be deficient. The Tribunal was also influenced by the documentary evidence, which consistently showed the applicant failing to meet expectations; *Zhang v. Queen's University*.

[23] *Quereshi v. Central High School of Commerce (No. 3)* (1989), 12 C.H.R.R. D/394 (Ont. Bd. Inq.). For a more detailed discussion of subtle forms of racial discrimination, please see the Ontario Human Rights Commission's *Policy and Guidelines on Racism and Racial Discrimination*: www.ohrc.on.ca.

[24] The *Charter* rights at issue in the two cases were mobility rights (s. 6 of the *Charter*), the right to life, liberty and security of the person (s. 7) and equality rights (s. 15).

benefits in accessing the medical profession that would have not otherwise been available.[25]

It may be significant that in the Saskatchewan case, foreign doctors had a choice of either entering into a specific type of agreement with restrictions on location of practice or pursuing the traditional means of obtaining a licence, without conditions. In the Quebec case, the evidence showed that there was an overabundance of physicians in the province, but a lack of representation in rural areas. Therefore, while the law did treat the applicant differently from North American graduates, it did not amount to discrimination under s. 15 of the *Charter* because the program in fact provided a benefit (it allowed the government to open up additional positions for foreign-trained graduates), and was a necessary measure to deal with the unequal distribution of doctors across the province. Therefore, it should be noted that where IMGs must enter into such agreements in order to be licensed, and non-IMGs are not required to, it may be important to be able to explain whether IMGs are obtaining a benefit or are experiencing a burden as a result of the requirement, and to demonstrate a public policy reason for treating IMGs differently.

Finally, as far as we are aware, there are no cases that have found that a limited number of positions or a lack of programs to assist foreign-trained physicians is discriminatory.

Legal challenges by IMGs

The following is a brief summary of some of the legal challenges brought by IMGs, with a focus on Ontario case law.

While to date none of the Ontario legal challenges has been successful, the cases often turn on their own facts and the strength of the evidence presented, in particular the justification for the policy or practice being challenged. As well, not all decision-makers have applied the current legal test for discrimination.

In a 1988 decision, *Jamorski v. Ontario (Attorney General),*[26] the Ontario Court of Appeal held that limitations on access to postgraduate training for IMGs did

---

[25] In *Kirsten v. College of Physicians and Surgeons of Saskatchewan*, 146 Sask. R. 161 (Q.B.), the Court found that the physician, who was originally from South Africa, had a choice between obtaining the necessary qualifications that would have allowed him to obtain a licence without conditions or applying for a conditional *locum tenens* permit, which required him to commit to five years of service in an underserviced community in Saskatchewan. Having chosen the latter, to obtain a benefit he considered advantageous, he had waived his *Charter* rights (assuming, without deciding, that his mobility rights were violated). In *Forghani c. Québec (Procureur général)* (1997), 155 D.L.R. (4th) 599 the Quebec Court of Appeal noted that the while there was differential treatment, applying the s. 15 case law from the Supreme Court of Canada, it did not amount to discrimination. Section 7 of the *Charter* was also not violated as the right to life, liberty, and security of the person does not include the right to practise a profession.

not violate s. 15 of the *Charter*. At the time, graduates of unaccredited medical schools had to compete for access to a limited number of spaces in a pre-internship program, while graduates of accredited schools had direct access to a different and larger pool of internship positions. The Court found that that the graduates of the unaccredited medical schools were not "similarly situated" to graduates of accredited schools, noting that their medical education was not known to, or monitored by, the relevant Ontario authorities.[27] Therefore the system under challenge was found to be a "sophisticated, *bona fide* system of assessing medical schools." It should be noted that *Jamorski* was decided before the Supreme Court set out its analysis of what constitutes discrimination under s. 15 of the *Charter*.[28] While this case is interesting from a historical perspective, great care must be taken in relying on it.

In *Beattie v. Ontario (Minister of Health)*,[29] the Ontario Court of Appeal heard challenges to changes to the medical licensing regulation launched by two Canadians studying medicine in Ireland. When they studied abroad, the relevant regulation named the United States and several Commonwealth countries as equivalent. However, the regulation had been changed to distinguish between accredited North American schools and all other medical schools. Their claim was dismissed. As *Jamorksi* had found the new Regulations constitutional, the Court had no power to rewrite or amend them to make special provision for the appellants, even though they had been in the middle of their medical studies abroad when the change took effect.

In *Ramlall v. Ontario*, a civil action by an IMG against the Ontario government was dismissed by the Court on the basis that it was plain and obvious the claim could not succeed. In part, the judge relied on *Jamorski* to conclude that the law with regard to access to the medical residency training program was "settled" and the facts did not disclose a breach of the *Charter*.

In contrast, in a 1999 decision the British Columbia Human Rights Tribunal found that the College of Physicians and Surgeons of BC and the Ministry of Health had discriminated against five graduates of foreign medical schools in

---

[26] (1988), 64 O.R. (3d) 162 (C.A.).

[27] The record in the case established that the reasons for implementing the pre-internship program included, in particular, a wide variation in the levels of competence of graduates of unaccredited medical schools.

[28] In *Bakht v. Newfoundland Medical Board*, [1986] N.J. No. 149(Nfld. C.A.), the Court of Appeal followed a similar approach and dismissed the argument that the categorization of medical schools was discriminatory without any real analysis. The Court accepted that the fact that a professional body requires additional training for graduates of foreign universities "merely reflects differences in approach and technique and certainly cannot be deemed to be discriminatory in any way." This case was also decided before the Supreme Court's decision in *Andrews*.

[29] [1988] O.J. No. 220 (C.A.).

Italy, Romania, Russia, and the Philippines; *Bitonti v. College of Physicians and Surgeons of British Columbia*. At the time, the BC College had a system that distinguished between applicants training in Category I countries (North America and the Commonwealth) and Category II countries (all others). Category II applicants were required to do two years of internship in a Category I country hospital, one of which had to be in Canada. Category I applicants had to do only a one-year internship in an approved hospital.

The Tribunal accepted a "high correlation between place of training and place of origin." The more onerous requirements placed on Category II applicants resulted in discrimination on the basis of place of origin. The Tribunal found that the distinction between Category I and Category II countries "was based on assumptions about the merits of the British education system" and that the College had failed over a period of some 40 or 50 years "to have made any effort to obtain an understanding of the medical education system anywhere else in the world." It further noted the absence of any mechanism by which graduates from Category II schools could demonstrate that their training met the standards demanded of Canadian doctors. The Tribunal refused to follow *Jamorski*, noting that in light of the Supreme Court of Canada's subsequent s. 15 decisions, *Jamorski* can no longer be considered sound law.

Although *Bitonti* is significant as a case where a Tribunal found discrimination against foreign-trained doctors, it largely turns on its facts, in particular, the assumptions associated with an "Anglo-Saxon" education and the lack of a means for those trained in other countries to demonstrate the equivalency of their qualifications.[30] However, it clearly demonstrates that discrimination is much more likely to be found where stereotypical notions about quality of education or qualifications are at play.

In 2007, the Human Rights Tribunal of Ontario (HRTO) considered a complaint that Ontario's system of allocating funded medical residency positions discriminated on the basis of place of origin, race, creed, ancestry, and ethnic origin; *Marakkaparambil v. Ontario (Health and Long-Term Care*.[31] The HRTO refused to rely on *Jamorski* and *Ramlall* to dismiss the complaint without a full hearing. The HRTO noted that in *Marakkaparambil* the challenge focused not on place of medical degree, but on the relationship between that factor and the protected ground of place of origin. In addition, the Courts in *Jamorski* and

---

[30] The foreign-trained doctors were only successful in part. For example, the decision found that hospitals that refused internships to all non-Canadian trained graduates had not engaged in discriminatory conduct. The Tribunal noted that although foreign-trained graduates had virtually no chance of being selected, this was based on the hospitals' legitimate goal of seeking out the best candidates. The Tribunal accepted the hospitals' argument that they were not in a position to properly evaluate foreign-trained graduates.

[31] 2007 HRTO 24 (CanLII).

Ramlall had not applied the discrimination analysis set out in the Supreme Court of Canada jurisprudence. It was therefore not "plain and obvious" that the *Marakkaparambil* complaint could not succeed. This case was settled.

In a recent decision, the HRTO dismissed a claim of discrimination by a Canadian citizen who was educated abroad; *Iqbal v. Ontario (Health and Long-Term Care).*[32] The applicant did not appear at the hearing. There were two aspects to the applicant's claim. First, the applicant claimed that as an IMG, he was initially restricted from applying for the residency of his choice. Although the restrictions were eventually lifted, he argued that his applications were unsuccessful because the restrictions were lifted very late in the process for him. The HRTO found that there was no evidence before it to support this aspect of his discrimination claim.

Second, the applicant claimed discrimination on the basis that, as an IMG, he was required to enter into a return of service agreement with the Ministry in exchange for funding his residency.[33] The HRTO found that evidence from the applicant was needed to make the link between the place where he was educated and his ethnic origin or place of origin. Other than the fact that the applicant stated that he was a Canadian citizen, there was no evidence related to place of origin or ethnic origin. There was nothing to support an inference that any distinctions between IMGs generally, or the applicant in particular, were a proxy for discrimination on the basis of place of origin or ethnic origin. The Application was dismissed.

In *Zhang v. Queen's University*, the HRTO dealt with a different type of discrimination claim brought by an IMG. Rather than a challenge to a policy or regulation related to IMGs, the Tribunal heard a claim alleging individual discrimination in how an IMG was evaluated in the 12-week Assessment Verification Program (AVP). Dr. Zhang received her medical training in China. She self-identified as a woman over the age of 50, from China, who was single-parenting her son at the relevant time. She claimed that her failure to successfully complete the 12-week AVP in family medicine at Queen's University resulted from discrimination based on race, place of origin, age, and family status.

After hearing the evidence of the applicant and four witnesses for the respondent, including the applicant's three evaluators during the program and the AVP program director, the Tribunal concluded that there was insufficient

---

[32] 2010 HRTO 2351 (CanLII).

[33] The Tribunal noted that although not essential to its reasons, this initiative is aimed at improving access to medical services in underserviced communities and also provides training opportunities to participants (including medical graduates other than IMGs) to assist them in meeting the requirements of the College of Physicians and Surgeons of Ontario.

evidence to support a connection between the applicant's failure to succeed in the program and any prohibited grounds of discrimination. The Tribunal decision-maker noted the inability of the applicant to communicate coherently during the hearing, despite having a very good command of the English language. As a result, it was not possible to get the applicant to provide the Tribunal with the background necessary to fully evaluate her allegations. As well, the Tribunal gave weight to the documentary evidence which consistently showed that the applicant was below average, with an insufficient knowledge base and clinical skills.

While the applicant was being closely monitored and was given additional support, this was not due to her place of origin or other personal characteristics, but rather because of a deficit in her clinical skills. Finally, the Tribunal noted that everyone in the AVP program comes from a place other than Canada. While this does not mean that discrimination in the program cannot exist, the applicant in this case was unable to prove that she experienced discrimination because of her race, place of origin, age, and family status.

In an interim decision dealing with procedural issues, namely delay and abuse of process,[34] the HRTO considered the claim of a doctor trained in the United States. In *Keith v. College of Physicians and Surgeons of Ontario,*[35] the applicant alleged that the failure of the College to individually assess his qualifications as a specialist between 1992 and 2007, and its reliance on specialist certification by the Royal College of Physicians and Surgeons of Canada, amounted to discrimination on the grounds of place of origin and citizenship because it undervalued his American training. The applicant also claimed that reliance on the Royal College process was discriminatory because it disadvantages older, foreign-trained physicians.

Moreover, the applicant alleged that after he was recognized as a specialist by the College in 2007 under its new process, the manner in which he is permitted to describe his specialty, or in which the Ontario College describes his specialty, e.g., on its website, distinguished between him and Royal College-certified specialists, and amounted to discrimination on the basis of place of origin, citizenship, and age.

The Tribunal dismissed the allegations about events pre-dating 2007 on the basis of delay (i.e., the applicant had not filed his claim of discrimination within one year of this alleged discrimination as required under the *Human Rights*

---

[34] The adjudicator refused to dismiss the application based on allegations of abuse of process resulting from a settlement, which was not clearly related to the claims made under the *Code.*

[35] 2010 HRTO 2310 (CanLII).

Code). As for the post-2007 policies and practices, the Tribunal found that they were part of a series of incidents that related to the issue of how the applicant's credentials were described to the public once he was granted College recognition of his specialty. Therefore his allegations of discrimination in that regard were timely.

There is no decision on the merits of this case as yet (and if the case is settled, there may never be). However, it is interesting insofar as it illustrates another type of discrimination claim that may be brought by a foreign-trained physician, namely how foreign specialists may describe themselves or be described by the provincial regulatory college. It is also an example of a discrimination claim based on the ground of age.

Legal challenges in other professions

Two Ontario human rights claims made by foreign-trained lawyers and architects are briefly summarized below. These cases could potentially be relevant to human rights issues affecting IMGs.

