Access of International Medical Graduates to Practice in Ontario

A Study of Narrative Descriptions

By

Eng-Soon Chan, MBBS, FRCPC

A Thesis
Submitted to the Faculty of Graduate Studies in
Partial Fulfillment of the Requirements for
the Degree of

MASTER OF SCIENCE

Department of Community Health Science
University of Manitoba
Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

Access of International Medical Graduates to Practice in Ontario

A Study of Narrative Descriptions

BY

Eng-Soon Chan

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree

of

MASTER OF SCIENCE

Acknowledgment

The author would like to thank the individuals who contributed invaluably to this thesis.

Special thanks to my parents, siblings and their spouses for their continuous support.

I am deeply indebted for the guidance provided by my advisor Dr. J. Kaufert and the thesis committee members Drs. Young, Elliot, and Morris.

The effort and commitment made by all study participants undoubtedly form the pillar of this thesis.

I am grateful for the help afforded to me by my best friend Rick Wilson and for the input provided by Mr. Moe Watkin, Ms. Elizabeth McIsaac, and my colleagues Drs. D'Cunha, Kurji, Jin, and Bontovics.

In addition, the contribution and support of the board of directors of the Association of International Physicians and Surgeons of Ontario (AIPSO) is hereby acknowledged with gratitude.

This thesis is dedicated to all present and future immigrant professionals in Canada. Should this endeavour somewhat contribute to streamlining the absorption processes and the successful integration of these immigrants – it would render my effort worthwhile.

E.S.C.
Toronto, Ontario
August 2004

Table of Contents

Author's Note regarding Quotations and Scripts: Quotes from interviewee's appears in *italicized* and indented paragraphs. Statements are displayed **verbatim**. For clarity, round brackets have been used to identify words or expressions that may be disregarded and square brackets to denote additions by the researcher.

Chapter One: Introduction

1.1. Statement of the Problem

Each year, Canada receives hundreds of thousands of immigrants from all over the world. According to Citizenship and Immigration Canada, in 2002, the department planned to accept between 210 and 235 thousand immigrants and, in actuality, 229,091 immigrants arrived during that year. In his research of evolving family living arrangements, Thomas (2001) confirms that immigrants comprise a significant part of Canada's population, and they are the main factor contributing to its growth. As well, as indicated by Citizenship and Immigration Canada (and other sources), immigration policies impact the nation's demographic structure and, consequently, affect regional and provincial planning.

In the Canadian context, the term 'immigrant' refers to a newcomer from another country that, based on selection and approval criteria, has been granted permission to permanently live in Canada. The new federal Immigration and Refugee Protection Act (IRPA),[1] refers to status immigrants as 'permanent residents.' In the Act, the term 'permanent resident' is defined as a person who has acquired such a status and has not lost it under Section 46 of the Act. The Act recognizes three categories of permanent residents:

- *Economic Class — skilled workers, business immigrants, provincial nominees, and live-in caregivers and members of their immediate family.*

---

[1] Enacted June 28, 2002 (Source: Canada Immigration website).

- *Family Class — spouses, partners, children, parents and grandparents of Canadian sponsors.*

- *Protected Persons Category — government-assisted and privately- or self-sponsored refugees.*

Under the provisions set out in the Act, the emphasis for selecting skilled workers has shifted from an occupation-based model to one that focuses more on choosing skilled workers with flexible and transferable skill sets, required to succeed in a fast-changing, knowledge-based economy.

New immigrants bring to bear a variety of skill sets. Many of them are trained professionals, such as medical doctors and engineers, who bring with them extensive knowledge and experience. Close to 54 percent of the new residents who entered Canada in 2002 (i.e., 123,357 newcomers) were classified as skilled workers. According to Citizenship and Immigration Canada, these immigrants are expected to have the skills, education, work experience, language ability and other qualities needed to participate in and contribute to the Canadian labour market. By the same token, from a national perspective, to adequately fulfill the objectives of the immigration policy adopted by the Canadian government, it is important to quickly utilize those 'readily-available' skills, and have the new immigrants productively engaged in the local economy.

Successful settlement of immigrants entails the ability to quickly utilize already-acquired knowledge and experience and have every newcomer effectively participating in the new society as a full functioning member. To mutually benefit from these attributes, immigrants must be able to actively involve and integrated into

the economy. However, reality may be different. Ample evidence confirms — as is in Thomas (2001) and Brouwer (1999) — that newly-arrived professionals face uncertainty and suffer from an unappreciated social status.

Kliewer and Jones (1996) suggest that the difference between the level of one's education and occupation exists quite often, and it is referred to as 'status inconsistency.' This term identifies the gap between one's ability based on qualifications and education level, and one's level of occupation that may be forced by circumstances to assume. In the context of immigrant populations, the term has also been used to describe a decrease in occupational status between the 'old' (the country of origin) and the 'new' country. Abramson et al (1984) find that, in some cases, status inconsistency has been linked to mental disorders in migrant populations.

Immigrants often face difficulties in having their academic or occupational credentials recognized[2] (Kliewer and Jones, 1996). As such, the individuals involved are forced to work in lower-status occupations. Moreover, migrants with the highest level of education have the highest prevalence of minor psychiatric disorders. Aycan and Berry (1996) have found that despite attainment of high level of education, two out of three participants in their study were either unemployed or underemployed.[3] The failure to recognize immigrant credentials affects more than the individuals

---

2 Kliewer and Jones studied migrant health and the use of health services in Australia. In many aspects, Canada is similar to Australia (e.g., demographics, socio-economic and cultural characteristics, and immigration policies and practices).

3 This study focused on Turkish immigrants to Canada.

involved;[4] it also impacts their surrounding environment (i.e., family members and colleagues).

Contrary to expectations, literature describing the personal experiences of immigrant professionals is scarce. Very little has been investigated about key areas involving IMGs' and their struggle to obtain meaningful employment. This statement holds true with respect to studies on IMGs' journey to proceed along the process or processes to re-qualify in their own profession, the difficulties they faced, and the strategies they apply to cope with those difficulties. As a result, research questions relevant to the experiences of those professionals have emerged. By way of example, two of the questions are: What barriers do immigrant professionals face, while searching for a meaningful employment or re-qualifying in their professions in Canada? And, what are their coping strategies in dealing with these barriers? These questions raise a variety of issues concerning the career opportunity of individuals, from arrival onto receiving professional accreditation in this country.

Integration into a new society requires the ability on the part of immigrants to function and actively participate in that society. One's ability to function within the new society is a key measure of effective integration in a new country. Aycan and Berry (1996) state that *...participation in every aspect of the new society, including the labour force, is critical especially for multicultural societies because the very existence of such societies depends on the successful integration of newcomers.*

---

[4] Stasiulis (1990) estimates a loss of 100 to 350 million U.S. dollars to the Australian national economy due to the non-recognition of foreign degrees.

A timely and fair accreditation process is essential for allowing immigrant professionals to utilize their skills and find a meaningful employment. To secure a level of employment consistent with the skills, experience, and knowledge that a foreign-trained professional brings to bear, a credible assessment and recognition of qualifications by a Canadian regulatory body is required. Among professional occupations, this requirement applies to engineers, teachers and – of course – medical practitioners.

1.2. Scope and Objectives

This study focuses on foreign-trained physicians, hereinafter referred to as International Medical Graduates (IMGs). The study explores the personal experiences of IMGs, while struggling to receive accreditation and a licence to practice in Canada. It is expected that the findings will contribute to the refinement of current immigration policies and to the implementation of strategic changes, aimed at improving health human-resource planning.

The researcher himself is an IMG who is currently licensed to practice as a physician in Canada. His own experience in obtaining a licence has given him insight into this research topic. Consequently, it is his hoped that through this research project, the author will positively influence the development of a more progressive government-policy toward immigrant professionals.

This study concentrates on IMGs, including physicians who:

- Are permanent residents or Canadian citizens residing in Ontario,

- Trained in medical schools outside Canada, and
- Have been unsuccessfully attempting to obtain a licence to practice medicine in Ontario.[5]

The researcher has set out the following objectives for this study:

- Describe IMGs' experiences in accessing medical careers in Canada through narrative provided by selected interviewees;
- Identify and analyze the types of barriers IMGs encounter, while attempting to obtain meaningful employment or re-qualifying to practice medicine in Canada;
- Explore coping strategies for IMGs to effectively deal with these barriers;
- Consolidate the interviewees' perspectives on policy changes required to improve access.

To best answer the research questions raised in this report, the study discusses various accreditation systems in Canada and the barriers they pose to IMGs. Evidence regarding IMG experiences has been gathered through a literature review and interviews with IMGs. As in Morse et al (1995), a qualitative study-methodology has been selected to explore the experience of several IMGs and their attempts to obtain a licence to practice. The process adopted allows the researcher to focus on narratives as means of documenting IMGs' perceptions. It also enables the author to provide an in-depth description of experiences, and identify common themes. In addition, it

---

[5] The ensuing discussion does not refer to IMGs from certain countries (e.g., South Africa, Ireland, Australia, New Zealand and the United Kingdom), whose access to licensure is pursued along a different pathway.

allows the study to present individual's perspectives on policy changes needed for better integrating IMGs into the medical profession.

Chapter Two: The Accreditation Process

2.1. Overview

Among the various groups of immigrant professionals, IMGs seem to endure the most difficult consequences in acquiring suitable employment and reentering into their profession. This is so primarily because the accreditation of immigrant professionals involves a complicated process. Moreover, for physicians and specialists, the system is fragmented and not geared to deal with 'outsiders' (e.g., individuals trained outside of the Canadian system of education and licensure). The Canadian system involves several different organizations, none of which has been given a clear mandate to coordinate the accreditation processes pertaining to immigrant professionals.

In Canada, the medical profession is regulated under provincial and territorial Acts, with thirteen distinct provincial and territorial licensing bodies. With a few exceptions, this constellation of organizations differs significantly from the licensing systems typically found in many of the countries, from which professional immigrants come. For example, in Myanmar (formerly Burma), the country of origin of this researcher, a licence to practice medicine is issued by a single organization — the National Department of Health. Also, the nomenclature of institutions is significantly different. In Canada, the process of defining which institution controls access and holds responsibility for IMGs' accreditation is ambiguous. A case in point is the College of Physicians and Surgeons, which is often incorrectly perceived as a training institution.

As indicated in publications issued by the Manitoba Government (a 2000 draft document) and in Ontario (by AIPSO, 1999), to lawfully practice as a physician in Canada, an IMG must obtain a licence from the appropriate licensing body in the province where he or she intends to practice. As is the case with a non-Canadian medical graduate, before a licence is granted, each IMG must fulfill all the requirements of the licensing body. This process involves a number of organizations. The following sections briefly describe the roles of these organizations in the process of certifying IMGs. As well, common pathways to receiving a licence to practice are also discussed.

2.2. Organizations Involved in Accreditation

2.2.1. The Provincial and Territorial Licensing Bodies

The British North America Act (BNA) of 1867 assigns jurisdiction over education and health to provincial governments (Judek, 1964). Referred to in a few jurisdictions as the Medical Profession Act, provincial medical Acts have given the College of Physicians and Surgeons in each province (also referred to as the Provincial Council or Medical Board), the right to determine the qualifications required for entry to medical schools, and set conditions for obtaining a licence to practice medicine in the respective province.

An IMG seeking licence to practice in any province must first have the licensing body in that province assess his or her credentials. When credentials are found to be below the provincial standard, a licence is not issued. In the absence of any formal appellate-process or an independent arbitration panel, there is no alternative process

for reviewing or altering the initial decision. Brouwer (1999) asserts that the licensing body has discretionary power to put as much (or as little) time and energy as it wishes into the development of structures or mechanisms to provide foreign-trained applicants with fair and equitable access to the system.

Judek (1964) argues that, generally, the sole legislated mandate of the provincial licensing bodies is to protect the health, safety and welfare of Canadians by ensuring that all practicing physicians meet a certain level of competence. However, Brouwer (1999) identifies concerns, which have surfaced over the fact that professional regulatory or licensing bodies are focusing on secondary, non-mandated issues. One such issue is controlling the supply of licensed professionals.

A 1998 brief by the Canadian Ethnocultural Council, as cited in Brouwer (1999), charges that:

> *Through the creation of artificial, arbitrary or unnecessary accreditation criteria, some associations have found that they could restrict the numbers of practising professionals or trades people. By controlling the supply, they could increase demand and thereby bring financial benefit to their members.*

With no proper mechanism to review the process or the decision made by any of the licensing bodies, and no proper appeal process, IMGs may be denied a licence for a variety of reasons. This position is stated by a number of sources, including Bowen et al (1998), Satkauskas et al (1990), Brouwer (1999) and AIPSO (2000); the last two sources go on to suggest that, presumably, this system was established for the purpose of promoting public health and safety.

The following sections provide a brief discussion on the relevant Canadian institutions and licensing (or pseudo-licensing) organizations involved in the process of obtaining a medical licence.

2.2.2. The Medical Council of Canada

As indicated on the website of the Medical Council of Canada (MCC), this institution was established in 1912 under the Canada Medical Act. The Council administers examinations in both French and English. These examinations are intended to ensure a single set of standards for educational attainment, which is also acceptable in all provinces (Lowry, 1989). Successful candidates receive the diploma of Licentiate of the Medical Council of Canada (LMCC), and they are eligible to register with the Canadian Medical Registrar.[6] Even though the MCC is not a licensing body, most provincial and territorial licensing organizations require physicians to acquire LMCC accreditation prior to granting a licence to practice.

An IMG must submit his or her credentials to the Medical Council of Canada before taking MCC exams. Subsequently, the applicant must pay the exam fee as set by MCC, and appear at a designated examination centre, which may not necessarily be in the province where the IMG resides. For an unemployed or underemployed IMG, the exam fee ($650 to $1200 Canadian dollars) is relatively expensive and, frequently unaffordable. However, owing to recent developments in computer technology,

---

[6] The diploma does not guarantee an access to practice in Canada and IMGs must fulfill other requirements set out by the licensing body in each province in order to practice in that province.

IMGs may no longer have to travel to another province for writing the MCC exams. Instead, they may take a computer-scored exam at a nearer location.

2.2.3. The Canadian Resident Matching Service

The Canadian Resident Matching Service (CaRMS) is a not-for-profit, fee-for-service corporation governed by a board of directors with representation from all stakeholders in the Canadian medical education system (CaRMS website). Working in cooperation with medical schools and students, CaRMS provides a 'match' for entry to postgraduate medical training. The match is carried out by a computer program that pairs resources on the basis of iterations (or processes) and a series of pre-programmed decisions. The program runs two separate and successive processes for matching medical graduates to residency positions. However, as evidenced by CaRMS-published information, IMGs have no access to the first selection stage, in which most of the applicants are successfully matched (e.g., more than 94 percent in 1999). In fact, AIPSO-published statistics for the years 1995 to 1999 show that, on average, less than ten percent of IMGs applicants were placed in residency programs across Canada.

2.2.4. The College of Family Physicians of Canada

Since 1954, the College of Family Physicians of Canada (CFPC) evaluates and accredits family medicine residency training programs in Canadian medical schools, and publishes information to that effect on its website and in other sources. Subsequent to this training program, residents must successfully complete the College Certification Examination to receive a CFPC designation. The certification

examination lasts two days and it is held two times a year. The exam consists of a written examination (first day), followed by an oral examination (second day). The College also conducts an examination that leads to Certificate of Special Competence in Emergency Medicine.

2.2.5. The Royal College of Physicians and Surgeons of Canada

The Royal College of Physicians and Surgeons of Canada (RCPSC) was established by a special Act of parliament in 1929, with the purpose of advancing the standards of postgraduate medical education and practice in the medical, laboratory and surgical specialties. The RCPSC accredits residency training in sixteen schools across Canada that offer postgraduate medical education. To be admitted as an RCPSC fellow, graduates from medical schools outside Canada and the U.S. must: (i.) have satisfactorily completed a postgraduate medical training, or residency training in a program accredited by the RCPSC; (ii.) pass the RCPSC certification exam; and, (iii.) obtain an LMCC diploma. The RCPSC allows IMGs to sit for a certification exam, only after having completed a residency program accredited by the college.

Since neither the RCPSC nor the CFPC accredits and recognizes residency training in most of the countries from which IMGs typically come, proceeding onto certification exams (which are administered by these organizations) is not feasible.[7] It appears, however, that the evaluation of professional competencies is based on the route taken by the individual to acquire a particular set of skills. The evaluation does not necessarily consider whether or not the candidate has already acquired the required

[7] An IMG who has completed residency training in Canada or the U.S. is exempted.

skills. For the majority of IMGs, this is a significant barrier because the route of training (as stipulated by both the RCPSC and the CFPC) is not accessible to them. Without certification from either of these two organizations, IMGs cannot be licensed to practice in Canada.

2.3. Access to Medical Training

As stated by Manitoba Labour Department (2000), medical schools across Canada provide education in general medicine and in specialty fields, including postgraduate training. An undergraduate medical degree (MD) usually takes four years to complete and, depending on the type of specialty chosen, postgraduate medical training takes between two and five years. In Canada, undergraduate medical degree programs are accredited by the Liaison Committee on the Medical Education (LCME website) and with the exception of family medicine programs, the RCPSC accredits postgraduate medical education, or residency training in medical schools. By contrast, family medicine programs are accredited by CFPC.

Funding for residency training is provided by the respective provincial governments. However, IMGs have limited access to these residency programs (Thomas, 2001). In Ontario and Québec, IMGs cannot apply to CaRMS, unless they are admitted to the respective provincial IMG programs. Unfortunately, these programs allocate a limited number of positions to IMGs. However, in other provinces, IMGs can apply to the second round of placement, in which only a few IMGs are matched and, subsequently, admitted into residency programs (AIPSO, 2000). In the past, Manitoba had implemented a Refugee Physicians Program, which allowed four

refugee physicians per year to pursue postgraduate medical education. This opportunity no longer exists (Klass, 1988). Currently, in Manitoba, the Medical Licensure Program for International Medical Graduates (MLPIMG) allows IMGs to apply for an assessment and enhanced training. Upon the successful completion of the program, IMGs are allowed to practice as primary-care physicians in under-serviced areas of that province.

2.4. Role of Provincial/Territorial Governments

Having been entrusted with developing and administering polices that best serve the public, provincial and territorial governments oversee the practice of certain professions and trades in their jurisdictions. Among other responsibilities, they ensure that the public is not exposed to any harm or malpractice by professionals in the respective occupations. Through legislation, however, the authority to self-regulate a specific profession is usually granted to the respective professional bodies. The system is structured in such a way that the organizations involved have broad discretion in setting their own standards. Indeed, they are allowed to develop their own licensing regulations and operate independently from each other. The provincial and territorial governments maintain the power to revoke regulatory privileges, should the licensing bodies fail to fulfill their mandates. But, in reality, governments refrain from direct intervention in professional and regulatory processes; instead, they play a more passive role (Brouwer, 1999).