In *White v. National Committee on Accreditation*, a Russian lawyer challenged a decision of the Committee that assesses legal training and professional experience obtained outside of Canada. The Committee had not recognized the applicant's Russian education and training as equivalent to legal training provided in a Canadian law school. The HRTO was prepared to assume, without deciding, that the applicant experienced adverse effect discrimination because of her place of origin (Russia) and ethnic origin (Russian). However, the Tribunal applied the three-step test from *Meiorin* (outlined above) to conclude that the discriminatory requirement was nevertheless justified as a *bona fide* and reasonable one.

The Tribunal found that the National Committee had made sufficient efforts to accommodate foreign-trained lawyers and therefore the applicant did not experience discrimination. In particular, the Tribunal found that, as required by the *Meiorin* test, the process provides for individualized assessments of foreign-trained lawyers who apply for a Certificate of Equivalency. Rather than assumptions that the Canadian legal education system is better than that of other jurisdictions, assessments are based on research and evaluation of the legal systems in other jurisdictions and the legal training and professional experience provided in those jurisdictions.

This decision suggests that evaluation standards will be found to be reasonable and justified if the education and training of international graduates is assessed on an individualized basis having regard to the actual training received, rather than assumptions about the quality of education in particular countries.

In a subsequent decision concerning a foreign-trained architect,[36] the HRTO reached a similar conclusion. The process to evaluate the academic credentials for architects who graduated from unaccredited schools was not discriminatory. The respondent did not base the assessment on assumptions about the academic credentials; rather, it conducted an individual assessment of academic qualifications to see if they meet the requirement of the Canadian Educational Standard for Admission to Provincial Architectural Associations in Canada. The higher certification fee for international applicants was also not discriminatory as the time required to assess international qualifications justifies a higher fee.

Quebec Human Rights Report, 2010

In 2010, the Quebec Human Rights Commission released its report after a systemic investigation of the IMG postgraduate selection process.[37] The Commission was concerned about reports that approved postgraduate training positions in Quebec were being left vacant, notwithstanding the number of IMG physicians whose degrees had been recognized as equivalent by the Collège des medecins. In 2007, 85 positions remained vacant in the four Quebec universities that were the focus of the investigation, including 62 in family medicine. By contrast, in Ontario in 2011, IMGs filled 221 first-year residency positions and only 11 positions were left unfilled across the entire system. This is an example of why care must be taken in considering how the Quebec findings might apply to the Ontario context since the investigation focused on circumstances unique to Quebec.

The Quebec investigation was designed to verify, for each stage of the selection process, whether there were elements likely to have a discriminatory impact on access to the postgraduate training program in medicine for IMGs, i.e., persons who had earned their medical degree outside Canada and the United States, based on race, ethnic or national origin, age, and sex. The Commission's analysis of the data led it to conclude that there was a clear relationship between the ethnic origin of the candidate and his or her choice of place of training: in almost every case, the candidate had undertaken medical training within the geographical areas of his or her birth.

The Commission found that there were several elements in the selection process that had a discriminatory effect on IMGs. These included reliance on the length of time away from practice or studies, knowledge of the Quebec medical system, the difficulty of assessing foreign training or practice, and

---

[36] *Durakovic v. Canadian Architectural Certification Board*, 2011 HRTO 333 (CanLII).

[37] *Inquiry into discrimination against International Medical Graduates,* Commission des droits de la personne et droits de la jeunesse (Quebec Human Rights Commission), Resolution CIM-559-5.1.1, Released November 10, 2010.

reliance on non-validated selection criteria and evaluation tools. The Commission also felt that IMGs had less access to essential information that was more readily available to Quebec graduates. Finally, the Commission found a lack of adequate support measures for IMGs.

The Commission made the following recommendations:

- **To the universities**
  - Revise the process and selection criteria to ensure real access for IMGs
  - Set up a validation process for the criteria and selection tools to ensure an objective and representative assessment process
  - Develop a support program, including information sessions, preparatory internships, and other resources, to promote better knowledge of medical practice in Quebec
  - Educate teachers and others who deal with IMGs as to their professional reality and culture
  - Report periodically to the government as to the measures established to promote the integration of IMGs
- **To the Ministère de la Sante et des Services sociaux**
  - Take steps to ensure that the number of positions set for the program is respected by the universities and that all the positions are filled
  - Make the issues of IMGs a priority in order to ensure and promote implementation of measures to improve their integration and success in the system, in collaboration with the College and universities
- **To the College des medecins du Quebec**
  - Ensure that the universities give full recognition to the equivalence of degrees obtained by IMGs
- **To all respondents**
  - Conserve data concerning the follow-up of candidates and make it available to the public
  - Establish a centralized and reliable information system regarding the admission and selection process for IMGs
  - Collaborate to develop a preparatory training course or supervision period of six months to provide better access to postdoctoral training for IMGs

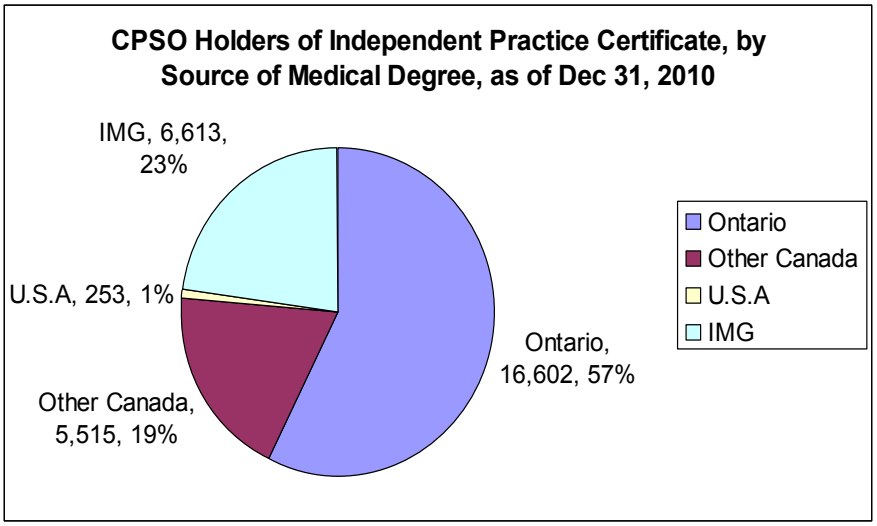
6. Ontario context

IMGs practising or training in Ontario

Independent practice certificates

According to the College of Physicians and Surgeons of Ontario, 28,983 physicians held an independent practice certificate in Ontario as of December 31, 2010. Of those, 6,613 (23%) were international medical graduates.

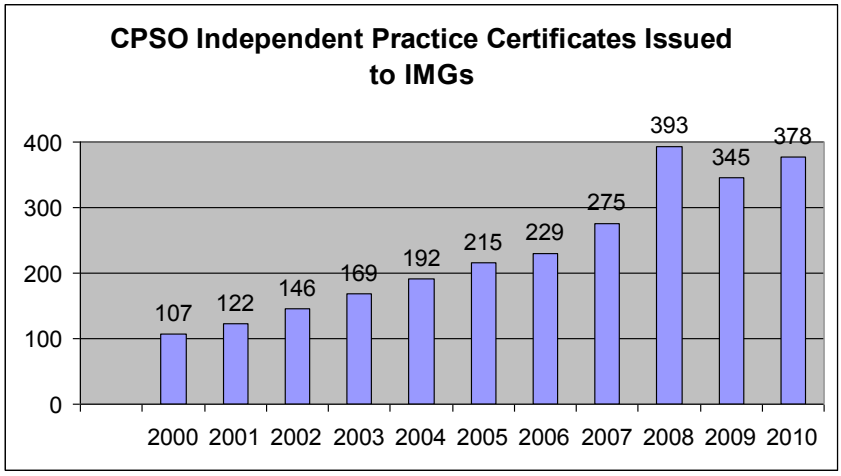
Figure 8



Source: Data provided by College of Physicians and Surgeons of Ontario; used with permission.

During 2010, CPSO issued 378 independent practice certificates to IMGs. This is more than three times the number issued in 2000.

Figure 9



Source: Registering Success, 2010 Registration Report, College of Physicians and Surgeons of Ontario, May 2011; used with permission.

CPSO's Registration Report highlights the following attributes of the 378 IMGs who received independent practice certificates in 2010:

(a) **49% most recently held a postgraduate education certificate.** While those with postgraduate certificates include IMGs doing clinical fellowships in a subspecialty as a "visa fellow," we assume that the vast majority of the 185 individuals were former IMG residents who had completed a residency at an Ontario faculty of medicine.

(b) **21% most recently held a restricted licence.** Indications are that the majority of these restricted certificates were issued under CPSO's "Restricted Certificates" policy to eligible individuals who had not yet passed their national certification exams.

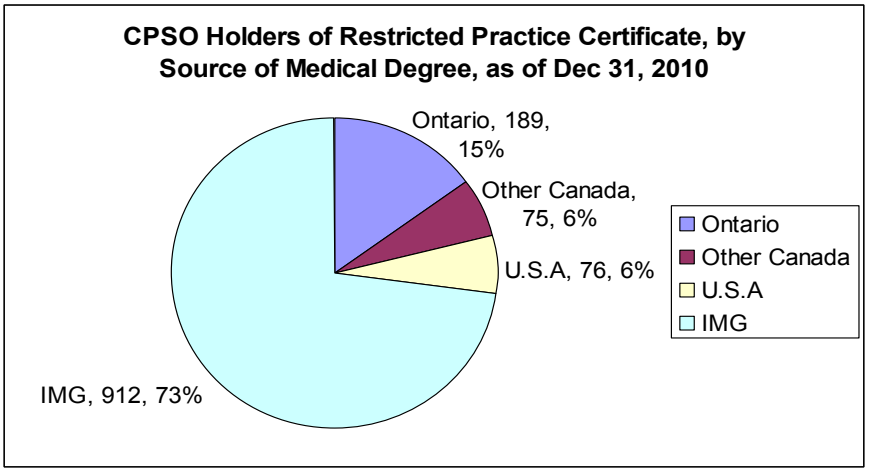
(c) **27% had never held a certificate of any kind from CPSO**. Indications are that many in this group were individuals who qualified in another province and then moved to Ontario.

The Ontario Physician Human Resources Data Centre produces data reports on physicians practising in Ontario and physicians in postgraduate medical training. Their data indicate that in 2009, IMGs represented 24.8% of active physicians in Ontario. In the same year, 17.2% of IMG physicians in Ontario had prior postgraduate training in Ontario as of 1993 or later, not including clinical fellowships.

Restricted Practice Certificates

In 2010, CPSO issued 229 restricted practice licences to IMGs, bringing the total number of IMGs with restricted licences to 912 as of December 31, 2010. Although IMGs represent 23% (approximately one-quarter) of independent-licence holders, they represent 73% (approximately three-quarters) of restricted-licence holders.

Figure 10



Source: Data provided by College of Physicians and Surgeons of Ontario; used with permission.

Restricted certificates can be issued to physicians under a variety of circumstances:

- Practitioners who have had a term or condition imposed by a CPSO committee or who voluntarily take on a restriction of any kind
- Individuals who are eligible to take one or more of the national examinations but have not yet passed
- IMGs who have completed a six-month practice ready assessment and have moved to a period of supervised practice
- Individuals going through CPSO's "pathways," which involve at least one year under a restricted licence
- Assistant professors who have not obtained full academic licences
- Individuals who want to "moonlight" for a period during their postgraduate studies

POSTGRADUATE CERTIFICATES

As of December 31, 2010, 1,876 IMGs held Ontario postgraduate certificates with appointments for residency training (including the Assessment Verification Period) or clinical fellowships (including the pre-evaluation assessment program), broken down as follows:

TABLE 39

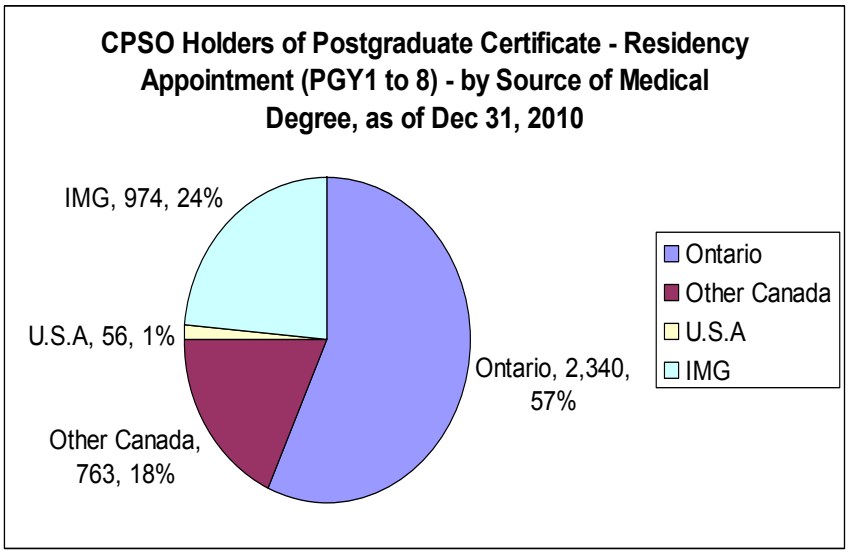
IMGs Holding CPSO Postgraduate Licences for Residency or Clinical Fellowships, as of Dec 31, 2010	
Residency	974
Clinical Fellowships	902
TOTAL	1,876

Source: Data provided by College of Physicians and Surgeons of Ontario; used with permission.

Typically, IMGs in clinical fellowships are "visa fellows" who come with funding for their position in a subspecialty and then return to their home country. We were unable to find statistics on how many visa fellows decide to stay in Canada and end up moving into a residency position. We did hear about a few cases where individuals have stayed on by obtaining either a residency position or an academic practice certificate.

As of December 2010, 24% of postgraduate certificates for residency appointments were held by IMGs, which is close to the percentage of IMGs holding independent licences in Ontario.

FIGURE 11



Source: Data provided by College of Physicians and Surgeons of Ontario; used with permission.

BREAKDOWNS

The above data is helpful in providing a general picture of IMG certificate-holders in Ontario. However, further breakdowns, whether from CPSO or other data-holders, would enable conclusions to be drawn in the following areas:

- To what extent can the increases in independent practice certificates issued to IMGs be attributed to the completion of Ontario postgraduate positions or attributed to other routes to independent practice?
- How many IMGs have obtained restricted licences under the different categories and to what extent do they lead to independent practice certificates (as opposed to temporary or permanent restricted practice certificates)?
- Within the various classes of IMG certificate-holders, what is the breakdown as between immigrant IMGs and CSAs?
- To what extent do visa fellows end up staying in Canada, whether by moving into a postgraduate position, by obtaining an academic licence, or by other means?

RISE IN THE NUMBER OF CANADIANS STUDYING ABROAD

"When decisions were made to designate 200 positions, which took effect in 2004, the intention was that they were for immigrants to Canada. The whole CSA issue wasn't on the radar at the time."

–Staff member from Ministry of Health and Long-Term Care.

In a 2010 study on "Canadian Students Studying Medicine Abroad," the Canadian Resident Matching Service found that approximately 80 schools in almost 30 countries outside North America have Canadian students enrolled in medicine. The study observed that new schools emerge every year, most of which target North American students who want to become physicians. Although CSAs (and the medical education they obtain) are diverse, the study notes that "what they have in common is their desire to come home to Canada to practice medicine." The study reports the following with respect to the numbers:

> The number of CSAs has grown exponentially since 2000. The estimated number has more than doubled since the first survey in 2006. As the majority of Canadians are enrolled in programs with a duration of four years, the output of these international medical schools could contribute almost 700 graduates per year (equal to the total number of graduates each year in all medical schools west of Ontario), or nearly 30% of the total Canadian medical school output.

In light of these findings, it is not surprising that CaRMS data show an increase over the past four years in the number of CSAs who apply for residency positions across Canada, the number who obtain a match, and the number who remain unmatched.

TABLE 40

Annual Match Results for Active IMGS 2008 – 2001							
	CSA			Other IMG			TOTAL
	Matched	Unmatched	Total	Matched	Unmatched	Total	
2011	182	291	473	198	1,249	1,447	1,920
2010	183	194	377	197	1,223	1,420	1,797
2009	136	171	307	256	1,090	1,346	1,653
2008	95	86	181	258	1,104	1,362	1,543

Source: CaRMS national data

The following table shows how, across Canada, CSAs have been obtaining an increasing share of residency positions available through the CaRMS matching process (although, as noted above, many remain unmatched).

TABLE 41

Annual Match Results for Active IMGS 2008 – 2001 Matched Applicants					
	CSA		Other IMG		TOTAL
	#	%	#	%	
2011	182	47.9	198	52.1	380
2010	183	48.2	197	51.8	380
2009	136	34.7	256	65.3	392
2008	95	26.9	258	73.1	353

Source: CaRMS national data

In Ontario, data from the Centre for the Evaluation of Health Professionals Educated Abroad indicate how the ratio of CSAs to immigrant IMGs has shifted over the past five years in Ontario. The numbers are based on registration in the pre-residency training and orientation programs, which are mandatory for all IMGs accepted into residency positions in the Ontario faculties of medicine.

TABLE 42

Orientation to Training and Practice in Canada Program for Specialists Pre-Residency Program for Family Medicine CSA and Immigrant IMG Cohort Data 2007 – 2011					
	Total Candidates	**CSAs**	**Immigrant IMGs**	**% of CSAs**	**% of Immigrant IMGs**
2007	100	15	85	15%	85%
2008	83	20	63	24%	76%
2009	229	78	151	34%	66%
2010	211	101	110	48%	52%
2011	231	120	111	52%	48%
TOTAL	854	334	520	39%	61%

Source: Centre for the Evaluation of Health Professionals Educated Abroad

EVOLUTION OF IMG PROGRAMS IN ONTARIO

> Prior to 1986, graduates of unaccredited medical schools who passed the MCCEE could apply for internships along with all other applicants although they had to defer to Canadian graduates in priority of placement. Also prior to 1986, when they were eliminated, unfunded internships were often available to candidates who failed to secure funded spots.[38]
>
> – ACCESS! Task Force, 1989

Table 43 shows the succession of IMG programs in Ontario over the years.

TABLE 43

History of Ontario Training and Assessment Positions for International Medical Graduates

																							CURRENT SYSTEM CEHPEA, Access Centre, etc.	
																	IMG-ONTARIO							
															APIMG									
							Ontario International Medical Graduate Program (OIMGP)																		
Pre-Internship Program (PIP)																								
87/88	88/89	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12

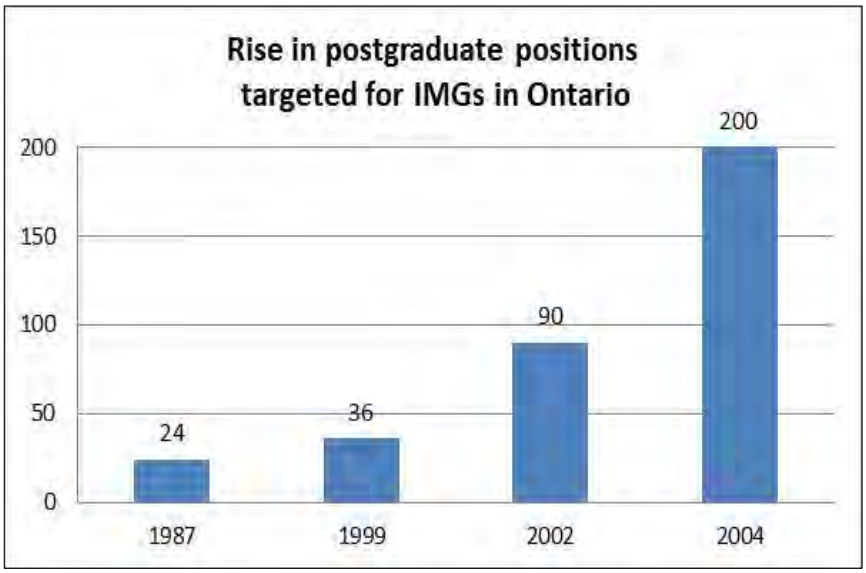
Programs to select IMGs for postgraduate medical training in Ontario began 25 years ago with the Pre-Internship Program (PIP). Prior to 1986, IMGs could approach program directors in Ontario faculties of medicine to seek postgraduate training positions, but there was no formal process. IMGs who failed to obtain a funded position were sometimes able to obtain an unfunded position.

Figure 12 shows how the number of designated IMG postgraduate positions has risen in Ontario since they began in 1987.

---

[38] Ontario. Ontario Ministry of Citizenship, *Access! Task Force on Access to Professions and Trades in Ontario*, Peter A. Cumming, Chair, Enid L. D. Lee and Dimitrios G. Oreopoulos, Commissioners. (Toronto: Publications Ontario, 1989. (Report)), 288.

FIGURE 12



Source: Ontario Ministry of Health and Long-Term Care

As noted earlier, the number of IMGs accepted into postgraduate programs can be higher than the number of designated positions. For example, IMGs may fill non-designated positions in the second iteration of the CaRMS match.

PRE-INTERNSHIP PROGRAM (PIP)

1987/88 to 1993/94

The Pre-Internship Program was a formal program that offered 24 rotational clerkship positions to evaluate and upgrade clinical and language skills of IMGs as a prelude to internship positions. The top 72 scorers on an entrance exam were invited to do an OSCE and interview. The top 24 candidates were then invited to attend the clerkship program, which was similar to the fourth year of medical school in Canada. After successfully completing the clerkship, IMGs were granted an internship position funded by the Ministry of Health. Applicants must have resided in Ontario for the previous 12 months and must have passed the Medical Council of Canada's evaluating exam.

Part of the genesis for the Pre-Internship Program was a legal challenge by several IMGs who argued that the preferred access to residency positions enjoyed by Canadian medical graduates contravened Section 15 of the *Charter*. This issue generated media reports at the time about "why Polish doctors were stuck delivering pizzas."[39]

[39] CBC Digital Archive, description of "Monitor" (current affairs show running from 1984 to 1990). Retrieved from http://archives.cbc.ca/programs/499/.

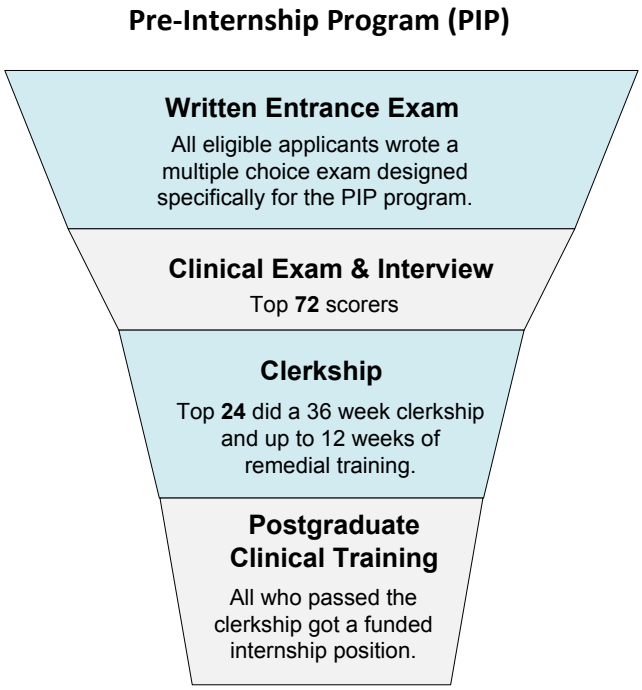
The number of positions (24) was based on a calculation related to the percentage of Ontario residents who were successful on their first application to medical school. Having a set number of positions was also seen as a way for government to control health care expenditures in light of projections of physician surpluses. The positions were available only for family medicine and not for other specialty programs.

The rationale for the clerkship component was to enable IMGs to obtain clinical experience in the Canadian medical system and to demonstrate their readiness to assume responsibilities in the less-supervised environment of a medical resident. PIP participants had to pay a fee for the clerkship ($1,200 initially, later increased to $2,000).

IMGs were assigned to faculties of medicine for the clerkship positions by lottery. Acceptance decisions were made by the IMG Director and committee members. A mini-match for internships was conducted by the Council of Ontario Universities.

The Pre-Internship Program was first introduced as a three-year pilot program coordinated by the Ontario Ministry of Health, the College of Physicians and Surgeons of Ontario, and the Council of Ontario Faculties of Medicine. The program had been recommended by a Joint Working Group of Graduates of Foreign Medical Schools. The PIP and its successor programs (Ontario IMG Program and IMG-Ontario) were administered by the University of Toronto.

FIGURE 13



Pre-Residency Program (PRP)

The Pre-Residency Program was in place during the time of the Pre-Internship Program, although we were unable to confirm when it began. Under the PRP, faculties of medicine assessed IMG applicants, over a period of four to 12 weeks, for suitability to fill postgraduate positions unoccupied by Canadian medical graduates in specialty programs. There was no standardized assessment process and the number of positions depended on available vacancies each year. These were funded and paid positions. The PRP was more a process than a program, and any faculty of medicine could choose to participate.

Ontario International Medical Graduate Program (OIMGP)

1994/95 to 2003/04

The Ontario IMG Program was essentially a continuation of the Pre-Internship Program under a new name. "Internship" was removed from the name of the program following changes in Ontario's broader medical education system in July 1993. At that time, the College of Physicians and Surgeons of Ontario replaced the pre-licensure requirement of a one-year rotating internship with certification by either the College of Family Physicians of Canada (minimum of two years' residency) or the Royal College (minimum four years' residency). These changes had financial implications for the government in funding longer periods of training, including training for successful graduates of the OIMGP clerkship program who were assured of funding for their subsequent postgraduate training.