Governments have always been the main providers of funds for postgraduate medical education. The National Action Plan for Physician Resource Management (1993)

cites that in the early 90s, the provincial governments decided to restrict IMGs' access to residency positions. For IMGs who are trying to obtain a licence to practice in Canada, this decision has resulted in additional barriers of great significance.

2.5. Role of Federal Government

Various resources, such as a draft document by the Manitoba Department of Labour (2000), clearly point out that the federal government has little or no role in licensing physicians. However, on a different level, Citizenship and Immigration Canada notes on its website that the Canadian Immigration and Refugee Protection Act empowers the Government of Canada to determine by category the number of immigrants that will be accepted each year. Thus, by extension, the immigration policy set by the federal authorities directly impacts on the number of IMGs arriving in Canada.

For most immigrants, the local Canadian consulate or embassy is the first official point-of-contact and the primary source of information about immigration to Canada. For a professional seeking a visa on the basis of the merit system, the mere acceptance as a skilled immigrant is often being mistaken as having been granted an approval and recognition of his or her qualifications. Unless specifically informed by an authorized official as to the possibility (or difficulties) of receiving a licence to practice, immigrants are unaware of the federal government's lack of jurisdiction in professional accreditation. This important process of information transfer seldom occurs, according to narratives appearing in various sources — Bowen et al (1998), Chan (1997), to name but two. As a matter of course, Canadian consulates and embassies abroad are not up-to-date on licensure issues and, therefore, prior to their

arrival in Canada, IMGs are provided with little information to that effect (Brouwer, 1999; AIPSO, 2000). According to a 2000 survey of AIPSO members, fifty nine percent of those surveyed rated their pre-arrival knowledge about the barriers to becoming a licensed physician in Canada as either fair or poor.

2.6. Pathway to Licensing — Examinations

2.6.1. Basic Requirements

Since different provincial authorities regulate the licensing of physicians, the routes and circumstances for IMGs to obtain a licence differ. However, as pointed out by Judek (1964), AIPSO (1999), and Manitoba Labour (a 2000 draft document), IMGs must fulfill certain requirements, which are common along alternate pathways:

- Successful completion of all MCC examinations,
- Completed postgraduate medical training,[8] and
- RCPSC or CFPC certification (i.e., pass the certification examination).

2.6.2. The Medical Council of Canada Evaluating Examination

As reflected in the literature (e.g., MCC, Manitoba Labour), the Medical Council of Canada Evaluating Examination (MCCEE) is the first exam IMGs are required to pass in order to demonstrate general medical knowledge.[9] The MCCEE exam has three distinct objectives:

---

[8] This requirement is set by the provincial medical licensing body where the IMG intends to practice. Usually it involves at least two years of postgraduate medical training.

[9] Currently, the exam is structured as a one-day, multiple-choice exam. It is offered three-to-four times per year in five Canadian cities. In 2004, three MCCEE will be held (Medical Council of Canada, 2004). An MCCEE passing grade is valid for five years (Manitoba Labour, 2000).

- *Avoid unnecessary dislocation (and expense) by international physicians seeking admission to Canada;*[10]
- *Evaluate general knowledge in the principle fields of medicine;*[11]
- *Provide a screening mechanism for determining acceptance criteria to each of the respective programs.*[12]

In terms of its requirements, the MCCEE presents some inconsistencies, as well as overlaps with the MCCQE I. The cost of one thousand dollars for the MCCEE exam raises the issue of affordability.[13] Indeed, cost may become an insurmountable barrier for IMGs and, as a result of this financial burden, a considerable number of IMGs do not pursue this exam and, consequently, abandon the process required to obtain a licence. Others need to work in menial jobs to support themselves during the course of the examinations.

---

10 This objective is irrelevant for IMGs already residing in Canada; as well, Citizenship and Immigration Canada (CIC) no longer regards it as valid. During the last several years, the MCCEE has not been considered as a requirement for granting a permanent resident status (AIPSO, 2000).

11. The route for LMCC eligibility is characterized by inefficiencies and duplications, stemming from the requirement to also complete the MCC Qualifying Exam Part I (MCCQE I). In terms of contents, MCCEE and MCCQE I are essentially similar, with the latter being more comprehensive and intensive. Likewise, the material tested and knowledge evaluated in the MCCEE are fully covered in the MCCQE I exam (AIPSO, 2000).

12. With the exception of two provinces (Saskatchewan and British Columbia) in the CaRMS process (and the IMG program in Ontario), the requirement of MCCEE is not made in isolation from MCCQE I. However, even in these two provinces, the MCCQE I has remained a mandatory requirement in the process, and can be used interchangeably in the current process without jeopardizing standards (AIPSO, 2000; Canada Immigration, 2000).

13. Between 1999 and 2000, the $500 fee doubled. It now includes a $100 credentials assessment fee (for the first writing) and $900 exam fee. The fee structure is inconsistent with the one used for the MCCQE Part I. By comparison, the latter is twice as long, includes non-multiple-choice questions, and costs only $650 (AIPSO 2000; Medical Council of Canada, 2004). In addition, the application deadline is four months ahead of the exam date. Applications are accepted as late as 65 days prior to the exam date, in which case, the applicant must pay late fee of $500 in addition to the exam fee (Medical Council of Canada, 2004).

2.6.3. The MCC Qualifying Examination Part I & II

The MCC Qualifying Examination (MCCQE) I evaluates the medical knowledge, skills and aptitude of the candidates applying for postgraduate medical training. Before becoming eligible to write the MCCQE I exam, IMGs must pass the MCCEE exams. This is now a one-day computer-scored exam contains multiple-choice questions, and it is offered several times a year in fifteen centres across Canada.[14] Nevertheless, if not for the MCCEE requirement, IMGs would have been able to directly proceed toward taking the MCCQE I exam.

MCCQE II evaluates the candidate's clinical skills under various simulated scenarios. The cost of the exam is one thousand dollars, and it is held twice a year; once in the Fall and once in the Spring.[15] This exam is a prerequisite for licensure in all provinces and, to write this exam, candidates must first pass MCCQE I and complete at least one year of recognized postgraduate training. For the purpose of this requirement, training may take place outside of Canada. This allows IMGs who have at least one year of postgraduate training to complete the exam. However, in some countries, internship is not considered a postgraduate training and is considered part of the graduate training.[16] Unless accepted into residency training in Canada, this training requirement becomes a serious barrier for any IMG in this situation.

---

14 In 2004, two exams are scheduled at various centres, located at most of the provincial capitals. However, there are three exam centres in Québec, two in Alberta, and none in News Brunswick, Prince Edward Island and the three territories (Medical Council of Canada, 2004).

15 Similar to MCCQE I, exam centers are located across provincial capitals (with some exceptions).

16 In such cases, family physicians gain a recognized status upon their completion of medical school and internship, after which time they are able to proceed to professional practice in the capacity of physician.

Figure 1, below, presents a flow diagram of Pathway to Licensure for IMGs in Ontario and elsewhere in Canada. In essence, the chart illustrates the information discussed above.

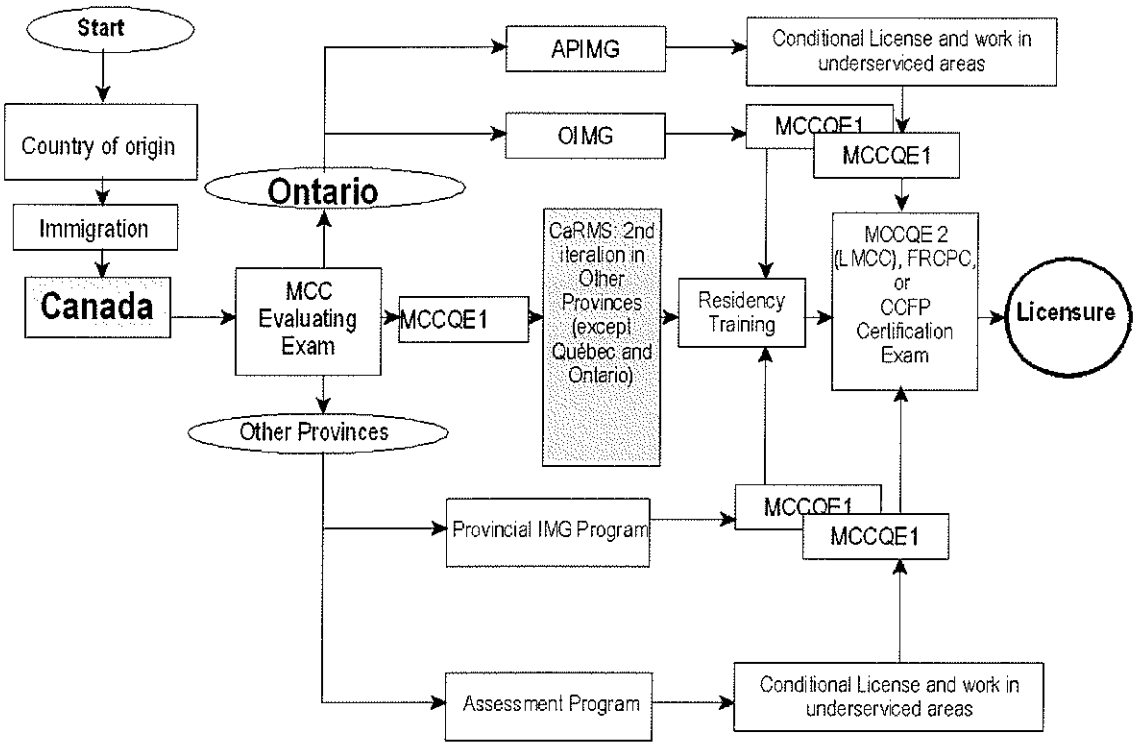

Figure 1: **IMGs Pathway to Licensure**

2.6.4. Test of English as Foreign Language & Test of Spoken English

As indicated by AIPSO (2000), acceptance into some residency programs requires verification of competence in written and spoken English through the successful completion of the Test of English as Foreign Language (TOEFL) and the Test of

Spoken English (TSE).[17] For authentication purposes, in certain situations, the receiving institution may require candidates to arrange for a direct submission of TOEFL or TSE results to the requesting organization. As indicated on its website, TOEFL results are retained for two years, after which time, candidates must retake the exam, pay the applicable fee, and arrange for direct submission of results, before a residency application is to be considered.[18] Not surprisingly, this inflexible policy creates another barrier for IMGs.

2.6.5. Certification Examinations

To receive certification by the respective institutions, candidates must pass the certification examinations held by the RCPSC or the CFPC at the end of the residency training programs (AIPSO, 1999; Manitoba Labour Department, a 2000 draft document). These exams include a written and an oral component. The exams are held annually, and they cost over one thousand dollars.[19] As stipulated by the RCPSC and CFPC, IMGs are not eligible to take these exams, unless they have fulfilled the residency training requirement. This negatively affects the majority of IMGs.

2.7. IMG Programs in Ontario

According to APIMG website information regarding training opportunities in Ontario, IMGs can apply for one of two programs:

---

17 TOEFL introduces a caveat to the fact that its test is neither indicative of proficiency in comprehensive English nor geared to a specific profession. The test is regarded as a measure of general know-how in the English language. The TOEFL exam costs $110 US and the TSE $125 US. Minimum scores are required for each, a practice that the TOEFL program advises against in its own guidelines.

18 This requirement is not applicable for an IMG who has already passed the exam and has since been living, studying, and working in Canada.

19 Cost varies by specialty.

- Ontario International Medical Graduate Program, and
- Assessment Program for International Medical Graduates.

2.7.1. The Ontario International Medical Graduates Program

The Ontario International Medical Graduates Program (OIMGP) was established in 1986 by the Government of Ontario, the College of Physicians and Surgeons of Ontario, and the Council of Universities. This program has a prime mandate to create an opportunity for IMGs to practice medicine in Ontario (Canada Immigration website). The program provides pre-residency training for the purpose of upgrading IMG qualifications. During the 2004/05 academic year, the program will offer as many as fifty pre-training spots for IMGs. To be eligible to apply, candidates must first pass the MCCEE. Before entering the program, they also must pass a written, multiple-choice entrance exam; and an oral, clinical exam,[20] TOEFL (with minimum score of 580) and TSE. As well, candidate must successfully pass a personal interview. However, unlike exams where a pass mark is sufficient, to enter this program, IMGs need to score among the top fifty applicants who are taking the two entry exams. Thereafter, upon acceptance, IMGs may join the program, which lasts 36 to 48 weeks. Candidates who have successfully completed the program may apply for designated residency positions in Ontario.

---

[20] Objective Structured Clinical Exam (OSCE).

2.7.2. The Assessment Program for International Medical Graduates (APIMG)

In response to a physician shortage in Ontario (and elsewhere in Canada), Ontario implemented the APIMG program in 2002.[21] The APIMG allows IMGs to bypass (or shorten) the residency training, and obtain licensure to practice in one of Ontario's underserviced areas. The selection process for this program includes the following steps: credential review, interview, multiple-choice exams, and six months of on-the-job assessment. Following a satisfactory assessment, based on a minimum five-year contract, the applicant is permitted to practice in an underserviced area. However, within this time period, the IMG needs to pass all MCC exams and, in particular, the exams administered by the RCPSC or the CFPC.

Other than the paths discussed above, no other avenues are available for IMGs in Ontario to enter into residency positions through the CaRMS match. Nevertheless, through the second 'iteration' of the CaRMS match, IMGs who have completed MCC exams are eligible to apply for residency positions in other provinces (e.g., Manitoba and Saskatchewan).

2.8. Financial Impact

The MCCEE costs about one thousand dollars. As well, if passed in each first attempt, the three MCC exams cost approximately three thousand dollars. To be selected for the OIMG program, an IMG must also pass two exams, at the cost of between two and three hundred dollar each. Applying for residency through CaRMS can also be costly. The basic application costs approximately two hundred dollars

---

[21] Other provinces (e.g., Newfoundland and Manitoba) are also implementing similar programs.

(plus twenty five dollars for each of the programs applied to). In total, the cost of participating in CaRMS match could be as high as five hundred dollars.[22]

Study materials are also expensive. To assist in the preparation toward the MCC exam, Toronto Notes[23] are purchased at the cost of over one hundred dollars. The cost of other needed publications is more than twenty five dollars each. In the Toronto area, several training courses are offered to prepare for MCC exams. The cost of these courses ranges from two hundred to one thousand dollars.

In total, the process of passing all exams can cost an IMG as much as ten thousand dollars. Moreover, the cost of the exams, CaRMS and study materials are in addition to living expenses. At the same time, IMGs are not eligible for student loans, normally offered to medical students by different government levels. Therefore, to pay for these expenses and be successful in the accreditation process, IMGs must find alternative financial resources. If not found, this burden can create a significant deterrent for IMGs.

---

22 Throughout the application process for the MCC exams and CaRMS, IMGs must also pay for certifying documents by lawyers/public notaries. In other instances, selected documents are couriered, or mailed directly from the issuing institutions in the country of origin at a considerable cost.

23 *Toronto Notes* is a medical manual published annually by the University of Toronto to assist students in their preparation for the MCC exams. The manual is used by students across Canada.

Chapter Three: Literature Review

3.1. Policy and Human Resource Issues

The vast majority of literature related to IMGs focuses on the issue of health human-resources in Canada. Only a relatively-small part of the literature deals with IMGs' experience in their new country.

3.1.1. Physician Resource Management and IMGs

The role of IMGs in physician resource management in Canada is well recognized in the literature (Barer et al, 1991; Nasmith, 1993). Barer and Stoddart (1992) state that *...as a substantial source (potential and actual) of physician supply, they [IMGs] represent a policy 'flash-point'....*

The same article goes on to argue that IMGs have also been regarded as part of the solution to existing human resources issues: *...historically these physicians [IMGs] have represented important solutions to Canadian physician resource supply problems....*

By the mid 1970s, due to rising healthcare costs and the perception of physician oversupply — strictly from a human resource viewpoint — IMGs were no longer welcome in Canada.[24] Moreover, IMGs were frequently blamed for the oversupply situation (Korock, 1975). This view led to the restriction of IMG entry into Canada. As for IMGs already in Canada, their entry to the medical profession became more

[24] This is raised by Barer et al (1991, 92), Bharwani (1985), Chouinard (1985), Isaccson (1980), Korock (1975, 81, 85), Chang (1974), Doan (1991), Bailey (1991), Paine (1991), Satkauskas et al (1990), Stewart (1972), Lowry (1989), Webber (1995), Clarke (1991), Voysey (1985).

difficult.[25] By the early 1980s, immigrant physicians were required to sign a statement, acknowledging that they may not gain access to practice in Canada without further training (Committee on Health Human Resources, 1993) — the need to satisfy this requirement in order to qualify for medical practice in Canada notwithstanding.

3.1.2. Policy-driven Restrictions

In 1992, subsequent to the recommendations made in the Barer and Stoddart Report (1991), federal, provincial and territorial health ministers decided to restrict IMG access to residency training. Consequently, IMGs were only allowed to access designated residency training positions in each province. Despite the fact that residency training is an essential requirement in obtaining a licence to practice in Canada, in all provinces, the number of positions designated to IMGs account for less than ten percent of the total number of available residency-training positions.
In addition to imposing restrictions on IMGs, a concurrent decision has reduced the enrolment to medical schools by ten percent (Committee on Health Human Resources, 1993).

Satkauskas et al (1990) point out that other barriers have been implemented to restrict IMG access to licensure in Canada. In 1979, the MCCEE was introduced as a screening tool for IMGs. By 1992, in order to obtain a licence to practice in any province, IMGs were required to pass three MCC exams and complete postgraduate medical training.[26] Restrictions were also imposed on IMG entry to residency training in Canada (Manitoba Labour, a 2000 draft document). For example, in

---

[25] This is argued by Adams (1989), Barer et al (1992), Sullivan et al (1996), Korock (1975), Satkauskas et al (1990), Wallace (1975).

[26] At least two years of residency in Canada or the U.S.

Ontario and Québec, IMGs are not allowed to apply to the matching service offered by CaRMS[27] (AIPSO, 2000; CaRMS website). In other provinces, IMGs are only allowed to apply to the second 'iteration' (i.e., the residual unmatched positions after the initial match).[28] On balance, it appears that access restrictions to residency training positions and the two-year postgraduate medical training (a requirement set out by the licensing bodies across Canada), have left IMGs with little hope of gaining a licence to practice in Canada.

By the year 2000, selected provinces started to implement changes in their policies toward IMGs. Most likely, this change was triggered by a public outcry associated with the shortage of physicians across Canada. In Ontario, the number of positions available through the OIMG increased from twenty four (in 1999) to fifty. This was the first step in a publicly-announced policy, calling for the creation of as many as seventy five positions, effective 2003.