In 1994, around the time that the Ontario IMG Program took effect, Ontario developed an integrated physician resources planning strategy to manage and control the number of physicians educated and practising in the province. The plan was designed to be consistent with the National Action Plan on Physician Resources Management, which included, for example, reducing undergraduate enrolment by 10% effective 1993.

Of the 24 OIMGP positions, 12 were situated at the University of Toronto and three went to each of the four other medical schools in Ontario. The number of positions increased to 36 after the 1999 McKendry Report and to 50 in 2002 after the 2000 Expert Panel on Health Professional Human Resources. When the positions were increased to 36, specialty positions became available in addition to family medicine.

Both McKendry and the Expert Panel talked about the need to increase the number of physicians in Ontario and the opportunity for IMGs to help. The Expert Panel's report, "Shaping Ontario's Physician Workforce," advocated increasing opportunities for qualified practice-ready IMGs. A mini-match was

approved by the Council of Faculties of Medicine and coordinated by the Council of Ontario Universities. In addition to application and test fees, those selected were charged $2,000 for tuition.

The purpose of the program was to maintain a standardized approach to evaluating and training IMGs to Canadian standards. It was also a means of enhancing control of the growth of IMGs in the physician human resource supply and control of future health care expenditures. All the positions were targeted to family medicine and general specialties needed in smaller communities across Ontario.

IMGs who entered postgraduate training through the program constituted "Pool B" in the Pools Framework implemented by the Council of Ontario Faculties of Medicine in 1994/95. The Pools Framework was developed to help control the overall number of new physicians able to practise in Ontario and to ensure that all qualified Ontario/Canadian undergraduates (citizens/permanent residents) received postgraduate placements despite the overall decrease in positions. There were five Pools, and only Pools A and B were eligible to become physicians in Ontario.

Assessment Program for International Medical Graduates (APIMG)

2002/03 to 2003/04

The Assessment Program for IMGs provided a six-month assessment for physicians who had practised medicine or been in training in an eligible specialty for 12 months within the previous three years. It was the precursor of the current six-month practice ready assessment. The program was developed in response to the 1999 McKendry Report and the 2000 Expert Panel on Health Professional Human Resources. The target was 40 positions. Added to the 50 entry positions in the OIMGP, this brought the total to 90 positions targeted for IMGs.

The candidates had to be graduates of medical schools approved by the World Health Organization and fully qualified and licensed to practise in their specialty in their home country. They also had to have demonstrated language fluency and passed the Medical Council of Canada's evaluating exam and Part 1 of the qualifying exam.

Candidates did not have to be Canadian citizens or permanent residents, and so could apply from outside Canada. Training was provided, if required (up to one year in family medicine or two years in specialty postgraduate training). This provided an accelerated route as an alternative to the OIMGP.

Candidates who met the basic eligibility criteria in a paper review then participated in a discipline-specific selection process with the relevant program directors. This included an interview, written examination, and clinical skills

assessment. Upon passing the program, they could move on to take the national certification examinations. Others were eligible for one to two years of additional postgraduate medical training, unless their skills were assessed as being too low to consider remedial training.

Participants received a stipend during the assessment, as they do under the current practice ready assessment program. Candidates offered a position were required to establish a five-year return of service agreement with a community that required their services. This was the first time return of service was required in Ontario.

APIMG was administered by the Council of Ontario Universities.

IMG-Ontario

2004/05 to 2006/07

IMG-Ontario was established as a centralized information, evaluation, and training centre for IMGs. It replaced the OIMGP for access to entry-level positions and APIMG for advanced-level assessments. At first, the program was called the Ontario IMG Clearinghouse, but the name was soon changed (by June 2004). In 2004, the Ontario government also increased the targeted positions for IMGs from 90 to 200.

The decision to establish IMG-Ontario flowed from the government's 2002 "8-Part Strategy" to reduce barriers to registration, assessment, and training for IMGs and other non-licensed physicians. In part, it was a response to the 2002 CPSO-led Physician Resource Task Force on IMGs. The government announcement regarding IMG-Ontario indicates that the program was developed by the Ministry of Health along with partners at the Council of Ontario Faculties of Medicine and the College of Physicians and Surgeons of Ontario.

IMG-Ontario was housed at the University of Toronto. Initially, it had four possible placement options: clerkship, first-year residency (PGY1), second-year residency for specialties only (PGY2), or practice ready assessment. In 2006/07, the clerkship option was removed.

Eligible IMGs took a written exam and their files were reviewed. The top candidates were invited to do an objective structured clinical examination (CE1 for first-year residency, CE2 for second-year residency or practice ready assessment). After completing the clinical exam, candidates were ranked according to their scores and offered positions based on the ranking. In 2006/07 the program began to accept Part 1 of the Medical Council of Canada qualifying exam as the written exam instead of requiring applicants for first-year residency positions to take an IMG-Ontario exam. These changes were designed to improve transparency and consistency and to reduce duplication and the number of exams.

The first 12 weeks of the residency program were the Assessment Verification Period, after which the faculties made a recommendation on the candidate's suitability to the College of Physicians and Surgeons of Ontario. IMGs were also required to sign return of service agreements to work in underserviced areas for up to five years.

In July 2005, IMG-Ontario's eligibility criteria was amended to allow Canadian citizens and permanent residents studying medicine abroad (CSAs) to apply for IMG positions in their final year of medical school, rather than having to first obtain a medical degree. That enabled this cohort of IMGs to move into residency without interruption in their training. It also increased the number of applicants eligible for the program. Also in 2005, IMGs became eligible to compete for non-designated positions left vacant after the first and second iterations of the CaRMS match. In 2006, IMGs became eligible to participate in the second iteration.

In 2005, IMG-Ontario also developed a two- to three-week pre-residency orientation program for family medicine. This evolved into a mandatory four-month pre-residency program in 2007. A five-week version for specialty programs was launched in 2009, subsequently became mandatory, was later reduced to four weeks, and is currently three weeks with an online component.

Changes to IMG-Ontario announced in 2006 included shifting the selection of candidates for residency positions from IMG-Ontario to the faculties of medicine. The faculties had been concerned that individuals were being assigned to them based simply on exam scores, and that their main role in the selection was to indicate how many positions they would offer.

Current model (CEHPEA, CaRMS, etc.)

2007/08 to Present

IMG-Ontario was disbanded in 2007 and responsibilities were divided among four bodies, thus formally separating the assessment, selection, placement, and counselling roles.

TABLE 44

Current Model for IMG Access to Postgraduate Positions		
	Role	**Description**
Access Centre	Counselling	In December 2006, the Access Centre for Internationally Educated Health Professionals opened as a department of the Ministry's HealthForceOntario Marketing and Recruitment Agency. The Access Centre provides free counselling and support services to internationally educated health professionals.
CEHPEA	Assessment	In April 2007, the Centre for the Evaluation of Health Professionals Educated Abroad began providing optional assessments for IMGs seeking first- or second-year residency positions or practice ready assessment positions in Ontario. In 2011, the provincial clinical exam for first-year applicants (CE1) was replaced with a national clinical exam (NAC OSCE). CEHPEA also runs mandatory pre-residency programs for IMGs selected into first-year residency programs. CEHPEA is a not-for-profit organization funded by the Ministry.
Faculties of Medicine	Ranking	As of 2007, the faculties of medicine are responsible for interviewing and ranking IMG candidates for first-year residency positions. They also interview and select IMGs for second-year and practice ready assessment positions.
CaRMS	Placement	As of 2007, IMGs apply for PGY1 residency positions through a dedicated stream in the CaRMS match. As of 2009, IMG and CMG positions are blended in the second iteration. Prior to 2009, there were designated positions in both the first and second iterations.

A major difference between the current and previous models is that, for IMGs seeking access to entry-level positions, the clinical assessment is now voluntary instead of mandatory. A major exception is the joint selection process for family medicine, which evaluates all but very recent graduates on their scores on that exam in order to determine who will be granted a file review and interview. Typically, specialty programs indicate on the CaRMS website that the exam is strongly encouraged, recommended, or preferred.

The objective in the decision to make the clinical exam optional was to accommodate CSAs who, it was thought, could not take it in their final year of medicine in time to apply for a residency position and thus had to wait a year. Another objective was to give IMGs a choice in light of the expense of taking the exam.

FIRST-YEAR RESIDENCY POSITIONS (PGY1)

IMG applicants apply to CaRMS for residency positions. They must be Canadian citizens or permanent residents, they must have graduated from an acceptable medical school, and they must have passed the Medical Council of Canada

evaluating exam. If the language of undergraduate medical education was not English or French, they must also have passed one of the specified tests for English or French proficiency. As noted above, applicants have the option of taking a clinical assessment from CEHPEA (formerly CE1, now NAC OSCE) or a comparable agency from another province to strengthen their portfolio.

The programs review applications and determine which candidates they will interview. After the interviews, applicants rank medical schools and the medical programs rank applicants. The CaRMS algorithm establishes the match that places applicants into residency positions.

Successful applicants must take a pre-residency or orientation program administered by CEHPEA. The family medicine pre-residency program began in 2007/08. It is currently a four-month program, including six weeks in the classroom and time at the residency site. The specialty Orientation to Training and Practice in Canada began in 2008/09. It was reduced from five weeks to four in 2010, and is now three weeks plus an online component. As was the case with IMG-Ontario, the first 12 weeks of the residency are the Assessment Verification Period, and residents must sign a return of service agreement.

ADVANCED-LEVEL POSITIONS

Before CEHPEA advertises advanced-level positions, the faculties of medicine indicate which specialty programs have capacity to create a position. The number of positions identified as advanced positions form part of the 200 designated positions for IMGs.

Eligibility requirements for applying for the advanced-level positions are the same as for first-year positions, but with the following additional requirements:

- **All:** Must have passed Part 1 of the Medical Council of Canada qualifying exam in addition to the evaluating exam
- **Second-year entry:** Must have completed at least one year of postgraduate medical education in the specialty area
- **Practice ready assessment:** Must have experience in an independent professional practice within the past five years and be board certified

Eligible candidates write a Specialty Written Exam (SWE) and a Specialty Specific Clinical Exam (CE2). For some specialties, program directors also require candidates to complete the CE1 (now NAC OSCE). Candidates deemed eligible by CEHPEA are interviewed by a panel of program directors or other postgraduate faculty members.

After the interviews, the faculty interviewers meet to identify candidates who would be acceptable to enter the system in a second-year residency position or in a six-month practice ready assessment. The decision is based on exam results, a review of prior clinical experience, reference letters, and interview

scores. After discussion, the program directors decide which of the acceptable applicants will be offered an advanced-level position.

The six-month practice ready assessment takes place in a supervised clinical setting at an Ontario faculty of medicine. The purpose is to ensure that these physicians are indeed ready for practice in an Ontario setting. If deemed practice ready at the end of the six months, the individual may apply for certification examinations from the Royal College and for registration with College of Physicians and Surgeons of Ontario. Alternatively, they can be assigned up to two years of postgraduate training, or they can be dismissed from the program. IMGs receive a stipend of $5,000 per month during the six-month practice ready assessment. Those assigned to a residency position receive a salary that is the same as the salary for residents who graduated from Canadian or US medical schools.

As with IMGs selected for first-year residency positions, individuals selected for second-year residency or practice ready assessment positions must sign a return of service agreement. However, practice ready assessment participants are not required to complete an Assessment Verification Period.

7. Other provinces

This section looks at the features of IMG programs in British Columbia, Alberta, Manitoba, and Quebec. These four provinces are illustrative of how approaches can vary across the country. The information is based on our telephone interviews with contacts in these jurisdictions, supplemented by a review of websites and other available materials.

Access to first-year residency positions

Designated positions for IMGs

British Columbia

The Ministry of Health Services of British Columbia funds a number of designated postgraduate positions for IMGs each year. In 2005, the number was raised from six to 18, with 12 positions in family medicine and six in specialty programs. The number of family medicine positions was increased to 13 in 2011. Subspecialty positions are not offered. There is a possibility that the number of family medicine positions will increase over the next five years.

Alberta

Alberta had 40 IMG positions in 2011, compared with 11 in 2001 when the provincially funded Alberta International Medical Graduate (AIMG) program began. The AIMG Steering Committee recommends an annual allocation of the available AIMG residency positions among family medicine and the other general specialties, based in part on the residency programs' willingness and ability to accept AIMG residency applicants. In 2001, the founding year of AIMG, all positions were allocated to family medicine. Positions are now allocated to other general specialties, but the majority remains in family medicine. Attached to each AIMG residency position is additional funding to support the additional mentoring IMGs require.

Manitoba

In Manitoba, there are no designated positions for IMGs. IMGs and graduates of Canadian medical schools compete together for first-year residency positions. In 2011, approximately 40 IMGs obtained residency positions in this way.

Quebec

In Quebec, there are no designated positions for IMGs. Instead, 65 positions have been added to the total number for graduates of Quebec medical schools. The government's manpower planning committee allocates the positions to the province's four medical schools. The allocation is approximately 50% family medicine and 50% other specialties.

Pre-application process

Quebec

Before applying for a residency position in Quebec, IMG applicants must first obtain recognition of the equivalence of their medical degree from the Collège des médecins du Québec. There is no citizenship requirement. Any degree from a university recognized by the Foundation for Advancement of International Medical Education and Research is accepted. The College will grant the recognition if the applicant has also passed the Medical Council of Canada evaluating exam, Part 1 of the qualifying exam, and a clinical exam. The clinical exam can be either the NAC OSCE (previously CMQ) or Part 2 of the qualifying exam.

Once the Medical Council of Canada makes Part 1 of the qualifying exam available internationally, the Collège will consider removing the requirement for IMGs to pass the evaluating exam as well. Part 1 of the qualifying exam is more demanding than the evaluating exam, contains a section on clinical decision-making, and has Canadian content.

The clinical exam is mandatory for IMGs in Quebec because the medical school programs want some sense of the applicants' clinical skills. Candidates pay the full cost of the NAC OSCE or Part 2 of the qualifying exam ($1,950). This cost is the same as for graduates of Canadian medical schools who take Part 2, plus $400 for opening a file.

Application process

British Columbia

The British Columbia IMG program is administered by IMG-BC, a provincially funded body based at St. Paul's Hospital in Vancouver.

Applicants fill out a two-part online application that establishes eligibility. This requires proof of graduation and transcripts from a recognized medical school, but medical students in their final year may apply as well. Applicants must be Canadian citizens, permanent residents, landed immigrants, or refugees. They must have passed the Medical Council of Canada's evaluating exam, and scores on Part 1 and Part 2 of the qualifying exam will be reviewed if taken.

Applicants must also provide proof of residence in BC for one year. The program recognizes that candidates may have been out of the province for education purposes.

Alberta

The Alberta International Medical Graduate Program (AIMG) assesses IMGs for placement in dedicated postgraduate residency positions, in family medicine

and other general specialties, at the University of Alberta and the University of Calgary.

AIMG is led by a steering committee with representatives from the Ministry of Health and Wellness, the College of Physicians and Surgeons of Alberta, Alberta Health Services, the Alberta Rural Physician Action Plan (an organization that trains, recruits, and retains physicians for rural Alberta), the Alberta IMG Association (an advocacy group for IMGs), and the province's two faculties of medicine.

IMGs have approximately two months to apply on line to AIMG, beginning in May. Applicants must show proof of graduation and transcripts from a recognized medical school that has been in existence for at least ten years. They must also include three reference letters, a personal statement, and scores from the Medical Council of Canada's evaluating exam and from Part 1 of the qualifying exam.

Language proficiency is indicated by scores on the Test of English as a Foreign Language Internet-Based Test (TOEFL-iBT) or the International English Language Testing System (IELTS). Following a recent evaluation of the Canadian Language Benchmark Assessment (CLBA), it was decided to no longer accept CLBA as a sufficient test of language skills.

Applicants must also provide proof of residence in Alberta for at least six weeks prior to the application deadline. Albertans studying abroad must demonstrate two years or more in high school or a post-secondary institution in Alberta.

AIMG conducts an initial review to ensure that the application is complete. Applicants select up to five disciplines to which they wish to be matched.

QUEBEC

Once the Collège des médecins du Québec has granted equivalence recognition, the IMG may apply for residency at one or more of the four medical schools, in as many programs as they wish. The CaRMS matching system is used for both iterations.

A recent Human Rights Commission decision highlighted the fact that available positions remained unfilled after the selection process. There is debate over whether this is primarily because Quebec graduates are going elsewhere or because of an unwillingness to take IMGs.

PRE-MATCH SELECTION PROCESS

BRITISH COLUMBIA

IMG-BC conducts a file review to select 70 applicants for a mandatory clinical exam, which is now the national exam (NAC-OSCE).

Since 2005, the 35 top scorers on the clinical exam are also offered the opportunity to take a one-week orientation program, followed by a 12-week clinical assessment prior to the CaRMS match. The assessment does not pass or fail candidates, but the selection committee uses the evaluations to assist in ranking candidates. The orientation and clinical assessment have been found to be valuable tools in assessing candidates. The results have also been found to be a more reliable discriminator than the clinical exam alone, especially for family medicine.

Individual residency programs decide on the ranking of applicants for the CaRMS match. In family medicine, the program director is assisted by an IMG residency committee selected for its breadth of teaching experience, familiarity with IMG issues, and awareness of community needs.

ALBERTA

Based on its assessment of completed applications, AIMG develops a list of approximately 150 applicants to invite to a clinical exam. In the past, the exam has been an AIMG exam and was offered in September at the University of Alberta in Edmonton and the University of Calgary. In the future, AIMG will use the NAC OSCE. If the number of eligible applicants exceeds capacity, the evaluating exam scores are used to narrow down the applicants invited to take the clinical exam.

The Alberta program now has two intakes during their annual assessment cycle. The clinical exam for the first intake is in September and in March for the second. CSAs in their final year of medical school can take the clinical exam at either of these two intakes, assuming that they meet the eligibility requirements.

Applicants who pass the clinical exam are invited to participate in Multiple Mini-Interviews. When necessary, clinical exam scores are used to limit the number to be interviewed. There are nine interview stations, with interviewers including professionals from medicine, other health disciplines, and human resources. The multidisciplinary approach is said to work well because the Multiple Mini-Interviews test communication and problem-solving skills—unlike the clinical exam, which is content-based and has right and wrong responses. In the Multiple Mini-Interviews, candidates are given scenarios and asked how they would deal with them. Interviewers ask probing questions to help elicit complete answers. At each station, candidates are given a rating, such as acceptable or excellent, and there is a place on the form to flag concerns.

The Multiple Mini-Interviews format was introduced in 2007. Although it is still too early to determine its role in predicting success in residency or in certification exams, AIMG officials report that an evaluation after the first year concluded that it demonstrated good reliability and validity, and that it was

widely accepted by applicants and examiners. The AIMG plans to continue using this interview format and has invested in research to assess the reliability and stability of individual stations.

Alberta modelled its interviews on the McMaster University Multiple Mini-Interviews process. The purpose was to move away from a one-hour interview with a single panel to a structured process in which each candidate would be seen by nine different people. This is thought to provide a more objective evaluation of an individual's interview performance.

Each residency program director receives a package from the AIMG for the IMGs who applied to their program. The package includes the completed application (including scores from the MCC evaluating exam and Part 1 of the qualifying exam, letters of reference, the clinical exam score, and the Multiple Mini-Interviews report). Program directors then decide who will be interviewed and how the applicants will be ranked. In some cases, program directors choose not to hold interviews, instead relying wholly on the material provided by the AIMG. The AIMG has no role in the selection process at this stage, but has observed that the program directors rely strongly on the clinical exam and Multiple Mini-Interviews results.

Beginning in 2012, the clinical exam and Multiple-Mini-Interviews process will be offered twice to take advantage of the NAC OSCE, and to better accommodate CSAs from both northern and southern hemisphere medical schools as well as applicants generally.

Residency match

British Columbia

All candidates who pass the clinical exam are entitled to apply to the CaRMS first iteration for one of the designated positions, whether or not they also took the one-week orientation and 12-week clinical assessment. If any of the designated positions remains unfilled after the first iteration, candidates may apply in the second iteration for these and any unfilled positions from the 250 non-designated CaRMS positions.

Alberta

IMGs applying for residency positions in Alberta do not participate in the first iteration of the CaRMS residency match. Instead, IMGs who meet the eligibility criteria, including residency in Alberta, apply to the AIMG for one or more of the funded positions available for IMGs. The AIMG administers a separate matching process for this.

In 2011, 45 IMGs secured positions in the Alberta match. All of them were permitted to enter the program, even though the number exceeded the 40 positions designated for this stage of the process.

The AIMG match takes place in December. Applicants assessed by AIMG as eligible and who are not matched to an AIMG residency position may apply in the second iteration of the CaRMS match. In 2011, up to 10 positions were available for IMGs at this stage. However, no candidates were successful in the second iteration that year.

MANITOBA

In Manitoba, IMGs can compete for entry-level residency positions in the CaRMS process with graduates of Canadian medical schools.

QUEBEC

As in Manitoba, IMGs in Quebec can compete with CMGs for entry-level residency positions in the CaRMS process. The difference is that in Quebec, additional positions are added in recognition of the fact that IMGs are also applying.

POST-MATCH PROCESS

ALBERTA EXTERNSHIP PROGRAM

Upon being matched to a residency position, IMGs begin a variable 16-week externship program in February. All or part of the externship may be waived, based on a determination by the candidate's residency program director. The bulk of the externship is run by the family medicine or other specialty program at the site where the residency will take place. In addition, the AIMG runs orientation workshops that are a mandatory part of the externship.

The on-site component of the externship is similar to the experience CMGs receive in the clerkship year. It includes both classroom and clinical work, as well as exercises that involve the use of medical, contextualized language with standard patients. There are several rotations and continuous evaluation by preceptors to ensure that participants are reaching the expected benchmarks. The program director may require externs to participate in extra remediation in some cases.

Externs receive $1,050 per month while in externship. Preceptors are paid $2,000 a month to manage an extern.

QUEBEC PRE-RESIDENCY PROGRAM

IMGs who obtain a residency position attend a pre-residency program at the university where they have been selected. For family medicine, the duration is four to five weeks. For the other specialties, the program is less structured.

RESIDENCY PROGRAM

BRITISH COLUMBIA

Applicants matched to a family medicine position complete their residency program at St. Paul's Hospital. This program, which began in 2005, is the first in North America to create a training site specifically for IMGs, with the added advantage that they work alongside Canadian-trained residents. The IMG residents in family medicine at St. Paul's receive extensive exposure to ethical, cultural, and behavioural medicine issues and spend more time analyzing doctor-patient relationships and communication issues.

IMGs matched to specialty positions are integrated into residency programs through the University of British Columbia, which uses hospitals throughout the province for training.

Initially, the IMGs in the IMG-BC family medicine program generally performed as well as other residents in their program evaluations, but not as well in the national CFPC certification exam when compared with all BC residents across the various hospital sites. However, IMGs have progressively improved their performance and their results are now comparable with those of their Canadian-trained colleagues. Much effort has been directed to preparing the IMGs for the certification exam, particularly the Simulated Office Orals where IMGs had historically done poorly. The director of IMG-BC remarked that, "The CFPC results have improved dramatically since we have taken more time to teach our residents the techniques required for exam success."

ALBERTA

If selected AIMG candidates pass the externship (and the failure rate is very low), they begin their residency along with CaRMS-selected residents in July. Applicants matched in the second iteration of CaRMS do their externship later and consequently may begin their residencies off cycle.

AIMG officials report that over the period of the program, the pass rate on CFPC/Royal College national certification exams has been very high (98% in a 2008 evaluation), although it was lower on the first try in 2010.

QUEBEC

All residents (CMGs and IMGs) start at the same time (July 1st). It is felt that this is important to maintain collegiality and cohesion among the residents. They must be Quebec residents when they begin their residency training. There is no probationary or assessment verification period, but IMGs may be assigned to easier rotations at the start of the residency period as a period of adjustment.

Quebec does not offer advanced-level residency placement. All IMGs enter in the first year, but they can be fast-tracked and authorized to apply to write

their certification exams early. It is for the university to decide whether they are ready early, provided that they have completed the minimum period of residency required by the Royal College.

The funding is assigned to the position rather than the resident and it continues as long as necessary. This means that residents may take extra training or return for more residency training if they fail the certification exam or are not considered ready at the end of the normal residency period.

All residents must take the ALDO-Québec Educational Activity (a constitutional, legal, and ethical workshop that is required to obtain a licence to practise medicine) and the relevant national exams. A recent research report looked at the success rates of Quebec IMGs in pre-residency and family medicine certification exams.[40] In both cases, IMGs did much worse than graduates of Canadian and US medical schools (CMGs). In the pre-residency clinical exams, their average success rate was below 50%, versus 98% for CMGs. For the national certification exam administered by the College of Family Physicians of Canada, the average success rate for IMGs was 56%, versus 93.5% for CMGs. Because of the way residency is funded in Quebec, the candidate can return for more training. Success rates are better on the second or third attempt, but still lower than the CMGs' rates. Subsequent research is showing that IMGs who go back and do the two-year clerkship do very well in the exams.

Return of Service

Policies about return of service agreements, and to whom they apply, vary by province. The descriptions below apply to IMGs who obtain first-year residency positions. (The section following this one describes "Additional IMG Programs," some of which include return of service components.)

British Columbia

IMGs must complete a return of service period in a rural, underserviced British Columbia community. Family medicine residents complete a two-year return of service and specialist residents complete a minimum of three years.

Alberta

There is no return of service requirement in Alberta for IMGs entering first-year residency positions.