In Ontario and Manitoba, provincial governments are working with their respective medical schools and licensing bodies to bypass the residency training requirement. In June 2001, the Ontario Government announced a 1.4 million dollar expenditure to assist forty fully-qualified, recently-practicing (or trained) foreign physicians. This initiative intended to provide needed physician services in underserviced communities in Ontario (Ontario Government website).

---

27 Formerly the Canadian Interns and Resident Matching Service.

28 In addition, there may be a geographic bias as in the case, for example, of Nova Scotia, which gives priority to those who live in that province (CaRMS website).

In 2002, the Ontario Government announced an eight-point plan to utilize IMGs as a pool of resources needed to solve the physician shortage. In 2003, the same government requested its College of Physicians and Surgeons (and the medical schools) to develop and implement a program, which streamlines and shortens the path to licensure through equitable assessment and training processes.[29] On June 23, 2004, the Ontario Health Minister announced a plan to invest $26 million to enable more qualified foreign-trained physicians to train and practice in the province which will increase the number of training positions for IMGs to 200 annually (Ontario Government newswire). The plan is to amalgamate the OIMG program and the APIMG program, through Ontario International Medical Graduate Clearinghouse (OIMGC) starting from 2004 (OIMGC website).

Economic barriers have also been erected. Satkauskas et al (1990) elaborate on the rapid increase in exam costs. As with the cost of the MCC exams (which doubled in a few years), this issue causes IMGs additional hardship.[30] IMGs who are unable to obtain residency training within five years after passing the MCCEE, need to re-write the exam. This is so because a passing grade is valid for a prescribed time period (Manitoba Labour, a 2000 draft document).[31]

No clear explanation exists to rationalize why the results of credential assessment become 'stale.' This is unusual, particularly in light of the fact that there is no

---

29 As part of this initiative, IMGs are to sign a contract with the provincial government to provide service for at least five years in underserviced areas, especially in the northern part of the province.

30 This amount excludes travel expenses. For IMGs residing in cities where no examination centres are located (e.g., Winnipeg, MB), travel represents a considerable problem.

31 Thereafter, IMG candidates must reapply for and redo the exam. Moreover, no reference or recognition is given to any previous assessment of credentials, or MCC application.

expiration policy for the MCCQE I. Despite the similarity in their objective (i.e., to assess medical knowledge), when it comes to validity of results, different rules apply to MCCEE and MCCQE I exams (AIPSO, 2000; Medical Council of Canada, 2004).

With no opportunity to practice medicine, or to access a continuing medical-education program, IMGs face difficulties in keeping up-to-date with current knowledge. This further aggravates the challenge of preparing toward passing the MCC exams, which are prescribed to evaluate the candidate's current medical knowledge in the Canadian context. For IMGs, the result is a 'Catch 22' situation, with no clear solution.

3.1.3. Rights, Challenges and Dispute Resolution

The reactions of IMGs to these barriers have varied. In the last twenty years, they have resulted in, among others, two hunger strikes involving IMGs (Satkauskas et al 1990; Lowry 1989).[32] In two provinces (and possibly more), complaints were made to the provincial Human Rights Commissions against licensing bodies, provincial governments and training institutions.[33] In British Columbia, a complaint resulted in adjudication, and the ensuing ruling by the B.C. Human Rights Commission ruled against the provincial College of Physicians and Surgeons, stating the said college unfairly excluded most IMGs from Class II category [of applicants].[34] In Manitoba, the Human Rights Commission dealt with complaints by the Association of Foreign

---

32 The outcomes of these hunger strikes were not widely publicized. However, both incidents led to negotiations with the respective provincial governments (Lowry, 1989).

33 This issue is described in the following references: B.C. Government website (1999), Williams et al (1999), Manitoba Health (2000), College of Physicians and Surgeons of Manitoba (2000).

34 Class II Category applies to IMGs from South Africa, United Kingdom, Ireland, Australia, and New Zealand.

Medical Graduates in Manitoba Inc. (AFMGM).[35] The commission investigated and found sufficient evidence that the institutions named in the complaint discriminated against IMGs in Manitoba. The commission recommended mediation.[36]

In 1998, the Association of International Physicians and Surgeons of Ontario (AIPSO) was created to advocate on behalf of IMGs residing in that province. In Alberta, a group of IMGs has been formed to provide mutual support.

In 2002, the Government of Canada set up a task force to deal with the accreditation of IMGs across Canada. The task force is made up of members of various national and provincial medical and professional organizations (e.g., RCPSC, MCC, CPSO), representatives from various governmental departments (e.g., CIC, HRDC), and provincial health departments. The task force reports to the Federal, Provincial and Territorial Committee of Health Ministers. It was given a mandate to develop a national strategy to integrate IMGs.[37]

3.2. IMG Experiences in Obtaining Licensure

Few studies have focussed on the experience endured by IMGs in their new country. *The Plight of Immigrants Physicians in Canada* by Satkauskas and Pavilanis (1990) is but one of them. This publication articulates the predicament of IMGs in Canada, and compares the experiences of foreign- and locally-trained physicians. The authors discuss issues involving foreign medical graduates. They describe the options and strategies of dealing with barriers, and present information about the MCCEE and

---

35 The lawsuit was filed on behalf of Dr. Singh (plaintiff) against the Manitoba Government, the University of Manitoba, and the College of Physicians of Surgeons of Manitoba (defendants).

36 As of 2003, the mediation process was continuing.

37 With a December 2003 target date.

postgraduate training positions. However, the study foregoes any analysis of personal experiences and hardships endured by individuals. Yet, it provides IMGs with credible information about the restrictive licensing procedures.

A report by the Alternate Careers Project submitted in 1998 — a joint initiative undertaken by the University of Manitoba and the Red River Community College — has identified over one hundred IMGs who resided in Manitoba at the time of study. The project report provides a detailed account based on survey interviews with seventy eight IMGs (Bowen et al, 1998). The results of this survey clearly indicate a high level of unemployment and under-employment.[38] Seventeen percent of the interviewees were employed full-time, and one third employed on a part-time or casual basis. Close to half of those employed, were working as nurse aides or attendants in home-care institutions. Only a small portion of the interviewees was employed as labourers or unskilled workers in the service sector.

The report produced by the Alternate Careers Project underlines the lack of an adequate program that focuses on orienting newly-arrived IMGs, and informing them on the accreditation system in Manitoba. Likewise, the lack of appropriate career counselling has also been identified.[39] It was noted that as far as employment counselling is concerned, most services (and individuals) had not provided current or sufficiently-detailed information on specific or relevant issues. IMGs who had used employment counselling rated the service as being inadequate for finding

---

38 Unemployment rates might have been higher, if adjusted to reflect the number of IMGs who had enrolled in other training programs, and were unable to find appropriate employment.

39 Through telephone interviews, the study gathered information relating to the 1991/92 time period. The study was set out to investigate possible training and employment opportunities in alternate careers. However, unlike this report, the Montreal-based study considered IMGs' personal experiences as being outside its scope of work.

employment. Not surprisingly, the report has found a low level of awareness and use of these services. In addition, despite a high level of interest from potential employers in utilizing IMGs, practical assistance was not provided on crucial issues, such as skill requirements, recruitment opportunities, screening processes, and training programs. Without proper assistance, many potentially-good employment opportunities for IMGs were lost.[40] The report also states that during their interviews, IMGs have expressed a high level of depression. However, it should be noted that the survey, which provided the raw data for the report was conducted with the view to investigate the training and employment opportunities in alternate careers. By contrast, the report did not provide narrative documentation on IMG personal experience.

Giri (1998), who studied the experiences of South Asian female physicians in the Montreal area, collected data through in-depth interviews and quantitative questionnaires.[41] The study identifies a systemic barrier to licensure, and it shows that while struggling to prove their medical qualifications, physicians have been subjected to unpleasant racial biases and discriminatory attitudes. They were made to feel inferior for being women who came from underdeveloped, 'third world' countries. The women felt obliged to prove that they were as smart, intelligent, and assertive as their Canadian colleagues. Nevertheless, the study subjects believed that their practical knowledge, which they acquired while working with patients suffering

---

40 The report also identifies other important issues: the lack of appropriate support to overcome cross-cultural communication difficulties and adjust to a new work culture. Unmet needs for on-the-job training in specific fields are also cited as a problem area.

41 The sample population had been in Canada since the 1960s and 1970s, and most respondents were practicing at the time of the study.

from various diseases, made them more skilled than many of their Western counterparts.

A study by McWhinnie (2001) titled *Beyond the Threshold: A look at four international medical graduates successful experience of becoming licensed to practice medicine in Ontario*, describes the successful experience of selected IMGs who had gained access to practice in that province. Using a phenomenological approach, McWhinnie conducts an in-depth interview to understand the meaningfulness of the experiences gained. The study finds that going through the licensing process in Ontario is painful, degrading and, at times, emotionally devastating. Participating IMGs claim that they have sacrificed certain aspects of their lives to successfully proceed along the licensing process. Diminished time with family and friends has been frequently identified as one such sacrifice. The study also suggests that further research is needed to explore alternate accreditation processes to replace the current OIMG program.[42]

As part of his course work requirement, this researcher completed a career-focussed interview with an IMG from India (Chan, 1997). The interview revealed information on medical education in that country, the values placed on being a physician, and the impact of current policies on the life of an IMG. Subsequently, a literature review has revealed no other similar study or studies that account for IMG experiences in a narrative way. For this reason, this challenging approach has been selected for this study.

---

[42] The study, however, does not explore the perception of barriers faced by IMGs. This perception often changes after the IMG gains access to medical practice.

Chapter Four: Methodology and Study Implementation

With the overview of policy context and system of licensure in mind, the primary focus of this research initiative is to document and analyze narratives describing personal experiences.

4.1. Study Design: Multi-part Interview

With the view of collecting information through direct contacts with IMGs, the researcher developed a template and a questionnaire (Appendix C) aimed at focusing on career-issues.[43] The interviews which followed were structured to sequentially cover the stages of immigration and the corresponding life situations, as experienced by the interviewees. To this end, a brief personal profile of the interviewees was compiled to document the medical training in the country of origin, experience as practicing physicians, career experience in Canada, perceptions of barriers, coping strategies, and thoughts on improving the situation. The impact of the perceived barriers on the lives of the interviewees and the mechanisms to coping with them was explored through recording narratives, describing their backgrounds, and career experience.

Through the study, it has become apparent that the level of respect commanded by medical professionals was closely related to their cultural background. Although it varies with each person, status and respect are important dimensions and play an important role in adapting to a new environment. Due to the sample size and

---

[43] In part, this was built on a framework that was used in a piloted career-focused interview with an IMG from India (Chan, 1997).

diversity of categories, it was difficult to stratify the IMGs by cultural background. For this reason, backgrounds were not explored in detail.[44] However, selected aspects have been explored; medical education, mother tongue, professional experience, value system, and the importance of being a doctor — to name but a few.

Interviewee Profile: The first part of the interview has dealt with personal information. A profile has been generated by collecting demographic data and migration history, including the following data elements: age group, country and region of origin, length of period since landing in Canada, and other relevant details about one's family.[45]

Experience in the Country of Origin: The second part of the interview has focussed on the interviewee's experience as a physician in the country of origin. Specific questions have been asked to describe the process leading to becoming a qualified practicing physician in that country and the experience gained thereafter. As well, to understand the human dimension, questions have been specifically directed to probe one's inspiration to become a physician.

Canadian Experience: The third part of the interview has concentrated on the experience in Canada, including one's pre- and post-arrival knowledge about the new country, personal expectations, and pre- and post-arrival career experience. A key

---

44 Study limitations render stratification of IMGs by cultural background and certain characteristics as impractical and undesirable. This holds true primarily because the size of the sample selected for the study cannot support the investigation of some aspects relating to IMGs' cultural background. Moreover, investigating a parameter deeply rooted in a value system presents a great challenge, particularly when the degree of importance which IMGs attach to their professional affiliation varies along a wide spectrum.

45 The study has collected selected personal information, which may shade light on personal lives. Specifically and purposefully, the study has not dealt with the cultural background of the study subjects.

element of this part has assessed the understanding of the process IMGs need to follow to become licensed physicians in Canada.

Barriers: The fourth part of the interview has explored the perception of barriers faced by IMGs in their quest to obtain licensure in Canada. One's level of awareness of those barriers and the difficulties faced while seeking meaningful employment have been ascertained. This part has been used by the researcher to cross-reference interview data and elaborate on many barriers, as described by the interviewees.

Coping Strategies: The fifth part of the interview had examined coping strategies, initiated by the interviewees to overcome barriers. Also, a brief discussion has been included on the impact of barriers on IMG lives, the source and availability of support services, and their perspectives on improving the situation.

Policy Changes: The last part of the interview has dealt with the interviewee's viewpoint as to how barriers can be eased or removed, and the role of stakeholders in so doing.

4.2. Study Population and Sample

This study has concentrated on IMGs who reside in Ontario. The reason for limiting the sample population to residents of a single province stems from the researcher's inability to locate IMG participants in other provinces.[46] While remaining in contact with some IMGs in Manitoba, the researcher has found that, unlike years ago, the

[46] In the original study proposal, the researcher expressed intention to include IMGs residing in Manitoba. At the time, the researcher lived in Manitoba and, during the ten years of living there, became acquainted with many potential interviewees. Since then, the researcher moved to Ontario and, during the last two years, has established relationships with IMGs residing in the Toronto area.

organization dealing with IMG issues in Manitoba is now functioning in a different capacity. As a result, the organization has not been in a position to assist in recruiting subjects for this study. Unable to recruit Manitobans, the researcher has taken advantage of an alternate opportunity to collect and document in-depth information from IMGs residing in another province (namely, Ontario) and facing the same licensing system.

IMGs eligible for participation in the study came from various countries.[47] Given the diversity in the countries of origin, the respective IMGs identified different issues, which manifested themselves during the process of adapting into Canadian society. With the exception of Ontario and Québec, the educational experience and credentials presented by the IMGs from selected countries (i.e., South Africa, Ireland, Australia, New Zealand and the U.K.[48]) have been recognized by the majority of licensing bodies across Canada. However, they are still required to pass the MCC exams. As well, many of these IMGs have been recruited by provincial governments to work in under-serviced areas, or by universities to assume academic positions (Maudsley, 1994). Understandably, gainfully-employed IMGs face a different kind of issues and, not surprisingly, they may have gained a different experience and encountered different barriers in gaining access to licensure.[49] Therefore, only IMGs coming from other than the above-named countries, and who are currently involved in the process of trying to gain access as practitioners in the Canadian medical system, have been included in this study.

---

47 IMGs that came from those countries were not included in the study sample.

48 Most IMGs have already passed the MCCEE before landing in Canada.

49 Arguably, studying this stratum of IMGs may be carried out in a separate study.

IMGs who had successfully obtained their licence have not been included in the study for two main reasons. The researcher has maintained only a few contacts with IMGs who are licensed to practice in Ontario, and generally these IMGs do not join the associations or groups of unlicensed IMGs (e.g., the Association of Foreign Medical Graduates in Manitoba Inc. (AFMGM), and the Association of the International Physicians and Surgeons of Ontario (AIPSO)). Without such contact, the researcher has been unable to recruit any member of this subgroup. By the same token, one needs to be reminded that the objective of this study is to examine the perceptions, barriers, and difficulties that IMGs face while attempting to obtain a licence. No doubt, once IMGs achieves licensure, perceptions of barriers and hardship may be altered, as is the process of reminiscing past experiences. In fact, over time, subjects could become more forgetful, and possibly more forgiving. However, an effort to 'reconstruct' past career struggles by individuals who have already re-entered the profession is beyond the scope of this study.

This researcher's experience in dealing with a few IMGs who successfully obtained a licence to practice in Canada confirms the existence of a 'desire' to quickly forget that part of their lives, when struggles and uncertainties continuously endured. Instead, IMGs want to concentrate on more positive things that life has to offer.

No credible data exist to identify the total number of IMGs in Ontario, as no central registry contains such data. However, AIPSO claims that more than 1,500 IMGs are registered in this association. Therefore, a direct appeal or contact with the entire population of prospective study subjects has been unequivocally impractical. As an alternative, a selective method has been used to identify a pool of IMGs who might be

suitable subjects for the qualitative interviews. In so doing, the researcher has purposefully selected subjects with certain characteristics. The overriding preference has been to explore differences based on geographical factors, associated with the country or region of origin. Thus, the researcher has included interviewees form Asia, Eastern Europe, Africa and Latin America. Moreover, the researcher had attempted to include IMGs with varying length of residence in Canada. This, however, has been a tougher goal to meet.

4.3. Approval Process

After receiving considerable input from the thesis supervisor and members of the Thesis Committee, the researcher submitted a proposal to the Committee and, in March 2002, was granted Committee approval. In addition to the proposal, the researcher presented a participant consent form, a questionnaire, and a letter of invitation to interviewees. In April 2002, the proposal package was submitted to the Health Research Ethics Board at the University of Manitoba, Bannatyne Campus. A month later, the Board granted its approval.

In June 2002, the researcher attended a regular board meeting of AIPSO to formally seek endorsement to conduct research on IMGs residing in Ontario. At the same meeting, AIPSO board unanimously granted an endorsement.

4.4. Subject Recruitment

The process of recruiting participants involved a few professional and cultural channels. IMGs who attended regular group study-sessions, received an invitation

letter (Appendix A), together with a summary version of the study proposal (Appendix D). In the next two study sessions, the researcher formally asked IMGs to participate in the study. Information regarding potential contacts and their availability was obtained from those IMGs who volunteered to take part in this study. During the following few weeks, prospective interviewees were contacted by phone, and interview strategies and details were discussed. At that stage, the researcher also answered any questions presented by the would-be interviewees. Participation was reconfirmed during the following two weeks, at which time an appointment schedule was drawn.

4.5. Conducting Interviews

Keeping with the agree-upon schedule, ten interviews were completed between July 29 and September 7 of 2002, at locations chosen by interviewees.[50] Before beginning the interviews, a brief discussion took place to describe the interview process and respond to process-related questions. The researcher stressed that participation in the interview was voluntary, and that the respondent could refuse to answer any question, or withdraw at any point during the interview. Respondents were assured that any and all of the information gathered would be kept strictly confidential, and no personal identifiers (e.g., name, age, country of origin) would be used or attributed to a certain individual. The interviews commenced after having the participant information and consent form (Appendix B) signed by both the interviewee and the interviewer. With the interviewee's agreement, a mini

[50] Seven interviews were conducted at the interviewee's place of residence; one at the researcher's home, and one at his office. One interview was carried out at the hospital, where the group study-sessions were held.

audiocassette was used to record the proceedings, after which time the information was transcribed into Microsoft Word documents. The documents were printed and analyzed by the researcher.

4.6. Data Analysis

To acquire a deep level of appreciation of the contents provided by the interviewees and, at the same time, streamline responses by logical groupings, all interviews were first transcribed and then regrouped by topic (contents), common themes, and level of responses.[51] During this process, the narratives were coded and rearranged by topics in an order consistent with the analysis and arguments made in this report (and other sources e.g., Morse et al, 1995). The order of presentation is also reflective of the interview structure and the list of priority issues, and this list corresponds to the issues most frequently identified in the literature. Subsequently, within each topic category, the themes were analyzed against the contextual material gathered through the literature review.[52]

4.7. Ethical Issues

Since the study involves life stories of IMGs, obtaining informed consent to using and presenting the narrative data has been a key procedural-requirement. During the interview, participants were given supplementary information on the intent of every

---

51 Among others, topic areas included the experience as a physician in the country of origin, expectations before arrival in Canada, experience in Canada, perception of barriers to practice in Canada, and opportunities for improvement. By way of example, under each theme/category, the categories 'frustrated,' 'useful,' and 'supportive' have been used as denote the 'intensity' of certain measures.

52 To describe these themes within the context of various experience-categories, findings have been captured and presented under selected headers.

question, and the benefits (and risk, or lack thereof) of answering any and all of the questions being posed. Given this approach, interviewees felt comfortable with the process, and agreed to readily and willingly answer all questions. As well, no remuneration or any other consideration was given to the study participants. However, the researcher did state that the study may ultimately help forming a more practical and equitable policies thereby influencing future access to licensure for IMGs, and improving training opportunities and career access. The existence of cordial and mutually respectful, colleague-to-colleague relationships between the researcher and the participants notwithstanding, the researcher put no pressure on interviewees to influence their responses or participate in the study.

During the discussion on the consent agreement, the researcher stressed that due to the public visibility of some interviewees, complete confidentiality and anonymity may not be fully guaranteed; nonetheless, it was a paramount consideration. To this end, a strict information-privacy protocol was adopted and adhered to, and all personal (and, wherever necessary, demographic) identifiers were removed. The protocol was articulated by the researcher and agreed to by both parties. The researcher also undertook to present narratives and quotations without identifying the individual respondent and without cross-referencing or linking contents. The interviewees were made aware of their refusal option. However, with no exception, all opted to become fully engaged in the process.

4.8. Researcher's Viewpoints: Apparent Bias

To a certain extent, the researcher's own experience may be viewed as a potential source of bias. The following paragraphs provide personal information relevant to understanding the researcher's perspective and commitment to maintaining objectivity in presenting and interpreting the narratives.

From 1992 to 1995, the researcher served as the president of the Association of Foreign Medical Graduates in Manitoba Inc. (AFMGM). Thereafter and up to the year 2003, he has continued to be actively involved in the association. After moving to Toronto, the researcher became a member of the Association of the International Physicians and Surgeons of Ontario (AIPSO) and, at the 2001 annual general meeting, was elected to the Board of Directors. The researcher has informally discussed this study with officials from these two organizations and received their 'unofficial' support. It was anticipated that the study would provide support and contribute to the development of more equitable polices toward IMGs. The researcher regularly attends educational activities organized by IMG groups in Toronto, and he has good rapport with about thirty IMGs from various countries.

The researcher himself is an IMG, who had faced barriers along the process toward licensure. This experience has provided him in-depth, contextual knowledge to adequately explore the experiences and career narratives of other physicians who are in a similar situation. This study is designed to gain insight into IMGs' perception of the barriers and the coping strategies in facing these barriers. However, the task of

validating these barriers and identifying their causes vis-à-vis existing policies or protocols set out by various institutions is beyond the scope of this study.

During residency training in Community Medicine at the University of Manitoba, the researcher served as Chief Resident and participated in selecting candidates for the residency program. Having been an IMG candidate and, later on, participating in the decision-making and selection process has allowed the researcher to gain the experience of being on both sides of the issue. This experience has given the researcher deeper understanding of the decisions made and the rationale applied in the selective process. Arguably, the insight into the issues involving IMG career access has helped the researcher in interpreting the study findings.

The guidance provided by the thesis supervisor has been both crucial and helpful, during the data interpretation and analysis phase. A key directive has been to focus on common themes and contextually interpret them on the basis of the narrative information gathered during the interviews. In addition, to ensure a balanced presentation, the researcher has been asked to substantiate observations with narrative and policy-based data analysis. An impartial discussion is considered vital for the validity and acceptance of this study.

Chapter Five: Demographic Characteristics of Participants

The following sections provide a description of the demographic data as provided by study participants.

5.1. Gender and Age

The sample of the IMGs selected for this study includes three males and seven females.[53] The higher number of female participants is coincidental but consistent with the gender ratio of the wider pool of potential participants available to this researcher. For the purpose of recruiting study participants, the researcher sought recruits from the pool of IMGs, who participated in a particular study group. For an unexplored reason, in that group, the gender ratio was in favour of females.

The age of the interviewees ranges from late twenties to late forties. As expected, age is an important factor in an IMG's career planning, and the level of their tenacity to access the medical system and practice in Canada. Considering the lengthy process required to obtaining a licence — i.e., from five to ten years and beyond[54] — one's age at the starting point affects one's decision. Based on his knowledge the author can confirm that some IMGs give up on the process required to become a licensed medical practitioner in Canada, primarily due to age considerations and the fear of nearing retirement by the time the licence is received.

---

53 This ratio is non-reflective of the male-to-female ratio in the IMG population in Ontario, which is unknown.

54 This includes passing all the required examinations and completing the residency-training program.

5.2. Country of Origin

The participants in this study came from south, southeast and east Asia, east Africa, South America, and Eastern Europe. The country of origin may be a determinant of success or failure in the journey to obtain a licence. This is because this indicator is often regarded as a measure of the educational system in which the IMGs completed his or her medical and clinical training. Another important consideration is the language spoken and the language in which the IMG received medical training.[55]

5.3. Length of Time in Canada

Five (and often more) years are required to complete the accreditation process. As a result, the length of time in Canada is closely related to the IMG's level of progress in the process of obtaining licensure. Within the context of this study, the length of time in Canada also indicates how long the participant has been unable to practice medicine. The length of such time is proportional to the risk of one losing academic and clinical skills. Moreover, eligibility for enrollment in a training program (i.e., APIMG) may depend on the capacity to demonstrate involvement in active clinical practice (anywhere in the world) within a two-year period prior to filing the application. Therefore, 'veteran' IMGs may be immediately disqualified. When asked to specify the length of time they had lived in Canada, study participants provided figures ranging from one to three years.

---

[55] IMGs coming from South Africa, England, Ireland, Australia, New Zealand, and the U.S. may negotiate a different process for obtaining licensure. In terms of barriers to practice, their experiences are different.

5.4. Family Status

Family is an important source of support during stressful periods. A 1998 report on mental health issues, *After the Door has been Opened*, cites psychosocial support provided by family as an important resource for promoting well-being and preventing emotional disorder. Being surrounded by family members is a crucial factor affecting the manner in which IMGs are coping with difficulties and frustration. During their attempt to obtain a licence, IMGs derive emotional support from their immediate environment. For the purpose of this study, the term 'family' refers to a spouse (with or without offspring), as well as parents, siblings and in-laws. Like many other immigrants, IMGs' family members may have arrived in Canada sometime after they had. During that separation period, IMGs may be affected by added stress, anxiety and concern about those loved ones who have been left behind. All participants in this study have been living with their respective families.

5.5. Immigration Status

With a few exceptions, practicing physicians in Canada needed to be Canadian citizens or permanent residents. Exceptions apply to, among others, visiting professors, foreign medical-trainees, or other work-permit holders. Therefore, tracking resident status has become necessary for ascertaining whether any of these exceptions apply. IMGs who are not permanent residents or citizens may experience additional difficulties in obtaining a licence. By contrast, in some instances, being a Canadian citizen may benefit the individual. For example, the University of Manitoba does not require IMGs who are Canadian citizens to take an English

proficiency test. But, non-citizens who apply for postgraduate-residency training program receive no such exemption. All participants in this study were permanent residents in Canada.

5.6. Licensure Status

Given the stated objective to identify the barriers faced by IMGs in their attempt to gain access to practice in Canada, only IMGs who are not yet licensed, but rather in the process of obtaining a licence to practice were included in the study, to the exclusion of all others. During the period at which the interviews were conducted, participants were in various stages of the accreditation process, but none had secured a licence.

5.7. Demographic Summary

Arriving from various parts of the world, study participants came from predominantly so-called 'developing' or 'third world' countries, where usually the political and economic situations were described as 'unstable.' This is evidenced in the narratives presented in the following sections.

Being in the 'prime years' of their lives, participants have been ready and eager to contribute to the Canadian society. However, when compared to the long time-period required to obtain licensure in Canada, study participants, who have arrived here within the last five years (prior to the interviews), have spent a relatively-short period of time along the multi-phased journey to licensure. Since they all live with their

respective family members, they may have benefited from receiving family support during their struggle to receive a licence to practice in Canada.

Chapter Six: Narrative Data

The background information and literature review presented in the previous chapters deals with systems and access issues preventing IMGs from practicing in Canada. While describing the requirements for accreditation and the corresponding barriers, the literature review has identified and elaborated on the organizations involved in this process and their respective roles. This information has helped to create an 'historical' background and a summary of the accreditation process, organizational policies, and their impact on IMGs. Although the structural and organizational dimension of the system could only be engaged to a limited extent during the interviews, narrative data from the study has provided an insight on IMGs' experience in a manner sufficient to fully understand their perspectives.

The narrative data presented in this chapter focuses on personal experiences. More often than not, the arguments made may not necessarily address or contradict an existing policy. The challenges highlighted by the interviewees are detailed in the context of barriers faced by IMGs, and as described in the literature review. As well, the researcher has attempted to interpret the narrative data within a broader policy realm.

For the purpose of better understanding the narrative data, the researcher has organized the data within a pre-designed framework. The sequential order of the narratives is in accordance with the phases of the general immigration process. Thus, for example, experiences are looked at in terms of pre- and post-migration experiences. The discussion on pre-migration experiences covers aspects such as the

social and economic situation in the country of origin, medical training and professional work as a physician, the perceived value of being a physician, and expectations before arrival in Canada. Post-migration experiences include the stages of seeking employment, finding the necessary information on the process of accreditation, perceptions of the barriers IMGs face during the process of accreditation, the impact of barriers on one's life, and aspirations for policy changes to improve the situation.

6.1. Pre-Migration Experience

This analysis examines the narratives provided by interviewees about the barriers they faced, while striving to obtain a licence to practice in Canada. To fully appreciate the impact of the information provided by the interviewees, some understanding of IMG pre-migration experiences is required.

In *A look at four international medical graduates' successful experience of becoming licensed to practice medicine in Ontario*, McWhinnie (2001) argues that participants' life experiences in their former countries are inexorably linked to the 'social and organizational context' they face upon arrival to Canada. Thus, the profiles derived from exploring this topic provide an important step toward understanding and appreciating the experiences gained in Canada. To this end, variables such as personal history, reasons for immigrating to Canada, and medical training have been considered and analyzed.

6.1.1. Reasons for Immigrating to Canada

Arguments to support moving to another country vary among immigrants. In *Migration, Social Change, and Health*, Janes (1990) points out that migration is influenced by 'pull' and 'push' factors. The writer argues that migration is often framed as a consequence of factors distributed along those two dimensions. The 'push' force sweeps individuals away from their societies of origin, and the 'pull' force attracts them to the country of preference.

Pull Factors: The old saying *the grass is greener on the other side* exposes a human desire driven by curiosity to constantly search for a greener pasture. Canada is well known internationally for its high standard of living. The availability of publicly-funded healthcare services, an excellent education system, respect for human rights, and multiculturalism policies have helped placing Canada among the best countries in the world to live in. In 1998, Canada ranked as number one in the world on the Human Development Index (UNDP website, 2000).[56]

Push Factors: Many countries do not enjoy the same political and economic stability as Canada does. Countries in Asia, Africa, Eastern Europe, the Middle East, and Latin America have suffered social unrest and volatility. In many cases, this situation has manifested itself in racial riots, guerrilla warfare, violence and oppression. These kinds of dangerous situations push immigrants to seek refuge in safer countries.

---

[56] This is a composite index containing indicators such as life expectancy, income, and adult literacy.

The following narrative describes the participant perception of Canada as the land of opportunity. Better education and better career opportunities are cited as 'pull' factors, whereas escaping riots in the country of origin are identified as 'push' factors:

> *It is the land of opportunity. And I realized that education here is pretty good, at least [it] is well organized compared to there [my country]. That is why I want to stay here. Of course, I want to work here also; I want to continue my education, of course. And that time, two years ago probably, there was a bit of riot in my country, right? — So, probably, it is not quite safe for me as a minority. So I came here.*

The following two narratives describe a similar perception of Canada. However, the 'pull' is identified as a better future for the family. One participant has mentioned the sacrifice made for the sake of a better future for the children; her satisfactory professional life in the country of origin notwithstanding:

> *Well, I know it was a developed country. It has a high standard of living and quality of life. Basically, I thought it was a place for my family.*
>
> *I was a practicing physician there, and I was working in the department of anaesthesiology, and my job was pretty good. I was also doing some private practice; so, I was very happy. I didn't want to come here. But, then, my husband wanted to come here for the sake of the future of our children. So, we planned to come here.*

As the reasons for emigration, the following two narratives identify 'push' factors, such as social unrest, job safety, crumbling economy, and political situation at the country of origin:

Okay, my country's political and economical situation is not very good, and that is why there is social unrest. That is why..., of course, there is [a] political unrest and a lot of insecurity. Insecurity in terms of job, as well as... you know, insecurity in terms of like... so we were not very... you know... happy over there, and my husband plan [planned] to apply for (the) immigration because of the job situation in my country was not as good as it should have been... and, that is why we came here.

A lot of people are leaving. We didn't want to leave. We were living in England at first, and then we went back to [the country of origin]. Then, you know, the crumbling economy and the political situation were really terrible, so a lot of professionals are leaving.

6.1.2. Medical Training in the Country of Origin

The professional accreditation process involves a systematic examination of pre-migration human factors. Among others, these factors include foreign education (and certification of status), language competency, and work experience. In his conference presentation at *Shaping the Future: Qualifications recognition in the 21st Century*, Mata (1999) defines accreditation as *the process by which an agency or association grants public recognition to a training institution, program, study or service, which meets certain pre-determined standards*. The author argues that accreditation entails an auditing of the training institution to ensure that certain Canadian requirements are met. As well, there is a systematic review of training aspects, which involves measures such as course content, duration requirement, methodologies, and trainer qualifications.

Along the accreditation process, the initial step IMGs need to take involves receiving recognition of their educational qualifications. To this end, academic degrees are

assessed in terms of Canadian equivalencies. As well, since medical training in one's country of origin is an important element in understanding IMG post-migration experiences and perceptions, participants were asked to rate their medical training, from entering medical school onward.

Acceptance to Medical School: In Canada, entry to medical school is an intensive and competitive process. Candidates must possess an undergraduate degree with a high grade point-average, pass an entrance examination with top scores, and successfully complete a personal interview. This process reflects a clear commitment to choosing the best candidates, who are most likely to excel and complete their medical training and become competent career physicians.

The study findings suggest that IMGs view the entry process to medical training in their countries of origin as rigorous and competitive as in Canada. In the following narrative the participant describes the limited number of positions and the competitive selection process to enter medical school:

> *From grade ten and eleven, we started preparing to get into medical school.... To enter the medical school, you have to take (the) [an] exam. ...There are certain numbers of [available] (positions) [spots]. This was when I graduated. It has (been) changed in the meantime. When I took this exam, we (have) [had]...like... different medical schools. So, the school where I went [to] take [the exam, had] about three hundreds positions in that year. Actually, I tried three times, and the third time I entered.... Yes, it is like..., this position is... like [there are one] thousand people, and three hundred positions only.*

In some of the former British colonies, the British system of medical training is still in place. The following describes a requirement for high performance ('distinction') for entering medical school:

> *We have (established) [adopted] the British system. So we have to do, like, equivalent of grade twelve. And, then I went to (the) university, and I (did the) [studied] medical technology, and you have to get a distinction in order to get into the medical program.*

The following narrative articulates the requirement to pass the entrance exams through different processes, involving publicly-funded and private universities:

> *Yep, like an entrance exam... like MCAT [medical entrance exam]; but, it is not (specially) [exclusively] for [a certain] medical school. It is also for the whole university [system] across the country. And, these are government universities. (Because) There are private universities also. In that case, in private universities, you just have to apply by their own MCAP exam [which is administered] by the(ir) university. I graduated from (the) [a] government[-run] university, so I (have) [had] to pass the entrance exam.*

Medical Training: As mentioned above, the basic medical training in Canada is a four-year program followed by two-to-five year postgraduate training. All postgraduate training programs in Canada are accredited by RCPSC and CFPC. It is generally assumed that training standards are consistent among the various institutions. All trainees must pass the respective accreditation exams held by these bodies. Throughout the training program, students must go through various evaluation processes, including oral and written examinations. However, there are

concerns that IMGs trained in different countries may have received training based on different standards (Korock, 1981).

All study participants were accredited as physicians in their country of origin. Basic medical training among the study participants raged from five to seven years, including one year of internship. The respondents graduated from either government-operated, or privately-run institutions. The majority of the participants practiced as physicians before leaving for Canada. Except one, all participants had postgraduate medical training. Four participants had required postgraduate training in countries other than their countries of origin. The length of postgraduate training ranged from one to more than ten years. Training programs varied by type: general practice, surgery, internal medicine, cardiology, anaesthesiology, ophthalmology, obstetrics and gynaecology, and community health. Five study participants used the English language during their basic medical training.