---

[40] See MacLellan, A-M, Brailovsky, C., Rainsberry, P, Bowmer, I. & Desrochers, M. (2010). Examination outcomes for IMGs pursuing or completing family medicine residency training in Quebec. *Canadian Family Physician*, Vol 56: September 2010.

MANITOBA

There is no general return of service requirement in Manitoba. However, in family medicine, there is a rural and remote stream. Candidates selected for this stream have a two-year return of service requirement.

QUEBEC

There is no return of service requirement for IMGs in Quebec residency programs.

CANADIANS STUDYING ABROAD

BRITISH COLUMBIA

Apart from steps taken to recognize the circumstances of those applying in their final year of medical school, CSAs and immigrant IMGs are treated alike. No CSAs were selected in 2011 for any of the designated positions. One CSA was selected in 2010.

ALBERTA

Adjustments have been made to enable medical students in their final year to complete the process. They are permitted to do the clinical exam and Multiple Mini-Interviews before they have their results from Part 1 of the qualifying exam. They can then participate in the first externship available after graduation. Medical students from the southern hemisphere who graduate in November can begin the process before graduation, and if successful, do the February externship.

The program does not publish data on the breakdown between immigrant IMGs and CSAs. However, last year's national report from the Canadian Post-M.D. Education Registry (CAPER) shows that the proportion of CSAs is growing. This was confirmed by AIMG personnel.

MANITOBA

Manitoba reports that the number of CSAs has been growing steadily, and that more than 50% of the IMGs selected in 2011 were CSAs.

ADDITIONAL IMG PROGRAMS

QUEBEC

CLERKSHIP PROGRAM

The Quebec clerkship approach was implemented about 10 years ago. If medical students withdraw from or are asked to leave medical school, universities can replace them with IMGs, who complete the full two-year

intensive clerkship and receive a Quebec medical degree. The admission process is managed by the medical school.

The graduates do very well in the certification exams. Approximately eight IMGs per year come through this program, which is seen as very successful. We have been advised that the two years in the medical school environment ensures that the IMGs acquire the skills needed to succeed in residency and the certification exam.

BRIDGING PROGRAM

Quebec has a new program for IMGs who obtained equivalence recognition from the Collège but were unsuccessful in securing a residency position. The purpose of the program is to improve their chances of obtaining a residency position when they apply again. The program is run by a non-profit organization created for this purpose. It involves an initial clinical exam and a four-month bridging program. The program is funded by the government and is expected to produce about 32 candidates per year.

MANITOBA

Manitoba has three accelerated programs. Two are for family medicine and one is for other specialty programs. The following information applies as of August 2011.

MEDICAL LICENSURE PROGRAM FOR INTERNATIONAL MEDICAL GRADUATES

This program is for physicians with previous experience in family medicine/general practice. It consists of four weeks of orientation and one year of residency-type training, followed by practice in a rural area under a conditional licence. This is a joint initiative of three organizations: Manitoba Health, the University of Manitoba, and the College of Physicians and Surgeons of Manitoba. It is located at the University of Manitoba and has been operating since 2001.

Applicants must be permanent residents or Canadian citizens and meet language proficiency requirements. They must have passed the Medical Council of Canada evaluating exam, Part 1 of the qualifying exam, and the NAC OSCE. A change being considered is to require the NAC OSCE at the time of application. Applicants must have had one year in general practice at some point and must also have worked as a physician within the past seven years. Language proficiency requirements may change to rely on the Test of English as a Foreign Language and no longer accept the option of the Canadian Language Benchmark Assessment.

A select number of applicants are invited to a 30-minute interview. Two or more interviewers independently rate the applicants' answers. A committee reviews the applications and decides who will be accepted into the program.

The weighting is 10% for application details, 50% for the NAC OSCE, and 40% for the interview. In 2011, there were 225 applicants and 19 were accepted.

Before beginning the program, accepted candidates obtain an education registration with the College of Physicians and Surgeons of Manitoba. The Physician Resource Coordination Office assists them in securing a written offer of rural employment with a sponsor, which can be a Regional Health Authority, a private clinic, or a hospital. They are expected to have a sponsor before they start the one-year training component. The contract with the sponsor will include a return of service requirement, usually for three years.

The training component involves 13 four-week postgraduate rotations, taken alongside other residents. IMG physicians are evaluated after each rotation. Failure in any one rotation results in remediation. Failure in any two rotations will result in dismissal from the program.

After successful completion of the program, IMGs can obtain a conditional licence to work for their sponsor employer. They are assigned practice advisors and undergo mandatory audits. They have five years to obtain their Medical Council of Canada Licentiate and seven years to pass the certification exam of the College of Family Physicians of Canada. Return of service obligations apply.

Recently, the program has tightened up admission to the program so that those unlikely to succeed are identified earlier in the process. All of the 19 successful candidates in 2011 had completed both Part 1 and Part 2 of the Medical Council of Canada's qualifying exams.

International Medical Graduate Assessment for Conditional Licensure

This program, which began in 2006, offers an accelerated route to licensure for family physicians who are "practice ready." Applicants must have completed two years of acceptable postgraduate training, or one year of acceptable postgraduate training and at least three years of practice experience in the past five years.

Eligible applicants complete a Clinician Assessment and Professional Enhancement (CAPE). This is a three-day assessment conducted through the Office of Continuing Medical Education at the University of Manitoba. CAPE has four components: multiple choice questions, a structured oral interview, therapeutics assessment, and clinical and communication skills evaluation using standardized patient scenarios. The top candidates from the assessment are invited to a 30-minute interview with at least two interviewers. Applicants are expected to apply to the College of Physicians and Surgeons of Manitoba for conditional licensure upon completing the assessment if they are shortlisted for an interview.

As the committee reviews the applications, the weighting is 10% for application details, 50% for CAPE, and 40% for the interview. The top applicants are offered positions in the program. From 2006 to 2010, the admission rate was 57%. In the 2011 assessment year, 73 candidates applied and five were admitted, for an admission rate of 6.8%. Once again, this reflects a decision to tighten up the admission process at the early stages. As in the Medical Licensure Program, here too the successful candidates had completed both parts of the Medical Council of Canada qualifying exams.

After acceptance, candidates obtain rural employment with a regional health authority, private clinic, hospital, or other employer that will fund their subsequent assessment. The Physician Resource Coordination Office assists candidates in connecting with potential employers. The contract with the employer will contain a return of service requirement of two to three years. Candidates also take a four-week structured orientation (in Winnipeg), which prepares them for the Canadian health care system, followed by a three-month assessment (which may be in multiple locations).

As with the Medical Licensure Program, successful candidates are assigned a mentor and practice supervisor, are subject to audits, and have five years to obtain their Licentiate and seven years to pass the national certification exam. There are no fees for the two family medicine programs, although there is a fee for the conditional licence. Currently, there is no language requirement for the program, but it is expected that the Test of English as a Foreign Language will be a requirement in the future.

The Non-Registered Specialist Assessment Program

The Non-Registered Specialist Assessment Program began in 1999. It facilitates three- to 12-month clinical assessments of non-registered specialists to ensure that they meet the requirements for licensure by the College of Physicians and Surgeons of Manitoba. Applicants must register with the Physician Recruitment Coordination Office, attaching a copy of their curriculum vitae and their score on the Test of English as a Foreign Language (TOEFL). The Regional Health Authorities post specialist vacancies, and the candidates connect with employers directly to seek a sponsorship. The candidate must have a sponsor before applying and the contract with the sponsor will set out any return of service requirement.

The Physician Recruitment Coordination Office reviews the application to determine if a potential sponsor has been identified and to confirm immigration status. Preference is given to Manitoba residents with permanent resident status. Applicants must have a score of 100 on TOEFL, with at least 25 in the speaking and listening component. They must also have completed the Medical Council of Canada evaluating exam. Preference is given to those who have also passed Parts 1 and 2 of the qualifying exam.

The Office then circulates, to a screening panel, a list of candidates who have met the screening criteria. The panel consists of representatives from the University of Manitoba IMG Program, Department of Assessment, and the V.P. Medical from sponsoring regions (or individuals appointed by the V.P. Medical group). The final slate of potential candidates is scheduled for an interview with the members of the screening panel and a representative from the Physician Recruitment Coordination Office.

From its inception in 1999 to June 22, 2010, 51 candidates have entered the program. There is no specific annual quota or maximum.

Successful applicants undergo assessment in the relevant specialty at the University of Manitoba's affiliated hospitals. Each program decides on the duration of the assessment, which can be from three months to 12 months. Supervisors and others complete interim and final reports on the participants. The head of the department submits a final report on whether the candidate has the clinical skills and knowledge to practise independently and safely, equivalent to the level of a final-year resident in the specialty. The final recommendation is forwarded to the College from the university, signed by the Coordinator of the Non-Registered Specialist Assessment Program and the Associate Dean of Postgraduate Medical Education, based on the departmental report.

After successfully completing the assessment program, the specialist physicians begin independent practice under a return of service agreement.

APPENDIX A: REFERENCES

The increased focus on IMGs over the past decade has generated a growing body of writing and research. At the same time, there has been research on the reliability of various tools and criteria for the selection of successful candidates, for employment or professional roles generally and for entry into medical school or postgraduate medical education programs in particular. Many such studies do not focus specifically on IMGs, but some recent work looks at the unique challenge of distinguishing among IMG candidates applying for entry into residency or practice.

Most of the North American research has focused on the residency selection process and the residency experience, likely because this is essentially the only route into practice for IMGs in the United States. In Canada, an effort to gather data on IMGs and their progress through the Canadian health care system has begun, but much of the most valuable information that this research will generate has yet to emerge.

We reviewed a number of relevant studies, reports, and literature reviews in preparing this report, many of which were referred to us by consultation participants, faculty members, academics, and other experts. They also drew our attention to a much larger body of literature dealing with IMG policies and programs, the IMG experience, selection methodologies, meeting the needs of IMGs, and related topics.

Given the complexity of the issues, especially those facing immigrant IMGs seeking an opportunity to practise in Canada, it is not surprising that the policy and research literature covers much broader ground than the issues in the IMG Review. We focused on the work that appeared most relevant to our mandate and have referred to some of that literature at various points in Volumes 1 and 2 of this report. Here, we present a longer list of materials. We hope that this will be of assistance to those who wish to pursue any of the issues in greater depth.

1. CANADIAN REPORTS RELATING TO IMG POLICIES AND PROGRAMS

Banner, S. (team leader) with McKiver, A., Rattanasithy, S., Cassie, J., Woodward, C., & Ford, R. (2010). *Canadian students studying medicine abroad.* Retrieved from Canadian Resident Matching Service (CaRMS) website: http://www.carms.ca/pdfs/2010_CSA_Report/CaRMS_2010_CSA_Report.pdf.

Dauphinee, W. D. (2006). The circle game: Understanding physician migration patterns within Canada. *Academic Medicine, 81*(2 Suppl), S49–S54.

Dauphinee, W. D., & Buske, L. (2006). Medical workforce policy-making in Canada, 1993–2003: Reconnecting the disconnected. *Academic Medicine, 81*(9), 830–836.

Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources. (2004). *Report of the Canadian task force on licensure of international medical graduates.*

Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources. (2004). *Report on the Canadian taskforce on licensure of international medical graduates. Forum 2004: IMG Taskforce Implementation*. Ottawa, Ontario, Canada: Health Canada.

Federation of Medical Regulatory Authorities of Canada. (2011, March). National standards for medical registration and foreign qualifications. Paper presented at the National Metropolis Conference. Toronto, ON. Retrieved from http://canada.metropolis.net/events/13th_nat_vancouver11/workshop_pdfs/Pre-conference/FCRO/Fleur-Ange%20Lefebvre_FCRO_4_e_v2.pdf.

Mok, P. S., Baerlocher, M. O., Abrahams, C., Tan, E. Y., Slade, S., & Verma, S. (2011). Comparison of Canadian medical graduates and international medical graduates in Canada: 1989–2007. *Academic Medicine, 86,* 962–967.

Office of the Fairness Commissioner. (2010).*Clearing the path: Recommendations for action in Ontario's professional licensing system.* Retrieved from http://www.fairnesscommissioner.ca/en/downloads/PDF/Clearing-the-Path_Recommendations-for-Action_2010-03-30.pdf.

Peters, C. (2011). *The bridging education and licensure of international medical doctors in Ontario: A call for commitment, consistency, and transparency* (Unpublished doctoral dissertation). University of Toronto, Toronto, Ontario, Canada.

Royal College of Physicians and Surgeons of Canada, Office of Education. (2009). *IMG assessment: Navigating through a changing landscape, Report on the 2009 international medical graduate (IMG) summit.* Retrieved from http://rcpsc.medical.org/publications/IMG_Report2009.pdf.

Walsh, A., Banner, S., Schabort, I., Armson, H., Bowmer, I., & Granata, B. *International medical graduates - Current issues.* Association of Faculties of Medicine of Canada (AFMC); 2011 [Forthcoming].

2. The IMG experience

Association of International Physicians and Surgeons of Ontario. (2010). Home - AIPSO. Retrieved from http://aipso.webs.com.