Below are highlights of descriptive data relating the interviewees' medical training:

> *In my country, we do seven years of medical school. And you start anatomy (for the very) [during the] first year. All the clinical subjects are (for) [taught in] the first three years; the next two years are medicine and surgery, and the last year is (the) rotating internship. So, that is (the) seven years. I am a specialist. (That is) my specialty is (ophthalmologist) [ophthalmology]. As part of my specialty in France, I did two years of training in Paris in several hospitals, for which I have been accredit[ed] for, and I did an(other) extra year in my country; (for) I did many (surgery) [surgeries].*

The following is an elaborate quote document in detail the level of comprehension and length of training provided in the country of origin:

Medical-school [studies lasted] (was) five years. First two years (was spending) [were spent] on basic sciences, which (includes) [included] anatomy, physiology, biochemistry, microbiology, pharmacology. At first, we have to dissect (the) [a] cadaver (in the) anatomy. Third year, (is when) you began (the) clinical training. Now, we have to go down to the hospital and we have training in (the) general surgery, internal medicine, paediatrics, and (the) obstetrics and gynaecology. Obstetrics and gynaecology in the third year; we have to deliver twenty normal deliveries under the supervision of a midwife. And, then we have to work (out) [on] ten abnormal deliveries. Abnormal deliveries..., I refer(red) to caesarean section and other abnormal deliveries like breech. And then the fourth year of medical school was spent in [the] specialties like ENT, ophthalmology. And, we also did (the) mother-and-child health, as well as (the) public health, pathology, (again) and pharmacology. And, then [during] the final year, (the) clinical sciences, (again) and (the) we added on (the) public health. So, at the end of the five years, we (have) [had] to (sit) [write] an exam, which involve[d] internal medicine, general surgery, obstetrics and gynaecology, paediatrics and (the) public health. Each discipline involved a written paper, and (the) practical cases. Practical cases involved long [detailed/complex] cases. They (will) give you a (long) [complex] case, and you take the history and ask you[r] questions for about half an hour. And, then short cases: they give you cases on the ward, show you ,say, chest region and ask you what you think about the chest, and ask you to examine the cardiovascular system; what do you find, and cases like that. You got about five cases.... And, then the rest (that)..., you do an oral exam. They ask you questions for about twenty minutes. After graduating, we have to do internship for one year, and [it] is mandatory. And, after the internship, you are registered and you can practice.... (Because) I practice[d] for one year before (being registered) [registration, and while] doing internship.... And, then I did two and a half year[s] in a missionary hospital; so, it is three and half year[s]. And then, I (apply) [applied] (to go back to0 [for a] ... scholarship, to go back for further

training. So, I (went to have) specialized in general surgery. So, it (was) [took] another three years. That was both practice and (the) research...[at the] graduate(d) [studies level] (in addition). I get really busy. We used to teach medical student[s] basic sciences and [the] clinical sciences as well.

The description provided by study participants shows that they went through a rigorous process to enter medical school. In addition to basic medical training, they completed postgraduate training. Unfortunately, the Canadian process does not recognize most of the demands placed by supervised training programs undertaken abroad. In general, licensing bodies across Canada only give due consideration to medical degrees awarded by medical schools, which are listed in the World Health Organization (WHO) medical directory. Medical graduates from other schools are usually overlooked and considered ineligible to proceed through the accreditation process.[57]

Considering the requirements of various licensing bodies across Canada in terms of contents and training standards, foreign medical training needs to be assessed in the context of comparable Canadian standards. Nevertheless, there is no uniform national accreditation system for IMGs in Canada, and the licensing bodies in each province are at will to set different standards and requirements. A review of the literature provides some answers.

Justice Hall (1964) raises this issue in his report *Medical Manpower in Canada.* The author points out the lack of a recognized medical organization in Canada for

---

[57] Except for Ontario and Québec which apply a more elaborate screening system, training programs in selected English-speaking countries are generally considered to be similar to Canadian training programs. IMGs from such countries may proceed along a different process toward licensure (Judek, 1964; B.C. Government website, 1999; Williams et al, 1999; The College of Physicians and Surgeons of Manitoba, 2000).

assessing the educational standards of foreign medical schools. Consequently, each provincial licensing authority must discharge this duty on its own. Hall argues that registration of foreign-trained physicians involves a difficult problem of assessing medical education and training, verifying documents having adequate knowledge of the English or French language, and adopting a fair screening process to protect the public and to safeguard the immigrant physicians' right to practice in Canada.[58]

The absence of common strategy has remained an unresolved issue. Mata (1999) points out that Canadian professional associations, which are the sole body empowered to accredit Canadian physicians, often lack the capacity to assess foreign education systems, and relevant work experiences in terms of Canadian equivalencies. As a result of this information gap concerning training in the country of origin, IMGs from different countries are classified into different categories. At the same time, IMGs trained in countries with a similar cultural background are placed in a different category than those trained in other countries with a different cultural background. This is likely due to the perception of a greater level of consistency among those who have been trained in countries considered to be more compatible with the Canadian system. When it comes to the former group, it appears that another yardstick is used for measurement; and, when it comes to the latter group, the outcome is less predictable. Justice Hall identifies three strata or lists of countries:

---

[58] Hall (1964) cautions about striking a balance between two interrelated principles: protecting the public, on the one hand; and safeguarding immigrants' physicians' rights, on the other hand.

- *The General List: physicians registered by the Branch Councils of England and Wales, Scotland and Ireland.*

- *The Commonwealth List: physicians who are fully registered by virtue of recognized qualifications, received in medical schools located in the Commonwealth.*

- *The Foreign list: a relatively insignificant list, containing the names of physicians who are fully registered by virtue of recognized qualifications, granted in foreign countries (including Rangoon Medical College).*[59]

Hall's report finds that IMGs coming from England and selected Commonwealth countries have been granted [Canadian] equivalencies, while facing less stringent screening than those coming from the 'Foreign list.' This is seemingly unrelated to the medical training model. The medical training system in Burma, the researcher's native land, continues to use British model with many links to that system. (e.g., many professors and departmental heads were trained in England).

In some jurisdictions, this discriminatory practice has continued until the present time, and it has resulted in human rights complaints against provincial licensing bodies.[60] As well, due to the licensing bodies' inability to evaluate the level of medical training in foreign countries, the onus is on the individuals to prove that in terms of knowledge and skills, they are equivalent to Canadian graduates and, furthermore, they can safely practice in Canada.

---

59 The researcher's own medical school.

60 This has been expressed in the following references: B.C. Government website (1999), Williams et al (1999), Manitoba Health (2000), The College of Physicians and Surgeons of Manitoba (2000).

6.1.3. Experiences as a Physician in Country of Origin

As a contributing group within the Canadian society, physicians are usually well respected. As proclaimed on the Ontario Government website, given the current shortage of physicians across Canada, trained physicians are needed and their added value to society is valued now more than ever. Study participants reported similar experiences of great respect by their community in the countries of origin. They perceived that they were well appreciated and needed, and felt as being vital to their society. They practiced their profession with a considerable degree of satisfaction.

The following quote describes one participant's experience as a respected practicing physician in the country of origin where she was satisfied with profession:

> *Oh, I love my profession and being a physician, you know, it was really wonderful. I did my internship in obstetrics and gynaecology, and I worked with the best professor in my country. And I got my internship with him on merit. And after that, I went (in)to the department of anaesthesiology, and there I found very good people, and they were really helpful. And, I like anaesthesiology very much. And, you know, working in the operation room was really, ...you know, it made me happy. And it was really wonderful. I liked it. ...I was doing so much for (the) people. Not just being in (the) anaesthesiology... (that) as a[n] anaesthetist, I was only anaesthetising people; but, there were so many people around me who needed my help all the time. My family members, my friends, and all other people who knew me, and they used to come to me and whatever help they wanted, in term[s] of medical... you know... medical problem..., I was always there..., I was really busy with them.... I am needed there.*

The following quotes describe similar experiences by participants who were well respected physicians abroad, and leaders in their community:

> *Yes, very well respected! And I am very well needed because the hospital where I worked is (the) [a] public hospital, [and] there are a lot(s) of people, and they are short of (that) [physicians]. So you work a lot.*

> *I really enjoyed practicing medicine.... I grew up in the same culture, so I knew the people very well, and I found it much easier to practice over there.... The respect..., of course, I think is much higher than it is in this country. They really respect you a lot (and even on, say,...) [for] some of the function[s you perform], like, in the village — they can call you to give a speech. This is because of your status as a doctor.*

> *Uh... people in my country (they) respect their doctors. I felt respected, and when I could help or treat the patient, I felt satisfaction. I always wanted to do more. So, I will go far... to finish (beyond my own). But, I felt like I still need[ed] to learn. Actually, I learn a lot from my supervisor.*

6.1.4. Reasons for Selecting a Medical Career

Becoming a physician anywhere in the world involves a challenging path. One must go through a rigorous and competitive entry process, and complete many years of stressful training, which includes multiple tests and evaluative processes. In addition, the cost of the training is relatively high. One must have strong determination and stay focussed, while diligently going through the various stages required to successfully acquire a licence to practice. This raises the question as to what are the driving forces behind one's decision and desire to become a physician.

The evidence gathered during the interviews suggests that two major reasons affect the desire to pursue a medical career. First, participants felt a need to help people; and second, to fulfill family aspirations (especially their parents).

The following narrative describes one participant's desire to fulfill her mother's aspiration and, at the same time, help people:

> *Oh..., because it was my dream — I wanted to become a doctor. And especially my mother; she wanted me to be a doctor. (Because) right from my childhood, (whenever) I used to help people, I used to be happy. And what I thought... that this is a very good profession, in which you can help people. You know, sometime you get paid..., [but] most of the time, you are not being paid for those services. And that really give[s] you (a) real happiness. Working only for money is not everything. Working for people, you know, really give[s] you (a) real happiness. So, that was the motive (behind) why I became a doctor.*

Similar to the above narrative, based of a variety of reasons, the following sections describe the desire to help people:

> *Yah, I always wanted to be a doctor and I am a 'people['s] person.' I like helping people; [it] give[s] me a sense of great accomplishment. And, working in the field of medicine has always been my dream.*

> *I say my inspiration was my dad. My dad was a diabetic, and (the) I used to escort him to (a) doctor visit(s) every time. I really (think) [thought] that I should become a physician, and it would help my dad. Because my dad (is) [was] a diabetic, and he had a complication from that. So, that inspired me to pursue career in medicine.*

A similar aspiration and desire is expressed by an individual who had been inspired by a family member:

> *Okay, (first) I (am) [have been] interested in medicine since the beginning. ...I have a family member that is also a doctor. So, it inspired me a lot to become a doctor; ...of course, my family want[ed] me to [become] a doctor; but, (for myself), I also wanted to become a doctor. First of all, this is a 'third world' country right? So a lot(s) of people suffered. And, I would really like to help them. Well, just for a little bit. In terms of their sickness..., people usually have problems, any kinds of problems. And one of them... — if I can help them — I am [a] doctor! so I can help them. It, sort of, combine[s] (me) [my own] and my family['s] wishes.*

6.1.5. Pre-migration Knowledge of the Accreditation Process

The accreditation process in Canada is most complicated. Mata (1999) points out that information or lack thereof, and a number of other barriers (including those relating to language, prevailing attitudes, and organizational structures), are present at every stage of the immigrant accreditation process. This study investigates the extent to which, prior to their arrival in Canada, immigrant physicians understood and had knowledge about existing barriers to practice.

From the researcher's own work experience (Chan, 1997), and based on a pilot career-focussed interview with an IMG, it appears that pre-arrival knowledge about the Canadian accreditation system is minimal. Mata (1999) argues that immigration officers in overseas offices are habitually the first point of contact for immigrants. However, these officers often do not have the necessary knowledge about

occupational designations. Furthermore, they lack information about certification requirements for various trades and professions.

As mentioned in the previous section, Brouwer (1999) asserts that, unless informed otherwise by a visa officer, many immigrants who are accepted as skilled workers understandably mistake the federal government's granting of 'merit points' for their occupation, education and training, as recognition and approval of their qualifications. The study findings suggest that participants were aware of some of the difficulties they would face in pursuing the accreditation process. However, from a complexity viewpoint, participants came to realize that these barriers were more complicated than expected, and more difficult to overcome. This may reflect the little understanding IMG generally have about the accreditation process in Canada, and the lack of knowledge about post-arrival barriers.

Poor pre-migration knowledge about barriers causes IMGs to expect overcoming barriers with ease or minimal effort. Moreover, participants who have been informed by immigration officers of certain difficulties involving the accreditation process were given no specifics or details.

A description of a participant's perception of accessing medical practice in Canada before arrival is provided below. The individual was asked to sign a paper acknowledging his awareness of not being able to get directly into the medical profession, but was given no information to that effect:

> *When I arrived in Canada, I thought it will be quite easy to get into medical practice here. But, right from the beginning, when we (apply) [applied] to do*

the Medical Council of Canada Evaluation Exam, the booklet (at) that I received at that time..., it had a warning that (the) Canada has enough physicians for its population. So, (the fact that) passing these exams (it) doesn't mean that you will get in. ...it was (kind of) discouraging, but my family was here, so I (will give) [gave] it a try.... Oh, with the immigration? Yes, with the immigration, I (have) [had] to sign a paper and was warned that, you know, as a doctor, you may not be able to get into your profession. Yes, I was warned.... Well, actually, I should say I signed the paper when I was here already. But, before I came, I did not know. I really didn't know that it (will) [would] be very hard as it is now. But, when I came here, when I was signing to become a landed [immigrant]..., my wife... [she] sponsored me.... That when I realized that it (is) [was] not going to be easy.

A similar theme is articulated below. It focuses on anticipation of difficulties in accessing medical practice in Canada. However, the individual expected that it would be easier due to her ability to speak English and her European medical training. The interviewees admitted that her perception was unfounded and the process was more complicated than she expected:

I knew that it will be difficult. But, I did consider(ed) that being able to speak English, having (had) [a] European background — part of my education has a European background — [and] having travel[led] enough, I thought I would be able to..., or have better chances if I have not been so.... I had no idea that it was...; if I could (range) [foresee] the difficulties that I (had) found. From zero to ten — my expectation of difficulty coming here was probably.... I expected that there would be problems; but, when I got here, the reality (is) [was] that it (is) [was] more complicated than the expectation..., and [the level of difficulty] rise[s] to five times more than I (would have) expected.

Prior knowledge of difficulties in accessing medical practice in Canada appeared to have been downplayed by immigration officials, at least in participant's case:

> *Yep, I (know) [knew] that this (is) [was] going to be difficult. But, (what) I wanted to be here..., as there (is) [was] still a chance. So, (when) I knew that (I said, that) [there] was some sort of hope... that I could still (became) [become] a doctor. I came with the idea to become a doctor. But, I didn't know how difficult [it was], no.... Yes, it is more difficult than.... I have to sign a paper saying that I know that my degree is not (equivalent) [recognized] in Canada. I think that (was) what the paper said. But, they told me it (is) [was] okay to sign this.... You have to take the exam there..., [or] something like that. I don't remember the exact (formulation) [wording] of the paper; but, I think it is (the same) [like that].*

6.2. Post-migration Status Changes

After arriving in a new country with a (much) colder climate and a different environment, and while attempting to integrate into a diverse social and cultural system, professional immigrants to Canada face additional challenges of adapting to a new regulated work-environment. Janes (1990) argues that *...it is often with a great sense of promise that migrants embark on their life-changing excursions. However great the promise, and however great the probability that anticipations will be fulfilled in a new land, migration exacts a psychological toll. Individuals must learn new skills, develop new problem-solving strategies, and reinterpret the ideals held from their cultures of origin in what is likely a far different environment.*

Like other immigrants, IMGs anticipate the fulfillment of aspirations in their new land without a full recognition of the *psychological toll* required to accommodate

their role changes. Professional migrants must reacquire skills, develop new problem-solving strategies, reformulate 'old' principles, and transform ideas to a different cultural platform while, possibly, set aside ideas held in the country of origin and accepting new ones.

In their study, Aycan and Berry (1996) find that socio-economic status may be an important source of one's self-concept. The authors describe *status* as 'evaluative judgments' which people make of one another, and of one another's attributes. Such attributes include education, occupation, and income. Social status is the evaluative judgment people make of one another as worthy human beings.

Immigrants are accepted into Canada on the basis of their qualifications, education, and skills. However, when faced with difficulties in finding employment, they may be especially prone to losing their sense of self-worth. Migration and the resultant change in employment and social status can seriously impact the psychological well-being of new immigrants and, in turn, influence the adaptation to the new country. According to Aycan and Berry (1996), social-cultural adaptation is based on the immigrant's progress in becoming a full participant in society, and acquiring skills to manage daily situations. As well, economic adaptation is conceptualized as the sense of accomplishment and full participation in the economic life of the new country.

This study explores the experience and impact of status change from pre-migration to post-migration.[61] Evidence on post-migration experiences deals with the perception

---

[61] In the previous section, key topics relating to pre-migration experiences were discussed. They included experience as a physician, perceived value of being a doctor, perceptions about Canada, and awareness of difficulties.

of barriers during the long process leading to becoming a licensee. It also explores the interviewees' experience while seeking other employment, the impact of hurdles on individuals and their relationships with family members, as well as coping strategies, and aspirations for policy changes to improve an undesirable situation.

6.2.1. Description of Barriers

As described in the literature, systemic barriers are present in the accreditation process of immigrant professionals, who face a range of problems.[62] Brouwer (1999) identifies the following main barriers:

- *Lack of information specifically compiled for newcomers about accessing certain professions or trades, and about licensing standards and requirements.*
- *Difficulty in gaining recognition of foreign academic credentials by Canadian academic institutions, occupational regulatory bodies, and prospective employers.*
- *Difficulty in gaining recognition of foreign work experience by occupational regulatory bodies and employers.*
- *The absence of institutionalized, arm's-length appeal processes for those unfairly denied entry to regulated occupations.*
- *Lack of access to adequate, occupation-specific educational and training programs including professional upgrading, and language training and testing.*

Mata (1999) describes the problem in terms of the system fragmentation:

---

62 To mention but a few references, this issue is discussed in Mata (1999), AIPSO (2000), Aycan and Berry (1996).

- *There is no national body responsible for the recognition of foreign degrees, professional accreditation and licensing.*
- *Canadian professional associations, which are the sole credit grantors within the Canadian system, often lack the necessary information on education systems abroad, and work experience equivalencies.*
- *Educational and occupational standards vary by province, and occupational and other characteristics of the labour market.*
- *Each Canadian province and territory has a different standard of setting education qualifications, training and certification of professionals.*

With little or no choice, IMGs intending to obtain a licence to practice in Canada face the challenge of overcoming any and all of the abovementioned barriers.
As referenced in Mata (1999), it is a personal 'journey' involving complex interactions with different institutions; a journey which can take years to complete. While this study does not necessarily elaborate on the systemic issues facing IMGs, it does analyze their experiences in dealing with licensing difficulties. Consistent with the approach adopted by this study, the perception of these barriers, the impact on IMGs' lives, and resolution mechanisms are also explored.

Since the path to licensure is multi-phased, long and difficult, this study selectively concentrates on six key steps along that path:

- Obtaining information about the accreditation process in Canada,
- Dealing with current knowledge regarding the accreditation process,
- Going through the required examinations,

- Overcoming language barriers,
- Obtaining residency training, and
- Resolving financial issues.

At the time of interviews, none of the study participants has either obtained residency training or a licence to practice in Ontario.[63] Therefore, the experiences described by study participants relate to the pre-residency training period.

The knowledge of the accreditation process is crucial for IMGs to proceed along the path to licensure. Clearly, IMGs must know where to start (and get an application form), what books to study, and what style of exam to study for (e.g., multiple choice, oral). In addition, to expediently passing the various examinations, IMGs need to become familiar with all the administrative requirements. As stated, one of the rooted problems is that the process of accreditation varies from province to province, and it involves several organizations with different mandates. Mata (1999) identifies immigrant experiences of seeking accreditation as a huge personal undertaking with many twists and complexities. To understand this human dimension, this study specifically explores how IMGs perceive that process, what credible information they possess, and how they navigate through this long journey.

6.2.2. Obtaining Information

The findings of this study are indicative of the difficulties involved in selecting a single source or event that can provide vital information about the accreditation

---

[63] Admission to residency training is usually indicative of 'getting in or moving along a sure way' toward receiving a licence.

process. This is likely due to the complexity of the information and the high level of fragmentation in the current licensing system. In a system with a multiple organizations responsible for the accreditation of immigrant professionals, confusion prevails.

For some participants, family members provide guidance to selecting the source of information. Other IMGs rely on members of their ethnic community. However, those participants with little or no connections to their cultural or ethnic community, the quest for receiving the needed information has been considerably more difficult. Participants with no community network find that certain organizations have been a very useful source of information (e.g., AIPSO – an organization which focuses exclusively on IMG issues). Below is description how one participant is unable to initially find the necessary information, prior to contacting AIPSO:

> *I think when one comes here as an IMG, they don't know anything; like, I didn't know anything; like, the whole procedure of getting myself, you know, in shape. I have not had a clue until I met someone. She was telling me that she had a friend who goes to (discuss) [group discussions sponsored by] (which is) AIPSO.... ...I would like to go (on) [to] the next meeting, and I started [to] find out the whole process.*

The following narrative describes a similar theme, but unexpectedly the link to the information source is through the children's schoolteacher:

> *Finding information was [an] (automatic) experience for me. I was really amazed how it started. Because, you know..., I got a phone call from my children's school, and... a (settlement) worker in their school called me [to inform] that I should go and see her. I went there.... She asked me a lot of*

> *questions, and she said: 'why don't you try for your [the] exams.' And, then she told me about the organization.... She told me about AIPSO. And then, you know, I just followed those paths. And, then I reached AIPSO's office (from where); actually; that was the (basic) organization, where I got most of the information. And that is true. I started from there.*

One participant describes a different source of information, where a spouse is the link:

> *I remember..., when I came to this country, my wife called the Medical Council of Canada, and they sent (the) [a] booklet with (the) information. I think she also called the ECFMG, and they sent the same information. That is how I got the information.*

The experience of one participant with her own ethnic community is articulated by recounting her difficulties in obtaining information on the accreditation process:

> *Well, I find that even within the foreign medical student [program], there is a certain limitation(s) with regard to (the) information. I find that some students (turn to) meet with their own ethnic groups, and share information with their own ethnic group. ...there are other students, like myself, that (do not have) [are not associated with] a big community or ethnic group.... So, those who do not belong to (those majority) ethnic group[s], find it very difficult to get information. But, eventually, eventually..., we (get) [got] there.*

6.2.3. Understanding of the Accreditation Process

Study findings demonstrate the lack of consistent understanding of the accreditation process. It appears that IMGs' knowledge of the process is neither sufficient nor systematically organized. Of equal importance is the lack of knowledge about the role and responsibilities of the various organizations involved in the process. Not

surprisingly, participants have been unable to analytically explain the entire accreditation process.

Participants' level of understanding of the process is usually limited *to successfully passing the examinations and applying for residency training programs*. Some participants appear to have more knowledge about the process than others. One describes the process in other provinces, with no reference to programs in Ontario. Others have stated that they had more knowledge about parallel processes and requirements in the... United States.[64] Participants have also noted that their understanding of the Canadian accreditation process has improved with their length of stay in this country.

The narrative below describes one participant's understanding of the required examinations, and the process for matching services and residency training:

> *First, you have to take the evaluation examination [MCCEE] and, once you pass that, then you can apply for IMG program in Ontario. But, first you have to pass the TOEFL and TSE tests. These are one of the requirements (for the) [in] Ontario. And, ...you have to have one year of..., you have to reside in Ontario for at least one year. That is [the process] (for([in] Ontario. Whereas, if I want to apply (for) [in] other provinces, MCCEE is not enough; and, for that, (they) [you] will need [to pass] Qualifying Examination Part I or Part II.... Different provinces have different requirements. After [the] IMG program (and then), we have to apply for (the nine months) internship, just like the one that I did before, (already) like the one in my country. And after that, (then) we can go into the matching program, which I think the IMG*

---

64 The views expressed by study participants suggest that compared to the American accreditation system, the Canadian system is lagging behind. However, a comparison between the systems is essentially beyond the scope of this study.

> *program is... (giving) [given a] certain amount of space, which..., the specialties (they want or they) need, and then they are trying to offer them to (the) foreign doctors. After [that], if we get accepted, then, we (have) [start] the residency [program]. After that, we can get (the) [a] licence from the Royal College of Physicians and Surgeons of Canada.*

Below is how IMG describes his lack of understanding — at least initially — of the accreditation process, and how he has gained knowledge over time:

> *Well, at first it was very unclear, but now my understanding is that you would write your Evaluating Exam, and you write (your) Part I and you can apply to CaRMS for residency-matching position, or you can write your evaluating exam, and you then you apply to the OPIMG; but, they only allow fifty per year.... And so, that is what I understand.*

Accreditation of IMGs in the U.S.: The Educational Commission for Foreign Medical Graduates (ECFMG) has a mandate to assess and verify IMG entry-qualifications to residency or fellowship-training programs. To obtain an ECFMG certificate, IMGs must pass a four-part examination referred to as USMLE (United States Medical Licensing Examinations). An IMG who holds proper certifications can compete with American graduates for entry to these training programs. Success in obtaining residency training is based on the scores obtained in the USMLE exams, prior professional experience in the country of origin, and a successful interview. Upon completion of a residency training program and specialty board exams, the IMG receives a licence to practice in the U.S.

By and large, participants in this study have perceived that the accreditation system for IMGs in the U.S. is more transparent and fairer, and less confusing. According to

the evidence provided, the underlined reason for this view stems from the fact that in the U.S., a single national body, (i.e., the ECFMG) administers the accreditation exams. As well, the fact that IMGs are given the opportunity to compete with American graduates in the first match has been regarded as an important measure, which ensures a more equitable access.

Below are excerpts about perceptions of the U.S. system. The expressed view is that the American system is more coherent, and provides a greater opportunity to obtain the necessary residency training. It is argued that in Canada, even if the IMG passes the required examinations, the chance of getting into residency training is uncertain:

> *The system (about) [in the United] States is very clear-cut, and you know if you pass the exam, [and] there are chances that you can get into the residency program. But, in Canada, due to the shortage of (the) seats..., there are only fifty seats for International Medical Graduates [IMGs]. And you have to go through a very, very competitive exam...; that is [the] IMG(s) program..., [a] written [exam], as well as Objective Structured Clinical Exam [OSCE]. And people who go (for) [through] these exams really work hard. And even if they pass (through, but), they are not [necessarily] selected (in) [as one of] those fifty people.*

The following narrative describes participant's perception of the U.S. system as being fairer by providing equal opportunities, and allowing IMGs to compete with American graduates. By comparison, in Canada, IMGs are only allowed to apply during the second CaRMS match for residency training:

> *I think, I understand it's really, really difficult and unfair... the process.... Now, for example, in the [United] States..., if you're a foreign doctor, you*

> *need to pass the USMLE Step 1, Step 2, and Step 3.... After that, you (will) have (the) [an] equal right..., to compete(nt) [with] (to be the) graduate[s] from the United States.... You (will) have (the) [an] equal right to [receive fair] compensation; ...the position.... But, in Canada, it's totally different..., the medical student graduate in Canada,... they will match first.... And, only (the) [a] few spots [are] left (over),... and (the) [a] foreign doctor has a chance to [be] match[ed].*

The narrative which follows is indicative of a clear perception of time as being an important factor: the longer the IMG has been in Canada, the more and better is the knowledge he or she acquires about the accreditation process. However, the participant appears confused in his understanding of the system in Ontario, as compared to the systems in other provinces:

> *My understanding right now is different from the impression I had when I just come [came]. Currently, it seems, there are so many routes that a person can follow(ed) to become licensed. One of them... you can do the Evaluating Exam, and (you) apply for the Canadian Residency Matching Service.*[65] *And if you are lucky, you may be matched (to) [through] a residency program. And you do the residency training, and then you become licensed. Another route may be to try to do the Evaluating and Qualifying I and II, and probably apply to a community, which is underserved and can sponsor(ed) you. This [way, it] may be easier for you to get into residency training, or some training of some sort (postgraduate training in the country other than Canada), and then you can get the licence. ...that is my understanding.*

Being unclear about the actual process of accreditation, participants are also confused about the roles and responsibilities of the various institutions involved in the process.

---

[65] This applies to other provinces, since Ontario does not allow IMGs to directly apply for residency positions through the CaRMS match.

The following quote describes the lack of understanding of the role of different levels of government in Canada:

> *I just know that the licensing body.... They just give licence[s] to doctors that graduate (over) here, and if there is malpractice or whatever, they will get (the) [a] disciplinary action (for) [against] the doctor. In terms of the government..., (and) federal..., I mean, provincial and federal governments, I am not really sure about that.... I (am) [do] not (really) fully understand (about) that. What are their roles and everything like that?*

In the following narrative, the interviewee appears to have been discouraged by a friend who has been in Canada for six years, but has not progressed along the accreditation process:

> *For about six to eight months, I (have) [had] no knowledge what to do. I have a friend who told me that, you know, (there), you have to do a lot(s) of exams. So she (was) [has been] here for the last six years, and she has done nothing. So, she told me that I cannot do anything. But, if you have enough energy you can try that.*

The lack of basic understanding of the process is evidenced through the individual's limited ability to obtain information from the examination booklet provided by the Medical Council of Canada:

> *...(because) by the time I came, like, ...my wife she is not a physician, not a medical person; she just knew the agency, I mean, the Medical Council of Canada, phone number, stuff like that. So, I was studying on my own. I didn't have anybody to call (out). So, that became a bit hard. But, the other information..., I was able to get from the booklet..., they sent me from the Medical Council of Canada. So, it was not easy.*

One participant who approached a local community organization for additional information on the accreditation process (and was unable to receive it), expresses his frustration and provides the following evidence:

> *Yes, because I have absolutely no idea how things go (about). I was very frustrated. Actually, I called the Harriet Tubman Institute because I noticed that.... I don't know if you know about that.... They help you..., like immigrants from the West Indies, and some Africans. ...I saw the ad..., and they said they help new immigrants; and they help them to streamline (themselves).... But, then when I called them..., okay, it was more social support and (was) not (the) medical.... I suppose they couldn't really point me to any direction.*

6.2.4. Passing Examinations

The task of completing a series of MCC examinations is the initial step in the accreditation process, without which IMGs cannot advance to the next stage. The MCCEE is the first of such exams which, by comparison, graduates of Canadian medical schools are not required to take. For most IMGs, it is the first exam they write in Canada and, in some cases, the first one in the English language.

The study findings suggest that apart from cost, the logistics of applying and preparing for the MCC exams is quite onerous.[66] In particular, participants are unfamiliar with the exam's format, content, and expectations. McWhinnie (2001) points out that finding the right material to prepare for the exams is a great challenge. In addition, as discussed in the next section, language difficulties may arise due to the lack of competency and fluency in English.

---

[66] At the time of the interviews, none of the study participants had taken the MCCQE II, which is an OSCE-style exam. Therefore, the experiences described in this report relate only to the first two written MCC exams.

Logistics of Applying for the Examination: IMGs are required by the MCC to forward a completed application and accompanying documents at least four months before the exam date.[67] If the submission deadline is missed, applicants may still apply up to two months prior to the exam date, in which case a five hundred dollar late fee is charged. No allowances are granted and no exceptions made after the set deadlines. Application forms and credentials must be notarized in a presence of a lawyer or public notary. In the past, the MCCEE was held twice a year, whereas the Qualifying Exam Part I (MCCQEI) — once a year. In the last two years, the MCC has increased the exam frequency, and three MCCEE exams are scheduled for 2004 (Medical Council of Canada, 2004). Evidence provided by the study participants confirms that newcomers to Canada are usually unfamiliar with the process, and this situation can present insurmountable problems to IMGs.

The following quote describes the difficulties faced by a participant during the first time she applied for the MCC exam:

> *The deadlines, okay, for the Evaluating Exam — it is pretty good because they (have) [schedule exams] four times a year. Before, it was only two times [a year]. So, the deadline is quite ahead. So, you have to adjust (with) [to] that. During my preparation for the first time, it was quite difficult because we have to translate our diploma and degree, and you have check if your school(s) is registered by the WHO. Also, [the documents] have to [be] signed by a lawyer.*

Format Barrier: MCC examinations are designed to test the candidate's medical knowledge in the Canadian context. In order to do well, IMGs must be familiar with

---

[67] For example, to apply for the May 13/04 exam, a completed application should have been submitted to the MCC by January 8/04.

the exam format. The first two exams contain multiple-choice questions, in which the examinee must select the correct answer within a short time period (i.e., less than one minute per question). The MCCQE II is conducted in a format similar to the Oral Structured Clinical Exam. Being generally unfamiliar with the multiple-choice format, study participants have expressed a great level of familiarity (and comfort) with an essay type of exam, where candidates are asked to respond to open-ended questions and demonstrate in-depth knowledge about a specific topic.

The following testimony relates the experience of a participant who encountered difficulty with multiple-choice format. The interviewee accounted her initial state of nervousness and recalls that she became more accustomed with the format, she changed her attitude and became more effective in dealing with it:

> *No; exams are not easy. ...the method of [the] exam is totally different. I was used to [a] different kind of exam, in which the format was all..., you know, essay type. We did not have multiple-choice questions. I was not used to that. So, (first) I went through my first exam; I was quite nervous, and I thought that I won't be able to do it. But, you know, when I did it and (I) pass it, (and) I started enjoying it.*

A participant who prefers essay-type of questions has stated the following:

> *The exams I used to have back in my country were mainly essay type. They ask you [a] question, say, discuss the management of the sigmoid colon cancer; discuss the management of rectal cancer. And, then you write and show them your points. But, (right) here, (I found) it was a multiple-choice exam. I found it difficult. It takes me time to 'digest' (to) the multiple-choice (kind of) questions.*

One study participant describes her view of the exam format and how she prepared for it. She points out that having medical knowledge is not sufficient to pass the exam, as one must also demonstrate how to apply that knowledge:

> *And, you know, I was thinking you have to know your information. But, that is not enough. As you think about it, what you gather from other IMGs..., like the questions; some of those really test your knowledge, and there are made to test the way you think. It is not really only medicine..., like the way you think. So, in my opinion..., (what) I am focusing more (is to) [on] know[ing] the information, the material to cover (it)... to do [the] test questions, a lot of questions, (the) multiple-choice questions or whatever..., and to really understand what they really want you (from) [to know regarding] the exam. This is my opinion. It is not enough just [to] study and say I am a good doctor, I know.*

Study Materials: The argument that medical knowledge should be universal with no geographic reference would seem to be quite acceptable. However, knowledge about healthcare delivery models — and public health infrastructure in particular — varies among the world's different regions. In addition, ethical practices of medicine fluctuate from one country to another. To be aware of this diversity, IMGs must have reasonable access to a wide range of relevant resources and reference materials. Study findings suggest that, in their quest to access the material required to properly prepare for the exams, participants have experienced a variety of difficulties, some of which are presented below.

One interviewee discusses the difficulties in understanding the expectation of the exams, and finding materials or professional support to prepare for them:

> *It is difficult. Still I find it difficult; (if) we don't really have anybody to ask — nothing. (Because if) we don't have any..., (match) materials that (the) Canadian medical schools use. So, we don't know what kind of knowledge they want [us to demonstrate]. It is quite different (over) here in (the) North America (and), [as compared to] Asia. So, that is the first one....*

The difficulty in relating to material is described in the following two narratives:

> *And, it is very frustrating (because just).... [While] writing the Evaluating Exam, I noticed that [in] the Toronto Notes that we use, there are a lot(s) of things that are not clear. And, the exam even..., I wrote the first exam...., it (is) [was] not clear.*

> *For me? ...I think I could start with studying..., finding (the) good resources... even if you have the MCCQE notes, which are really good; (which)[however,] initially I found them very difficult to 'digest.' And this was just the first time [of] reading (up and) [after] three years of not reading, or studying medicine. I found it difficult.*

Evidence confirms that more often than not, medical knowledge may be insufficient to pass the exams. This is so because other than selecting the correct answers, candidates must also be able to communicate orally and prove their knowledge to an examiner. In terms of context and material, the oral examination focuses on the Canadian healthcare system. Hence, without exposure to this system, IMGs have no ideas what to expect during these sessions. As a result, most find this obstacle hard to overcome. In addition, the task of finding the right material to study is a great challenge by itself, as is the unfamiliarity with the exam format. This applies equally to the MCC exams, as well as the TSE exam.

The degree of participants' understanding of the process varies. Below is evidence as to how study participants relate to the importance of communication skills:

> *...when I took my TSE... I found out that... it (is) [had] nothing to do with [the] medical profession. But, you know, it is more like how do you express yourself.... You have to communicate with patients.... So, they check your expression [ability]. They check your communication skills, and [whether] are you capable of expressing yourself properly or not.*

Language Concerns: To be in the medical profession in Canada, one must be able to communicate well in either English or French.[68] In addition, as an entrance requirement, most residency programs require IMG candidates to pass an English proficiency test.[69] For non-English speakers, overcoming language barriers is an important step in the accreditation process. As mentioned in the previous section, five of the ten participants received their basic medical training in English, despite having another language as their mother tongue. Therefore, it should come with no surprise — even within the small sample used in this study — that the level of language competency has varied significantly. For those who did not study medicine in English, language has been a major barrier.