Baumann, A., Blythe, J., & Ross, D. (2010).Internationally educated health professionals: Workforce integration and retention. *New Models for the New Healthcare*, *10*(2), 1-58.

Bourgeault, I. L., Neiterman, E., LeBrun, J., Viers, K., & Winkup, J. (2010). BRAIN GAIN, DRAIN & WASTE: The experience of internationally educated health

professionals in Canada. Retrieved from http://www.threesource.ca/documents/February2011/brain_drain.pdf.

Boyd, M., & Schellenberg, G. (2007). Re-accreditation and the occupations of immigrant doctors and engineers. *Canadian Social Trends*. Retrieved from http://www.statcan.ca/english/freepub/11-008-XIE/2007004/pdf/11-008-XIE200700410312.pdf accessed 18 February 2008.

R. A. Malatest & Associates. (2010).*Getting your professional licence in Ontario: The experiences of international and Canadian applicants.* Prepared for the Ontario Fairness Commissioner. Retrieved from http://www.fairnesscommissioner.ca/en/downloads/PDF/Getting_Your_Professional_Licence_in_Ontario-The_Experiences_of_International_and_Canadian_Applicants.pdf.

Sahrieff, W., & Kakus, D. (2006). Resource utilization and costs borne by international medical graduates in their pursuit for practice license in Ontario, Canada. *Pakistan Journal of Medical Sciences*, *22*(2), 110–115. Retrieved from http://www.pjms.com.pk/issues/aprjun06/pdf/resource_utilization.pdf.

Seid, C. (2007). From malaria to MI: A professional journey into the Canadian medical system. *Canadian Family Physician, 53,* 1750–1751.

Violato, C., Watt, D., & Lake, D. (2011). *A longitudinal cross-sequential study of the professional integration of international medical graduates (IMGs): From application to licensure: An interim report 2011.* Retrieved from http://www.m-cap.ca/pdf/IMGStudyInterimReport_Apr2011.pdf.

Wong, A., & Lohfield, L. (2008). Recertifying as a doctor in Canada: International medical graduates and the journey from entry to adaptation. *Medical Education*, *42*, 53–60.

3. Selection tools, techniques, and criteria

General

Carmichael, K. D., Westmoreland, J. B., Thomas, J. A., & Patterson, R. M. (2005). Relation of residency selection factors to subsequent orthopaedic in-training examination performance. *Southern Medical Journal*, *98*(5), 528–532.

Dirschl, D. R., Dahners, L. E., Adams, G. L., Crouch, J. H., & Wilson, F. C. (2002). Correlating selection criteria with subsequent performance as residents. *Clinical Orthopaedics & Related Research*, *399*, 265–271.

Gonsalves, W. C., Wrightson, A. S., Love, M. M., & Torbeck, L. J. (2005). Practices and perceptions of family practice residency directors towards international medical graduate applicants: A national survey. *Medical Education Online*, *10,* 1–9. Retrieved from http://med-ed-online.net/index.php/meo/article/view/4371.

Shiroma, P. R., & Alarcon, R. D. (2010). Selection factors among international medical graduates and psychiatric residency performance. *Academic Psychiatry*, *34*(2), 128–131. Retrieved from http://ap.psychiatryonline.org.

Van Zanten, M., & Boulet, J. (2008). Medical education in the Caribbean: Variability in medical school programs and performance of students. *Academic Medicine*, *83*(10 Suppl), S33–S36.

Van Zanten, M., Boulet, J., & McKinley, D. (2003). Correlates of performance of the ECFMG Clinical Skills Assessment: Influences of candidate characteristics on performance. *Academic Medicine*, *78*(10), S72–S74.

EXAMS

Bell, J., Kanellitsas, I., & Shaffer, J. (2002). Selection of obstetrics & gynecology residents on the basis of medical school performance. *American Journal of Obstetrics &Gynecology*, *186*, 1091–1094.

Dirschl, D. R., Campion, E. R., & Gilliam, K. (2006). Resident selection and predictors of performance: Can we be evidence based? *Clinical Orthopaedics & Related Research*, *449*, 44–49.

Gayed, N. M. (1991).Residency directors' assessments of which selection criteria best predict performances of foreign-born foreign medical graduates during internal medicine residencies. *Academic Medicine, 66*(11), 699–701.

Kanna, B., Gu, Y., Akhuetie, J., & Dimitrov, V. (2009). Predicting performance using background characteristics of international medical graduates in an inner-city university-affiliated internal medicine residency training program. *BMC Medical Education, 9,* 42–50.

Leigh, T. M., Johnson, T. P., & Pisacano, N. J. (1990). Predictive validity of the American board of family practice in-training examination. *Academic Medicine, 65*(7), 454–457.

Part, H. M., & Markert, R. J. (1993). Predicting the first-year performance of international medical graduates in an internal medicine residency. *Academic Medicine, 68*(11), 856–858.

Perez, J. A., & Greer, E. S. (2009). Correlation of United States medical licensing examination and internal medicine in-training examination performance. *Advances in Health Sciences Education, 14*, 753–758.

Tamblyn, R., Abrahamowicz, M., Dauphinee, D., Wenghofer, E., Jacques, A., Klass, D.,…Hanley, J. A. (2007). Physician scores on a national clinical skills examination as predictors of complaints to medical regulatory authorities. *Journal of American Medical Association*, *298*(9), 993–1001.

Wenghofer, E., Klass, D., Abrahamowicz, M., Dauphinee, D., Jacques, A., Smee, S.,…Tamblyn, R. (2009). Doctor scores on national qualifying examinations predict quality of care in future practice. *Medical Education, 43,* 1166–1173.

REFERENCES AND PERSONAL STATEMENTS

Albanese, M. A., Snow, M. H., Skochelak, S. E., Huggett, K. N., & Farell, P.M. (2003). Assessing personal qualities in medical school admissions. *Academic Medicine, 78*(3), 313–321.

Dirschl, D., Dahners, L., Adams, G., Crouch, J., & Wilson, F. (2002). Correlating selection criteria with subsequent performance as residents. *Clinical Orthopaedics and Related Research*, *399*, 265–271.

Ferguson, E., James, D., & Madeley, L. (2002). Factors associated with success in medical school: Systematic review of the literature. *British Medical Journal, 324*, 952–957.

Hayden, S., Hayden, M., & Gamst, A. (2005). What characteristics of applicants to emergency residency programs predict future success as an emergency medicine resident? *Academic Emergency Medicine, 12*(3), 206–210.

Lee, A., Golnik, K., Oetting, T., Beaver, H., Boldt, H., Olson, R.,…Carter, K. (2008). Re-engineering the resident application process in opthalmology: A literature review and recommendations for improvement. *Survey of Opthalmology*, *53*(2), 164–176.

Salvatori, P. (2001). Reliability and validity of admissions tools used to select students for the health professions. *Advances in Health Sciences Education, 6*(2), 159–175.

Siu, E., & Reiter, H. I. (2009). Overview: What's worked and what hasn't as a guide towards predictive admissions tools development. *Advances in Health Sciences Education, 14*, 759–775.

Thordarson, D. E. (2007). Resident selection: How are we doing and why? *Clinical Orthopaedics & Related Research*, *459*, 255–259.

GRADES AND AWARDS

Dirschl, D., Dahners, L., Adams, G., Crouch, J., & Wilson, F. (2002). Correlating selection criteria with subsequent performance as residents. *Clinical Orthopaedics and Related Research*, *399*, 265–271.

Illing, J., Campbell, M., Kergon, C., Thompson, N., Burford, B., Morrow, G.,…Spencer, J. (2009). *Selection methods for foundation programme: A literature review.* Retrieved from www.medschools.ac.uk/aboutus/projects/documents/appendix%20K%20Newcastle%20Literature%20Review.

Kreiter, C. D. (2007). A commentary on the use of cut-scores to increase the emphasis of non-cognitive variables in medical school admissions. *Advances in Health Sciences Education, 12*, 315–319.

Kreiter, C. D., & Kreiter, Y. (2007). A validity generalization perspective on the ability of undergraduate GPA and the medical college admission test to predict important outcomes. *Teaching and Learning in Medicine, 19*(2), 95–100.

LaGrasso, J. R., Kennedy, D. A., Hoehn, J. G., Ashruf, S., & Przybyla, A. M. (2008). Selection criteria for the integrated model of plastic surgery residency. *Plastic & Reconstructive Surgery*, *121*(3), 121e–125e.

Siu, E., & Reiter, H. I. (2009). Overview: What's worked and what hasn't as a guide towards predictive admissions tools development. *Advances in Health Sciences Education, 14*, 759–775.

RECENT CLINICAL EXPERIENCE, GRADUATION, AGE

Bessant, R., Bessant, D., Chesser, A., & Coakley, G. (2006). Analysis of predictors of success in the MCRP (UK) PACES examination in candidates attending a revision course. *Postgraduate Medical Journal*, *82*, 145–151.

Blonski, J., & Rahm, S. (2003). The relationship of residency performance to match status and US versus international graduate status. *Family Medicine, 35*(2), 100–104.

Kanna, B., Gu, Y., Akhuetie, J., & Dimitrov, V. (2009). Predicting performance using background characteristics of international medical graduates in an inner-city university-affiliated internal medicine residency training program. *BMC Medical Education, 9,* 42–50.

Part, H. M., & Markert, R. J. (1993). Predicting the first-year performance of international medical graduates in an internal medicine residency. *Academic Medicine, 68*(11), 856–858.

INTERVIEWS

Albanese, M. A., Snow, M. H., Skochelak, S. E., Huggett, K. N., & Farell, P.M. (2003). Assessing personal qualities in medical school admissions. *Academic Medicine, 78*(3), 313–321.

Bandiera, G., & Regehr, G. (2004). Reliability of a structured interview scoring instrument for a Canadian postgraduate emergency medicine training program. *Academic Emergency Medicine, 11*(1), 27–32.

Blouin, D. (2010). Reliability of a structured interview for admission to an emergency medicine residency program. *Teaching and Learning in Medicine, 22*(4), 246–250.

Blouin, D., & Dagnone, J. (2008). Performance criteria for emergency medicine residents: A job analysis. *Canadian Journal of Emergency Medicine*, *10*(6), 539–544.

Fan, A. P., Tsai, T. C., Su, T. P., Kosik, R. O., Morsiky, D. E., Chen, C. H.,…Lee, C. H. (2010). A longitudinal study of the impact of interviews on medical school admissions in Taiwan. *Evaluation and the Health Professions, 33*(2), 140–163.

Goho, J., & Blackman, A. (2006). The effectiveness of academic admission interviews: An exploratory meta-analysis. *Medical Teacher, 28*(4), 335–340.

Gumperz, J .J. (1992). Interviewing in intercultural situations. In P. Drew & J. Heritage (Eds.), *Talk at work: Interaction in institutional settings* (pp. 302–327). Cambridge, England: Cambridge University Press.

Illing, J., Campbell, M., Kergon, C., Thompson, N., Burford, B., Morrow, G.,…Spencer, J. (2009). *Selection methods for foundation programme: A literature review.* Retrieved from www.medschools.ac.uk/aboutus/projects/documents/appendix%20K%20Newcastle%20Literature%20Review.

Patrick, L. E., Altmaier, E. M., Kuperman, S., & Ugolinin, K. (2001). A structured interview for medical school admission, phase 1: Initial procedures and results. *Academic Medicine, 76*, 66–71.

Poole, A., Catano, V. M., & Cunningham, D. P. (2007). Predicting performance in Canadian dental schools: The new CDA structured interview, a new personality assessment, and the DAT. *Journal of Dental Education, 71*(5), 664–676.

Posthuma, R., Morgeson, F., & Campion, M. (2002). Beyond employment interview validity: A comprehensive narrative review of recent research and trends over time. *Personnel Psychology*, *55*, 1–81.

Quintero, A., Segal, L., King, S., & Black, K. (2009). The personal interview: Assessing the potential for personality similarity to bias the selection of orthopaedic residents. *Academic Medicine*, *84*, 1364–1372.

Rao, N., Meinzer, A., Primavera, L., & Augustine, A. (1991). Psychiatry residency selection criteria for American and foreign medical graduates. *Academic Psychiatry*, *15*, 69–79.

Roberts, C., Sarangi, S., Southgate, L., Wakford, R., & Wass, V. (2000). Oral examinations – equal opportunities, ethnicity, and fairness in the MRCGP. *British Medical Journal, 320*, 370–375.

Shiroma, P. R., & Alarcon, R. D. (2010). Selection factors among international medical graduates and psychiatric residency performance. *Academic Psychiatry*, *34*(2), 128–131. Retrieved from http://ap.psychiatryonline.org.

Smilen, S., Funai, E., & Bianco, A. (2001). Residency Selection: Should interviewers be given applicants' board scores? *American Journal of Obstetrics & Gynecology*, *184*, 508–513.