One participant tells how she learned to understand the Canadian accent. She believes that she improved her language skills while demonstrating a positive approach:

> *I didn't have a lot of [practice in] speaking [English]. I studied [and] I knew [my vocabulary] (vocabularies), but it was difficult to pronounce and*

---

68 MCC exams are offered in both English and French.

69 Issues related to TOEFL and TSE as standard tests for English proficiency are discussed on page 20.

> *(difficult to) understand the Canadian accent. (Initially, the) ...[for] lay people..., when you go to [a] store, they speak so quickly, you know.... It was interesting.... It was difficult, but (was) interesting. Because you realize(d) [that] you progress every day. So, it is okay and not that bad. If you think you stay [at] the same level, then you get worried. But, if you want to learn (quicker) [more quickly]..., sometime is not possible. Language [problem] was an experience [for me].*

However, one interviewee who experienced language difficulties because she studied medicine in a non-English speaking environment, was challenged by the medical terminology used in Canada:

> *For me... actually, (the)... language, I think, (also) is (the) one major barrier for some doctor[s] (including him) from foreign countries. For example, some doctor[s] get (the) training in... actually, they are [not] educated in English or French.... The medical school (so) — it's difficult to learn (the) different medical terminology.... It's different....*

By comparison, the following paragraphs describe the experience of interviewees, who received medical training in English and habitually spoke another language. They experienced barriers in communicating with patients, but were much more familiar and comfortable with certain aspects; terminology being a key one:

> *Our textbooks were in English. The terminology, (quite a bit) is quite the same, yeah. It is just (the main) [basic] language that they use (over) here...; but, [it is] different (for) [from] there.... (But) the textbooks we used [were] in English..., and the journals that we used also..., not many of them (are) [can be found] here. And (also,) we communicate [with] patients (with) [in] our language. We present our paper in our language (also), and not in*

> *English. So, basically, start learning English! It is also another barrier we face.*

> *Yeah, English is my second language. And (the), of course, my accent is not like mainstream Canadian accent. And, I find that it is a barrier too because (maybe) when you talk to someone, (and) they [may] say: 'what did you say', or 'say it again,' ...like (sort of), you have to repeat the word over and over again. But, it is true that (you said) the language of instruction (on) [in] the primary school in my country was (in) English. We have been taught in English.*

The experience of a participant who speaks English as her first language has been quite positive and, as expected, for her, language has presented no difficulty:

> *...English is my mother tongue. I know all..., everything in English. I even went to England and (study) [studied] there. Actually, my husband('s)was educated totally [under the] British [system]. He has a PhD in chemistry. So, I understand English. That is not a problem.*

Language is a major barrier for those participants who learned medicine in a language other than English. The task of learning to routinely communicate with others becomes almost insurmountable for those who need to learn and comprehend medical terminology, and understand the medical jargon used in Canada. For those who studied medicine in a foreign language, this unprecedented practice is challenging, especially during the MCC exams, when the requirement to quickly read, understand, and select the correct answers is key to successfully completing these exams. The degree of medical knowledge notwithstanding, in the absence of reasonably-developed language skills, IMGs cannot demonstrate their knowledge.

6.2.5. Obtaining Access to Residency Training

The completion of postgraduate training from an accredited Canadian medical school is one of the mandatory requirements for obtaining a licence to practice in Ontario (CPSO website). Unless admitted to the respective provincial programs, IMGs are not allowed to apply to CaRMS in Ontario.[70] There are, however, a limited number of positions specifically reserved for IMGs. In recent years, the number of pre-allocated positions in Ontario has doubled (from twenty four to fifty),[71] but this increase does not consider or reflect the growth in the number of IMGs seeking residency training in Ontario, without which they are unable to obtain a licence to practice.

Given the great demand for these training positions, the selection process is fiercely competitive. To be selected, IMG candidates must pass the required exams (both the multiple-choice and oral clinical exams) with top scores, and excel during the personal interview.[72] All interviewees have identified the limited availability of residency positions and the competitive nature of the selection process, as major barriers to licensure. Moreover, they perceive the difficulty of accessing the mandatory residency training as being unfair. Thus, despite having successfully passing the exams, IMGs may simply remain 'trapped.'

The following two narratives describe participant perceptions vis-à-vis the availability of residency training positions. This limitation is viewed as the most

---

70 This restriction also holds true for the province Québec.

71 Fifty is also the number of positions available for IMGs during the fiscal year 2004/05.

72 Based on estimates, the acceptance rate is 1:6. Each year, more than three hundred IMGs apply and compete for the fifty positions available for this program.

significant barrier to overcome. Owing to the extremely competitive selection process, IMGs express helplessness in securing a training spot:

> *Well, I think the most significant barrier that I can really see now is the number of positions. The number of positions available for foreign medical graduates is very limited. For instance, I tried the OIMG exam in 2000, and (we are) about four hundred international medical graduates participated, and they (only) pick[ed] only fifty. So, it is really competitive, and all of us can't be licensed. It is very, very difficult that way.*

> *I think the biggest barrier [involves] (I see in) the (very) admission [process]..., the number of international physician allow(s)[ed] into the system in (the) Canada. It is not fair at all. And for some of us who trained in (the) different countries..., [the issue] is the number of international medical graduates allow[ed] into the system.*

The following quote articulates similar perception, emphasizing that passing the exams is not enough to obtain residency training. This is so due to the limited number of available positions:

> *Well, actually, I came to Canada and I realized that it was not a matter of just passing the exams. It was very competitive, and they were only taking thirty six graduates every year — i.e., IMGs into [the] IMG program. And, I met a few persons who had completed all the exams; yet, [they] (had) [have] not received residency positions. So, I am thinking; you know what I should do?*

Below is a description of the limitation inherent in the competitive process of obtaining residency training as related by a participant, who appears to have received the information from a third party:

> *Especially for [the] IMG program..., I heard from somebody. Four hundred people [are] usually enrolled for the program, and they only (take) [accept]*

one hundred and fifty per year. And, then after that, the second exam is an oral type, OSCE type exam. And they only (take) [accept] one third of the one hundred and fifty, which is fifty. So..., from four hundred to fifty! It is quite a small (amount) [number] of (the) physicians that they (will take) [accept] (in)to the program. I think it is a really hard competition... especially, [when] you have physicians from other countries; I mean, all over the world. It is really hard.

6.2.6. Financial Burden

For IMGs, the cost of the accreditation process is, no doubt, expensive and the financial impact on their lives is significant. In addition to living expenses, IMGs must pay for all examinations, application and processing fees, training, and study materials. At the same time, IMGs are often unemployed, underemployed or underpaid. Nevertheless, the costs related to the accreditation process are not subsidized by any institution in Ontario.

The evidence provided by the study participants confirms IMG perceptions on the barriers related to the costs of accessing their profession. They complain about the concurrent need to support themselves and their families, while dealing with this added burden. However, the financial hurdle has not deterred or stopped any of the study participants from pursuing accreditation. To this end, various coping mechanisms have been identified, including the receiving of support from spouses and partners, taking on any available employment, and working at two jobs concurrently. However, despite the need to simultaneously work and study, participants consider their personal situation as 'manageable,' stating they can work hard and save money to cover their costs.

The following narrative addresses the experience of a study participant who is supported by her husband, but feels that she is overburdened. In her words, her family is 'just living,' unable to afford any other extra spending:

> *Yes, my husband is working, and he got a proper job.... So, it is a little bit easier for me to write the exam. But, obviously he is overburdened. And we have a very simple living.*

Two quotes outline the experience of participants who are required to work and support themselves and their families, while studying hard to prepare for their exams. The interviewees identify the difficulties of concurrently working and studying, and the lack of time for other interests imposed by the need to earn a living:

> *Yes, the exams are quite expensive. And, at the same time, I have to support (the) [my] family here, and I also have to work. So..., even time to study is not really sufficient. Maybe, if I am a full-time student studying [toward] my exams, it may be sufficient. But, if you have to support your family, [setting aside] (some) time to study for [the] exam[s] is difficult.*

> *And I also have to work, right! So, we have to arrange our time. It is very difficult if you work full time, or if you work [on] two jobs. By the time you get home, [it] is very tiring for you. And you have other problems, I mean, you have to support yourself in (the) daily life. And, also, the fee of the exam is very expensive. How can we afford that? I mean, it is really expensive. And (also) the cost of living is also high, right?*

6.2.7. Experience in Seeking Other Employment

To fully integrate into the Canadian society, immigrant professionals must find 'meaningful employment.' Aycan and Berry (1996) argue that involvement in every aspect of the Canadian life is dependant on one's participation and performance in the

labour market. They find that those who have better adapted to their new environment are more satisfied with their employment situation. The authors indicate that immigrant professionals, who are selected by immigration officers, presumably due to their high educational and occupational qualifications, represent a rich human-resource. However, evidence suggests that this resource is not always used effectively, and quite often is partly 'wasted.'

Admittedly, IMGs in Canada represent a largely untapped resource, and this situation has received attention from the Ontario government. The government revised its policy and announced its intention to increase the number of training positions for IMGs. In a press release (2001), the Ontario government clearly stated that IMGs were considered a valuable source of skilled healthcare providers, who could bolster the supply of doctors in communities and specialties in need, within a short amount of time.

While sharing their experiences in finding meaningful employment, study participants have noted that, when lacking Canadian experience and credentials, job searching has been difficult. Subsequently, when employment is found, it often involves a temporary position, or an unstable work environment. The experiences reported are indicative of the IMGs' unfavourable situation of being underemployed and underpaid. With no licence to practice medicine in Canada, IMGs seek other employment opportunities in related or unrelated fields. [73] Interviewees have underlined the significance of their underemployment conditions in relation to their

---

[73] Some underemployment opportunities cited by study participants include nursing-home or home-care attendant, orderly or hospital support-worker, and research assistant.

level of knowledge, skills and experience. However, some study participants have been successful in obtaining accreditation for an alternate medical profession (e.g., nursing or laboratory technician), in which case, they appear to have gained respect and received adequate pay.

One participant summarizes his difficulty in finding a job in the manner presented below, indicating that the job found was not permanent and was unrelated to his profession. The participant attributes his limited success to the fact that it was easier for him to find a job in a large city like Toronto:

> *Find[ing] a job has been very, very hard, 'cause (before) I used to live in Ottawa; and, (being) [in] a smaller city, jobs are very rare. I looked for [a] job in any place. I could [not] find..., (but) it was very hard to get. I even (try the) [tried a] job in [a] funeral home because I know how to (impound) [embalm] bodies; but, they didn't give me a job (in such a) [that] place. So, (however,) I got a side job for about two (months) or three months. I (have to) helped (some) in research with the Ministry of Training and Education. Other than that, it was very hard to get a job. But, in Toronto? It has been much different. I find different jobs here. I have been working in (the) [a] factory, I worked as a security guard, and now I am working as a personal support worker to assist the physically disabled.*

In the following quote, a participant indicates her inability to find a suitable job. Consequently, she has been underemployed and underpaid, feeling that with no Canadian experience, her foreign credentials were valueless. For her, this has been a humiliating experience:

> *In my (background) [experience]..., I have been relatively lucky. I did not have to search a long time for a job. But, what I did find (is) that I was*

> *probably getting the job not because of my educational background, [but rather] because I was (being) underpaid. So, I find that sort of condition... very different: the (title) [appreciation] of foreign doctors..., not having your..., not having (the title of) Canadian [experience as a] practicing doctor. (When entered into)..., the title of foreign doctor (which) means the same as nothing, (which means) to me, [it is] (looking) similar as a person who cleans (the) windows. So, that has taken me (to) some time.... I find myself [in a] humiliating situation. I have been offered the very same job that anybody [else] would have (thought) [been] entitle[d to]. But, I have been offered salaries that are half or less than half [of] what (it) [the job] should (be paid) [pay].*

In the narrative that follows, the participant tells about her ability to find employment in a related field, after agreeing to unfavourable pay conditions. However, prospective employers have treated her differently after she has received a license to practice nursing in Canada. Consequently, it has been easier for her to find a better-paying job:

> *Yep, I felt it was very difficult initially..., like, to find a job without any Canadian paper. But, once I get the nursing licence, it is really easy now. Especially, like now, there (are) [is a] shortage of nurses. It is easier now.... Like, I work where I want to work right now. Yep, people look at you differently when you have Canadian paper[s]. You can look for a better job and you get paid better. I worked in the medical field (though) before [obtaining] the licence; but, after I got the licence, I could work in (the) [a] hospital. But before, no! It was in (the) [a] different clinic, and I did not get paid (good) [enough].*

6.2.8. Impact on Daily Life

Aycan and Berry (1996) assert that usually it takes a long time to overcome barriers stemming from the lack of recognition of credentials in trades or professions. Consequently, the ability of IMGs to fully integrate in the labour force is impeded. The personal toll spreads beyond the realm of psychological problems and difficulties in adapting to an 'unrewarding environment.' Reviewing other studies, the authors point out that among various immigrant groups, work-related problems and low socio-economic status are associated with depressive symptoms and stress.[74] Moreover, underemployment resulting from an inability to work at the level for which the individual has been trained represents a potential risk for 'psychological well-being.'

Due to a variety of barriers, at the time of the interviews, none of the study participants has been able to obtain a licence to practice in Canada. They were either unemployed or underemployed and, at the same time, were facing other challenges.[75] This study attempts to assess the general impact of these barriers on participants' lives.

There has been an overwhelming sense of frustration among participants. In their oral submissions, dissatisfaction was linked to the lack of career progress, the need to re-qualify and reestablish credentials, and the length of time required for completing this process. Having already completed postgraduate training in the country of origin, the need to redo it here was perceived as an 'ineffective use of time.'

---

74 Three study groups (i.e., Mexicans, South Indians, and Koreans) are cited therein.

75 Other challenges include time availability (due to the need to work and study concurrently), need to support a family (and pay for the accreditation process), the drawbacks of status-change from a practicing physician in the native country and a layman in the new country.

The participant quoted below criticizes the fact that she required a few more years to pass all the exams and complete the residency training. According to her, repeating this process, while concurrently studying and working, meant losing valuable time:

> *It (makes me as) [is] hard..., because as the time goes by..., actually, it is a kind of waste of time. More than two years to prepare for all these exams that I still have to pass; maybe three or four more years to go, if I get into the residency [program] (and everything). So..., well, (basically for) the first two years [of training]; I already had it back home in medical school. I think it really takes a lot(s) of time (also). And it is hard. In the meantime, if you want to study, you have to work also. So, you cannot really study full-time, because I cannot support myself. I cannot support myself, right? So, it is really hard. I think.*

Social Implications: The need to study and hold a job at the same time has prevented participants from spending time with their families. This outcome may strain family relationships and, in particular, affect participants who have dependants. As expected, parents have felt a tremendous sense of guilt because they were unable to spend quality-time with their children. This point is presented in the following paragraphs, in which the participant expresses feelings that her children are neglected, while she is studying hard for her exams. Feeling guilty for insufficiently attending to her children's needs, the interviewee also expresses frustration stemming from her inability to remedy the situation:

> *Oh yes... it is quite frustrating. You know, I have to study and work so hard all over again. So, it is quite frustrating for my family. My children..., they are..., you know, when I am studying very hard..., they are sort of neglected. And they complain (that)... why are you studying? ...why are you doing this? ...And you know, they need some [of my] time (from me). But, at [that] time, I*

(feel) [felt] very guilty that I (can) [could] not attend [to] them properly. It is quite disturbing..., quite frustrating....

Researcher: *Does it (effect) [affect] your relationship with your husband?*

Yes. It does..., sometimes it does...because, you know me and my husband, both of us become very frustrated, and the relationship is definitely affected.

A similar experience is cited below with a different turn; the participant addresses a more compelling issue stemming form the 'need to settle in her profession:

The only thing is [that] it takes away from my family time. I would like to spend more time with my children. I would like to be(come) more settle[d down] in my profession and be comfortable, instead of studying all the time. I know the physician['s] role...; they have to study all the time, but not under these circumstances. Sometime it makes me (get) frustrated.

A few study participants have expressed frustration associated with profound feelings regarding the time spent as underpaid workers, while on the path to accreditation. As a result, they claim, their career advancement has been hindered. And with no apparent progress, learning itself is viewed as a process in stagnation. In essence, from a professional viewpoint, the individual is being 'put on hold.' Participants have strongly voiced a negative opinion about the loss of an opportunity to contribute to society at a level consistent with their professional capability. On a personal level, employment and underemployment have prevented IMGs from earning a fair income. Consequently, selected interviewees have expressed a pessimistic sentiment of 'doing nothing.' Inevitably, thoughts about returning to the country of origin frequently emerge. This point is raised below by a study participant, who feels that she is

neither learning nor producing anything associated with career progress. Moreover, being underpaid, she cannot financially support her family:

> *Of course, it is very frustrating to know that you are not getting anywhere; you are not producing anything, (you are) not earning anything, (you are) not learning anything. (Because supposing) [suppose] I decide[d] to go back to my country (in) [at] this time..., I would have advanced nothing. I would take no skill[s] back. I would not be able to say...: 'Well, I have learned this in Canada.' I (have this else that is) [am] useful (for) [in] my community. ...So, that is very frustrating.... Of course, not being able to work, and the right [to be a] physician.... Being underpaid means that I can not help my family (in the) economical[ly] (aspect). Not that we are expecting a lot(s) of money, but being underpaid means that there are (series of) [serious] limitations.*

One interviewee has presented an interesting and unique case. Young and married with no children, she has articulated insurmountable difficulties with the accreditation process. Poignantly, she has expressed anxiety about her lost or wasted time. Her experience seems to be overwhelmingly negative, and she claims to have increasingly become frustrated with her inability to quickly obtain a licence to practice in Canada. For her, the plan to complete the accreditation process interferes with family life. Torn between a decision to pursue or alternatively forgo personal opportunities, she describes her need to postpone familial aspirations:

> Researcher: *Okay, those barriers that you described — (do) have they impacted your life?*
>
> *I feel like I should hurry because I haven't practice, and every year that goes by, ...like, [it] is a negative thing for me. If I rush much..., but... I need*

certain time to prepare and be at the level that is required for [doing well in] the competition [for a training spot].

...I work[ed] a lot. But the job was very important (also) for me. I wanted to do both. And, I (have) [had] to sacrifice (the) time. And then, (all the) [every] weekends, either I work, (either) [or] (I) take this course.... So, every weekend, [it] is kind of busy.

Sometimes, I (was) [would become] afraid of the time..., the time that has passed [by] and..., I didn't (do) [practice] medicine. I am afraid that this may (keep) [set] me back [in my career].

Researcher: *Did you worry?*

I *Yep; every year (they) [that] go[es] by.... I mean, I am happy with my achievement; but, this is not what I (just) want to do. In terms of being a doctor, if I want to see what I have done; I have done nothing so far. And, (the like) the barriers?*

Researcher: *How do you feel about those barriers? How have they affected your life?*

It made me change my decision. First I wanted to just study and take (my) lessons, (if it) should [that have been] (be) possible. But, you learn more, and you realize that you are not.... I realized that I am not good enough to.... Okay, next year, I am going to go into [a] residency [training program]. This was my plan for last year. My plan for this year was to go into residency in the fall (like now). And, then I evaluated my(self more) [position], and I realized (myself) that I am not good enough (still)..., and I didn't want my family life to be totally ... (just) left out, just because I have to do this. I wanted to have a family, I wanted to have a house, I wanted to have a car. So (then), I [was] just postponing them from August to November. And then (still), we bought the house. But, sometimes I don't know [if] it is good or not. I mean, this is what we want[ed]... because, you know, (the) time goes by....

I am not sure..., in case I go into residency, like..., if I have to go for my pre-residency somewhere in Ontario, in Kingston or in London, for nine (months) or ten months; then, when you have [a] house, it is not so easy to move. We can't do that suddenly; like..., [it involves] just me.