LANGUAGE

Boulet, J. R., van Zanten, M., McKinley, D. W., & Gary, N. E. (2001). Evaluating the spoken English proficiency of graduates of foreign medical schools. *Medical Education, 35,* 767–773.

Rothman, A. I., & Cusimano, M. (2000). A comparison of physician examiners', standardized patients', and communication experts' ratings of international medical graduates' English proficiency. *Academic Medicine, 75*(12), 1206–1211.

Rothman, A. I., & Cusimano, M. (2001). Assessment of English proficiency in international medical graduates by physician examiners and standardized patients. *Medical Education, 35*(8), 762–766.

Toronto Immigrant Employment Data Initiative (TIEDI) (2010). *Language skills and immigrant labour market outcomes.* Toronto, Ontario, Canada: York University. Retrieved from http://www.yorku.ca/tiedi/pubreports11.html.

Toronto Immigrant Employment Data Initiative (TIEDI). (2010). *Does self-reported English and French speaking ability affect labour market outcomes for immigrants?* Toronto, Ontario, Canada: York University. Retrieved from http://www.yorku.ca/tiedi/pubreports6.html.

van Zanten, M., Boulet, J. R., McKinley, D. W., DeChamplain, A., & Jobe, A. C. (2007). Assessing the communication and interpersonal skills of graduates of international medical schools as part of the United States medical licensing exam (USMLE) step 2 clinical skills (CS) exam. *Academic Medicine, 82*(10 Suppl), S65–S68.

van Zanten, M., Boulet, J. R., McKinley, D., & Whelan, G. P. (2003). Evaluating the spoken English proficiency of international medical graduates: Detecting threats to the validity of standardised patient ratings. *Medical Education, 37*(1), 69–76.

Watt, D., Lake, D., Cabrnoch, T., & Leonard, K. (2003). Assessing the English language proficiency of international medical graduates in their integration into Canada's physician supply. Retrieved from http://www.m-cap.ca/pdf/Assessing%20ELP%20of%20IMGs_Final_2003.pdf.

4. New methods of evaluation

Multiple Mini-Interviews

Dore, K. L., Kreuger, S., Ladhani, M., Rolfson, D., Kurtz, D., Kulasegaram, K.,…Reiter, H. I. (2010). The reliability and acceptability of the multiple mini-interview as a selection instrument for postgraduate admissions. *Academic Medicine*, *85*(10 Suppl), S60–S63.

Eva, K., Reiter, H. I., Rosenfeld, J., & Norman, G. (2004). The ability of the multiple mini-interview to predict preclerkship performance in medical school. *Academic Medicine*, *79*(10 Suppl), S40–S42.

Eva, K. W., Reiter, H. I., Trinh, K., Wasi, P., Rosenfeld, J., & Norman, G. R**. (**2009). Predictive validity of the multiple mini-interview for selecting medical trainees. *Medical Education*, *43*, 767–785.

Hofmeister, M., Lockyer, J., & Crutcher, R. (2009). The multiple mini-interview for selection of international medical graduates into family medicine residency education. *Medical Education, 43,* 573–579.

Other new methods of evaluation

Dore, K. L., Reiter, H. I., Eva, K. W., Krueger, S., Scriven, E., Siu, E.,…Norman, G. R. (2009). Extending the interview to all medical school candidates–Computer-based multiple sample evaluation of noncognitive skills (CMSENS). *Academic Medicine, 84*(10 Suppl), S9–S12.

Dore, K., Siu, E., Reiter, H. I., Kreuger, S., Eva, K., & Norman, G. (2009). OP-03: A Reliable and Valid Pre-Interview Measure of Non-Cognitive Skills: Computer-Based Multiple Sampling Evaluation of Non-Cognitive Skills (CMSENS). *Medical Education, 43*(1 Suppl), 1–2.

5. Assessing and meeting the needs of IMGs

Assessing the needs of IMGs

Allan, G. M., Manca, D., Szafran, O., & Korownyk, C. (2007). EBM a challenge for international medical graduates. *Family Medicine*, *39*(3), 160.

Chur-Hansen, A., Elliott, T. E., Klein, N. C., & Howell, C. A. (2007). Assessment of English-language proficiency for general practitioner registrars. *Journal of Continuing Education in the Health Professions, 27*(1), 36–41.

Cordella, M., & Musgrave, S. (2009). Oral communication skills of international medical graduates: Assessing empathy in discourse. *Communication & Medicine, 6*(2), 129–142.

Lockyer, J., Blackmore, D., Fidler, H., Crutcher, R., Salte, B., & Shaw, K. (2006). A study of a multi-source feedback system for international medical graduates holding defined licences. *Medical Education, 40*(4), 340–347.

Lockyer, J., Fidler, H., de Gara, D., & Keefe, J. (2010). Learning to practice in Canada: The hidden curriculum of international medical graduates. *Journal of Continuing Education in the Health Professions, 30*(1), 37–43.

Meghani, S. H., & Rajput, V. (2011). The need for practice socialization of international medical graduates - An exemplar from pain medicine. *Academic Medicine, 86,* 571–574.

Pilotto, L. S., Duncan, G. F., & Anderson-Wurf, J. (2007). Issues for clinicians training international medical graduates: A systematic review. *Medical Journal of Australia, 187*(4), 225–228.

Watt, D., Lake, D., Cabrnoch, T., & Leonard, K. (2003). Assessing the English language proficiency of international medical graduates in their integration into Canada's physician supply. Retrieved from http://www.m-cap.ca/pdf/Assessing%20ELP%20of%20IMGs_Final_2003.pdf.

Zulla, R., Baerlocher, M. O., & Verma, S. (2008). International medical graduates (IMGs) needs assessment study: Comparison between current IMG trainees and program directors. *Medical Education, 8,* 42–47.

MEETING THE NEEDS OF IMGS

Andrew, R., & Bates, J. (2000). Program for licensure for international medical graduates in British Columbia: 7 years of experience. *CMAJ*, *162*(6), 801–803.

Curran, V., Hollett, A., Hann, S., & Bradbury, C. (2008). A qualitative study of the international medical graduate and the orientation process. *Canadian Journal of Rural Medicine: The Official Journal of the Society of Rural Physicians of Canada, 13*,163–169.

Emery, J. C. H., Crutcher, R. A., Harrison, A. C. M., & Wright, H. (2006). Social rates of return to investment in skills assessment and residency training of international medical graduates in Alberta. *Health Policy (Amsterdam, Netherlands), 79*(2-3), 165-174.

Hoekje, B. J. (2007). Medical discourse and ESP courses for international medical graduates (IMGs). English *for Specific Purposes, 26,* 327–343.

Lax, L. R., Russell, M. L., Nelles, L. J., & Smith, C. M. (2009). Scaffolding knowledge building in a web-based communication and cultural competence program for international medical graduates. *Academic Medicine, 84*(10 Suppl), S5-S8.

Peters, C. (2011). *The bridging education and licensure of international medical doctors in Ontario: A call for commitment, consistency, and transparency* (Unpublished doctoral dissertation). University of Toronto, Toronto, Ontario, Canada.

Porter, J. L., Townley, T., Huggett, K., & Warrier, R. (2008). An acculturation curriculum: Orienting international medical graduates to an internal medicine residency program. *Teaching and Learning in Medicine, 20*(1), 37-43.

Violato, C., Watt, D., & Lake, D. (2011). *A longitudinal cross-sequential study of the professional integration of international medical graduates (IMGs): From application to licensure: An interim report 2011.* Retrieved from http://www.m-cap.ca/pdf/IMGStudyInterimReport_Apr2011.pdf.

Watt, D., Crutcher, R., & Lake, D. (2006). *Language communication assessment project (L-CAP): An Alberta pilot project for international medical graduates.* Calgary, Alberta, Canada. Retrieved from http://www.m-cap.ca/pdf/LCAP%20Final%20Report%202006.pdf.

Watt, D., Violato, C., Lake, D., & Baig, L. (2010). Effectiveness of a clinically relevant educational program for improving medical communication and clinical skills of international medical graduates. *Canadian Medical Education Journal, 1*(2), e70–e80.

Wong, A., & Lohfield, L. (2008). Recertifying as a doctor in Canada: International medical graduates and the journey from entry to adaptation. *Medical Education, 42,* 53–60.

FACULTY TRAINING

Centre for Intercultural Communication, University of British Columbia. (2011). Certificate in intercultural studies: Program details. Retrieved from The University of British Columbia website: http://cic.cstudies.ubc.ca/cis/details.html.

Pilotto, L. S., Duncan, G. F., & Anderson-Wurf, J. (2007). Issues for clinicians training international medical graduates: A systematic review. *Medical Journal of Australia, 187*(4), 225–228.

Porter, J. L., Townley, T., Huggett, K., & Warrier, R. (2008). An acculturation curriculum: Orienting international medical graduates to an internal medicine residency program. *Teaching and Learning in Medicine, 20*(1), 37-43.

Steinert, Y. (2006). *Building on diversity: A faculty development program for teachers of international medical graduates.* Ottawa, Ontario, Canada: The Association of Faculties of Medicine of Canada. Retrieved from http://www.afmc.ca/img/pdf/Intro_AppA_en.pdf. [Full program available at www.afmc.ca/img/.]

IMG PROGRESS IN RESIDENCY AND ON CERTIFICATION EXAMS

Andrew, R. F. (2010). How do IMGs compare with Canadian medical school graduates in a family practice residency program? *Canadian Family Physician, 56,* e318–e322.

MacLellan, A., Brailovsky, C., Rainsberry, P., Bowmer, I., & Desrochers, M. (2010). Examination outcomes for international medical graduates pursuing or completing family medicine residency training in Quebec. *Canadian Family Physician, 56,* 912–918.

APPENDIX B: ACRONYMS

The following are some of the many acronyms we encountered during the IMG Review, not all of which are used in this report.

AFMC	Association of Faculties of Medicine of Canada
ACGME	Accreditation Council for Graduate Medical Education (US)
AIPSO	Association of International Physicians and Surgeons of Ontario
AVP	Assessment Verification Period
CACM	Committee on Accreditation of Canadian Medical Schools
CAPER	Canadian Post-M.D. Education Registry
CASPer	Computer-based Assessment for Sampling PERsonal characteristics
CaRMS	Canadian Resident Matching Service
CE1	General Comprehensive Clinical Exam (tests readiness for post graduate year one (PGY1) level.
CEPHEA	Centre for the Evaluation of Health Professionals Educated Abroad
CFPC	College of Family Physicians of Canada
COFM	Council of Ontario Faculties of Medicine
COMLEX	Comprehensive Osteopathic Licensing Examination (US)
CLEO	Considerations of Legal, Ethical and Organization
COU	Council of Ontario Universities
CPSO	College of Physicians and Surgeons of Ontario
CSA	Canadian studying abroad
ECFMG	United States Education Commission for Foreign Medical Graduates
ERAS	Electronic Residency Application System (US version of CaRMS)
FAIMER	Foundation for Advancement of International Medical Education and Research
FHRCO	Federation of Health Regulatory Colleges of Ontario

FMEC	Future of Medical Education in Canada
FMRAC	Federation of Medical Regulatory Authorities of Canada
FHGs	Family health groups
FHNs	Family health networks
FHTs	Family health teams
GIS	Graduate of international school (Canadian who studied abroad)
HFO MRA	HealthForceOntario Marketing and Recruitment Agency
IMG	International Medical Graduate
LCME	Liaison Committee on Medical Education
LMCC	Licentiate of the Medical Council of Canada
MCC	Medical Council of Canada
MCCEE	Medical Council of Canada Evaluating Exam
MCCQEI and II	Medical Council of Canada Qualifying Exams Part I and Part II
MCI	Ontario Ministry of Citizenship and Immigration
MINC	Medical Identification Number for Canada
MMI	Multiple Mini-Interview
MOHLTC	Ontario Ministry of Health and Long-Term Care
NAC	National Assessment Collaboration
NAC OSCE	National Assessment Collaboration Objective Structured Clinical Examination
Northern	Northern Ontario School of Medicine
OPHRDC	Ontario Physician Human Resources Data Centre
OTPC	Orientation to Training and Practice in Canada
OSCE	Objective Structured Clinical Examination

OTPC	Orientation to Training and Practice in Canada
PAIRO	Professional Association of Internes and Residents of Ontario
PCRP	Physician Credential Registry of Canada
PGM:COFM	Postgraduate Management Committee, Council of Ontario Faculties of Medicine
PGE:COFM	Postgraduate Education Committee, Council of Ontario Faculties of Medicine
PGY1	Postgraduate Year 1 (entry level postgraduate training)
PGY2+	Postgraduate Year 2+ (advanced level postgraduate training)
PEAP	Pre-Evaluation Assessment Program
PRA	Practice Ready Assessment
PRP	Pre-Residency Program
RHPA	Regulated Health Professions Act
RCPSC	Royal College of Physicians and Surgeons of Canada
ROS	Return of Service
RPA	Registration through Practice Assessment
SWE	Specialty written exam
TOEFL	Test of English as a Foreign Language
USMLE	United States Medical Licensing Exam