This is one aspect.... And when I am done, I want to have kids. I am not sure when is the best time..., I am always occupied. Because I started to study and I have invested a lot(s) of money (for) [in] studying, and I am still going to [do so]. And, I don't want to leave it. You know..., take it easy for a while, have kid[s] and go back; ...I don't know; or, thinking to try both at the same time. So, I want to have (both) [a] family and be(ing)[come] a doctor. At some point, I wanted to just be(ing) a doctor; but, then, you know, I realized that at (this) [my] age, I cannot just think about it. I don't [know] if this is going to affect my career. It (could be) may.... But, so far..., I will do it.

Researcher: *So, you are torn between your career life and family life.*

Yep, I am. I want to bring my mother. I am thinking..., if I will have enough time to spend with her, enough time.... So, that is why (you) [she] should (be) come(ing) to be with us. So I think [that for me], this is the main item right now.

It appears that the participant's unique situation has put her in a difficult position. On the one hand, she inspires to quickly become a doctor; yet, on the other hand, she needs to postpone her plan to have a family. Realizing that it takes time to go through the accreditation process, as time passes by, her anxiety increases.

Another interviewee speaks about her frustration. Referring to the need to work and study at the same time, she recalls that applying for a job was a difficult experience for her, as she was considered as being overqualified, or lacking the so-called 'Canadian experience:'

The hurdles are that..., see, ...when we are here... and when I [will] have passed the few exams, I (applied) [will apply for a job] somewhere. They say: (that) 'you haven't passed all the exams.' You don't have (a) Canadian experience. That is the main hurdle. When we are writing the exams..., how can we work..., and who is going to offer us [a] job here. Nobody will offer us [a] job here. But still, you know, this is such a diplomatic statement.... When I go to apply for a job, they say 'you are overqualified for this job'.... They say: 'No, you don't have Canadian experience.' How can we give you a job? I don't know what to do. You know, either you can write your exam[s], or you can (do) [work on] a job. But, both things?... When you are writing your exam[s], you are not (having) [gaining] any Canadian experience. So, in two or three years, you are completely lost. (Because) [Still], you don't have any Canadian experience when you are done with your exams, [and this is the time] when you need your experience [the most]. So, what to do? I don't know.

The frustration of applying for work during a nine-month period is expressed by another participant. While contemplating to go back to her homeland, she has decided to stay in Canada to secure a better future for her children. After having invested considerable efforts in applying for a job, with a few exceptions, she has received no reply. She has been advised by those who did respond, as a physician, she was considered to be overqualified:

Nine months to find that job at Seneca College. I was very frustrated at first because I contemplated going back to [my] country of origin. As a matter of fact, (when I came) [after coming here], I went back (about) twice. Then, I made up my mind to stay because my children weren't doing too well in school.... Well, I would send my résumé..., (and lots of) [many] résumé[s] and, at that time, I [would] always go to the local post office to fax the résumé, and then I would have to pay a dollar or two (dollars), or three

(dollars) to fax to each person. And then I received no reply. ...A few replies I received; they said: 'Oh, you are overqualified for the job'.... It is pretty frustrating for me.

6.3. Coping Strategies

In *Theories of Migration and Mental Health: An Empirical Testing on Chinese-Americans,* Kuo (1976) suggests that migration involves not only the physical separation from the homeland, but also separation from one's *orienting set of mutual rights, obligations, and networks of social interactions.* This last measure is believed to be the root cause for the most tumultuous and destructive experiences associated with immigration. Kuo points out that migrants often experience strong feelings of loneliness, alienation and de-socialization, low self-esteem, and an inability to cultivate or sustain social relationships.

Mata (1999) argues that the psychosocial impact of an ineffective accreditation process on immigrant professionals is underestimated. Given that the journey toward licensure is painstaking and long, two questions emerge: How do IMGs cope with the negative impacts of non-accreditation? What kind of support is available to help them deal with the situation? The next subsections discuss the types of support received by the participants and their related perceptions.

6.3.1. Family Support

Narrative evidence gathered from interviewees strongly suggests that family members, especially partners, play an important role in providing social and financial support. This support is particularly crucial for unemployed IMGs. Participants have cited family support as a crucial mechanism for coping with the difficulties posed by

systemic and incidental barriers. By way of example, moral support provided by family members has been mentioned in the following statements:

> *We are coping, sometimes...; we are fighting (in)... sometimes, you know.... It is okay.... So, until now... it is not very bad... because, you know..., one of us is settled; so, it is good. And, thank(s) God, (that) we do not have those problems that have been faced by other immigrants, because... my husband got his job in ten days after coming (in)to Canada. So, that was really a good thing. That gives us hope that we can do something. And, it was good.*

> *My family really support[s] me... [to] be (the) [a] physician, again. So, they really [and] strongly support me; [they] give me the spirit; support also...; [they] give me a lot of time to prepare and attend (the) different conference[s].*

> *In term[s] of (living) [life values], my family is definitely number one. Without your family, you can not really.... I will have (more) [a greater] difficulty of coping with the whole thing: exam, job, and studying and, yeah, maybe living, really?*

> *Well, with my family first, my family is very supportive and [so are] the kids. They are always there for me.*

6.3.2. Support from Local Ethnic Community

Janes (1990) discusses in detail the role of social support and structured support networks.[76] Based on empirical evidence, he argues, social support promotes health (especially in 'buffering stressors'). In a complementary fashion, study participants have indicated that receiving support from their ethnic community (and, specifically from people who came from the same country of origin) is helpful. In addressing the

---

[76] The study focuses on the Samoan immigrant community in California.

issue of receiving information and moral support from landsmen, one participant has related her experience with her own ethnic community in the following manner:

> *In general, there is no special organization. We go to church. This is what we, like.... There is information, like newspaper.... Lot of thing[s], but we don't go a lot. We could go sometime, but [it] depend[s on] our time.... We know a lot of other individuals from same country (family) [and families] — (even) some of them are doctors. Fortunately, we help each other, (and) keep in touch, and talk to each other about the experience. That is helpful. And as I said earlier, my husband works; I can afford to study..., study more and work less.*

6.3.3. Support from Nongovernmental Organizations

A variety of community-based agencies have sought to provide remedial help and support to immigrant professionals (Brouwer, 1999). These nongovernmental agencies provide some assistance in finding employment to immigrants, who must seek employment for the sake of survival — job suitability or sustainability notwithstanding. In terms of helping participants move toward licensure, these agencies did not appear to be helpful. As newcomers to Canada, IMGs need to self-search for a job reflective of their qualifications. They also need to learn how to adequately compose a résumé to properly demonstrate their educational background and work-experiences, and prepare for a job interview in a new working environment. Agencies such as *Skills for Change* deliver programs designed to help immigrants find employment through the process of enhancing their job-search skills. Below is a description of one participant's experience, who was involved in a job-search program. While the program offered her no job, the interviewee felt that she did

acquire some useful skills and knowledge about the protocols and expectations pertaining to job interview:

> *At some point, at some point..., like, I went to attend a program..., like Skills for Change — a big program. So the[y] taught how a professional can find a job. And, you know, I learned interesting things. Just (into) a few months in Canada, you don't know a lot(s). But, I learned..., like, about the interview, what the interviewer look[s] at (you), what (do) they expect, certain rules, legal tricks. But, they didn't offer [me] any job, which was what I wanted at that point. I was very disappointed. But, later on, I realized that I learned actually, and I didn't waste the time.*

In general, participants perceived that they had received little help in finding jobs:

> Researcher: *So in terms of other none governmental (settlement) agencies for immigrants, are they helpful at all?*
>
> *I don't think they are really helpful. Not too helpful in finding me a job in [a] specific field like healthcare.*
>
> Researcher: *How about preparing for the exam?*
>
> *...No, not at all.*

The narratives presented below identify the positive experience derived from volunteer work. As with the search for a paying job, other than limited information, the participant has received no help in job finding. However, in terms of reward, volunteer work has provided him with the necessary contacts to obtain a job. Using this experience as a benchmark, a proposal is being made for IMGs to 'shadow' a practicing physician thereby getting the necessary exposure to the Canadian healthcare system:

Researcher: *What seems to be helpful? Given (all) your experience, what really helped you find a job? ... You [have] already said that your community was helpful in providing you with a job opportunity; how helpful was it?*

Just for (the) [your] information, [there was no]... job opportunity. I still (have) [had] to do it [by] myself; all..., finding a job (myself) from the newspaper. This is what I got from a newspaper.... Actually, I got one. (The) one I think is really useful... is if you are volunteering in (one association) [an organization], which is you (have to) work without being paid. Eventually, I got (the) [a] job... because I already volunteered (over) there [for] more than one year, and (then) [they] get used to it.... In terms of (this) foreign doctors, I was thinking, probably they should (open) [create] more [opportunities] because, I think, they need more people to help them; I mean, more healthcare professional[s] (for help). So, why don't they open (some kind of) [a] program on shadowing a doctor or nurse, or whatever, especially a doctor, so that this foreign doctor can observe and actually (can) help them also, right? So, I never saw this kind of [a] program.

Other nongovernmental agencies, such as AIPSO,[77] provide selected services to IMGs in Ontario. In particular, it informs IMGs on the accreditation process. Participants, especially those with no other support from their ethnic community or family, have found this service to be a useful source of information. This is how one participant describes the experience with AIPSO:

A lot(s) of (them) [other agencies, as] I mentioned before, (are) [were] not specifically [created] for (the medicine, or) the medical field. It is just, (only just) [for] (the) general [purpose]. If you, for example, (you) want to work somewhere not in (the) [a] health-related field..., probably, [there is] quite a lot of support from (the) community [agencies. However, in...] the healthcare

---

77 Founded by IMGs in Ontario as an advocacy group that exclusively deals with IMG-related issues, AIPSO is up-to-date and well-positioned to carry out its mandate.

field..., I think..., there is less support from (the) community [agencies]. I couldn't find anything at that time, which (especially supporting) [was specifically designed to support] our people [who are] working in the healthcare field.... And what happen[s] if I don't have family (over) here? What happen[s] if I don't have any friends (over) here? I don't think I can (have) [obtain] all (these) [this] information. I think that the Association is (very informative) [providing useful information] — the Association of International Physicians and Surgeon of Ontario. That is really helpful..., I think. So, (it) maybe (after) two-three months after I came here, (and then) I [be]came (to know) [aware of] the association. Before that, I didn't know anything about that.

6.3.4. Other Support Groups

In the year 2000, AIPSO initiated a group study-session with set objectives to help IMGs prepare for their exams, and share materials and knowledge among group participants. Initially, five-to-ten IMGs attended these sessions regularly. One year later, the group grew to about fifty IMGs (with an average of about thirty participants per session). As well, the session frequency has intensified to once a week, with more frequent meetings during pre-exam periods. At the time of writing this thesis, at least two other similar groups are active in Ontario.[78]

These self-support sessions have quickly become a platform for information exchange for all participants. During the sessions, they discuss in detail information regarding the accreditation process; they distribute and share study materials, and study them in a group setting. Participants, who already wrote the exams, relate their experiences

---

[78] The researcher attended their sessions and, when requested, provided organizational and knowledge support. By way of feedback, comments about the researcher's participation have been expressed during the interviews. However, they have been excluded from this report, as they are beyond the scope of this study.

by passing along some *dos and don'ts*. The group also organizes a series of self-funded lectures and seminars, where lecturers and senior residents from a variety of medical specialties help IMGs upgrade themselves and better prepare for the exams.

Study interviewees have expressed a feeling that self-support group-sessions provide a good source of information and an opportunity to share problems and moral support. As a direct result, participants are spared from experiencing the feelings of being alone. IMGs from many countries attend these sessions and no one is left out. Individually and collectively, they feel strongly that the sessions help them study and pass the exams, and their experience is nothing but positive. The following excerpts describe how some of the participants view the study sessions and, in particular, the moral support received during the sessions:

> *I have joined a study group and (the) that study group is very helpful. That had given me the spirit. And, you know, sitting with (all of the) physicians like me and discussing our problems, and studying with them is a very, very good experience. People from all over the world [are] sitting together, and they discuss(ed) their problems and they study together. That is really amazing, and I enjoy it so much. We go there every Thursday, and we talk(ed) to them. That is really good.*

One participant was depressed, helpless and unsure if she would be taking the exam. However, after joining the study sessions, she found out that she was not alone, as many other IMGs were facing the same situation. Subsequently, she felt relieved and was motivated to proceed along the accreditation process. She reevaluated her situation and felt that it was right for her to consider and relate to herself as a 'doctor':

Okay, first I came (on) to the study group, before I was sure when I was going to take the exam[s]. And then, I was quite depressed. I remember, I tried to study by myself. I wanted to give up (the) [my] job for a while, and just study. Then, I realize[d] it (does) [did not] work. I felt like [being] helpless. Then I decide[d], 'if I can not do [by] myself, I want to find out what other people [do]..., to see what is going on.' I started making phone calls... and, when I went to the group, I felt better. I saw other people that [were] not [necessarily] in the same situation; but, any (way) [one] (have) [had] different difficulties. So, I didn't feel like I was alone. When I studied at home..., I [felt] like I was alone. I said to myself: 'at this age?' I don't know. I just know that I won't be able to do it alone.

Researcher: *That gave you moral support?*

Yep; that is exactly the idea. So, morally, I felt warm. I still like it. That is why I go there.... (It was) sometime, (like) [the required material] (is) [was] not what I (study) [studied for], but I always learn[ed] something.... And, you know, [it] give[s] you the idea about so many IMGs that (they) took the exams, and have this experience. And I really like that. You know, [it] make[s] you think about what types of questions [there] are. I don't say.... I really learn how to [answer] the questions, or anything.... (But) [it] make[s] me aware [of] what [I] can..., what to expect. (Like) when I read..., I (do my) [am] studying, [while] (maybe make) [answering some] questions. Okay, I remember all..., this was an important aspect. Sometimes..., you read and you never know; you might miss some points. You get them later, or you don't get them; I don't know.

...Plus, sometimes, exchanging (even like) handouts and finding out about different books (that) [makes it] easier. (...And, anyway...), [this is also the case with] meeting people, and (really) talking and getting to know each other — which I miss. When I (went) [go] for a job [interview], (and) nobody knows that I am a doctor; I am okay [with that]. With my colleagues..., I feel

okay; (but I just) meet[ing] at (this) [that] spot, and having the group.... So, since I (started) [joined] the group, I [have] feel [felt] (like) free; free to say (actually): 'Okay, I am a doctor! I should feel like a doctor.' ...So far, I am really surprised with the idea. I mean, I just forget it, because it was not helpful to say 'you are a doctor,' or (to) feel [like one]. Like..., I have a friend, and she said she cannot... feel she is a doctor, and she cannot do anything that would make her feel... [otherwise]. But, I can do that.

The study participants consider group sessions as useful for sharing knowledge, experience and information. Of particular interest are study materials and tips to prepare for the exams and respond to questions. As a group, participants feel that their individual knowledge is complemented by each other and, collectively, they are able to fill all gaps. In addition, discussing the issues together help them remember the information:

You can exchange (your) knowledge [and views] from different perspective[s articulated by] (from) different doctors (over there).... (When) you are discussing [topics, and] (compared to you) [just] reading [them] (alone). Sometime, you forget all [of] the thing[s] that you read before, (just) ...maybe yesterday or the day before. (But...) while you are discussing it, you develop more understanding of that specific topic, and [you receive] a lot of information. (Also), they have some guest lecturers coming, (and) usually Canadian guest lecturers, or other foreign doctors that [have] already been in the system, (...already accepted into the system). So, it is really helpful.

What we do is that... everybody has a 'pool' of (some) questions. And, you know..., we discuss those questions. And, whatever [the] question is, we discuss the whole topic (with it, most of the time). Most of the time[s], the topic is discussed.... And then, you know, discussing these medical problems among all of us.... You know, it helps remember many things. Otherwise, if

we study at home only..., it is not helpful, because at my age..., I forget a lot(s) of things.

Yes..., through this study group, I came to know that there are many courses..., (and that being) organized by many international physicians. And, I have joined one of those...; it is a really good course. That is really helpful because they tell us about [the] management of many, you know..., routine diseases and emergency situations, [and] how are they dealing in the hospital with these emergency medical situations. So, that is really helpful because..., you know, there are differences [as to] how we used to do things in our countries, and how they are doing (it) [them here]. Plus, a lot(s) of research is (coming) [being done] (on).... And everyday, (the) medicine and management is changing. So, by attending these courses, they are keeping us up to-date.

Participants feel that the study sessions have been helpful in passing the required exams:

This study session really helped me..., I think; [it] really helped everybody. Actually, last year, almost [half of] the study group, around twenty..., I think, around twenty people passed the Evaluation Exam [MCCEE].

(It) [the self-support group] is growing day by day, and people are getting a lot of help from (that) [it]. I must say that a lot of people have passed the exam[s] because of this study group. At least, I passed both [of] my exams through this study group.

Below a study participants describe how these study sessions are conducted:

Researcher: *Tell me about the study group. What this study group means to you? How does it work?*

...Actually, I know (the) some more detail[s].... For example, I (get) [joined] (in) this study group..., just in the middle [of the session schedule]. In the beginning, there (is) [was] a couple of people, five or six people attending, but they continue[d]... half [a] year, or one year. Only (the) two or three doctor[s are] attending; sometimes...; ...almost discontinue[d].

I think the biggest help (actually) from our study group (actually).... Actually, I got really great (strong) support; for example, I had the (many) knowledge about all the examination[s].... Actually, these doctors help each other prepare [for] the examination[s].

Researcher: *So how does the group work (now)? Do members meet once a week? How many people are attending? What do they do during the study session?*

Actually, right now, we have around fifty people. Uh..., almost forty..., but sometimes around (the) fifty.... This group [meets] almost... once a week, and they (also) have a guest lecturer and case discussion. Also, (have the some) [they are] discussing some questions.... Um, actually in our study group, we tried to organize (the) different way[s] to prepare [toward] those exams. For example, we [go over] different questions and practice questions. And then, we discuss these questions. If we don't understand(ing) the questions, we go through the Toronto Notes, get all the current [reviews on] medicine, or [other] working manual[s]. We get... and discuss [relevant] details in the group. We, for example, [share] the experience [off] learnt specialists that came from different countries, [and who] ...have (different) knowledge in (the specialty on) different fields. Sometimes, they will give (the different) [a] talk. Some other doctor[s], for example, [may talk on] cardiology. The third thing, we invite some guest lecturer[s who], for example, are [accredited] professional[s] or already (get) in the OPIMG program. They (came) [come] back to teach us something....

In summary, as demonstrated in most North American and international literatures on social networks, the family appears to be a pivotal source of support for IMG moral support. It is not surprising that even in the country of origin, the family played an important role in influencing one's decision to become a physician.

Interactions among IMGs in a group setting appear to be a vital support mechanism for coping with barriers. This may be over represented due to the fact that all study participants were recruited from these study sessions. Nevertheless, the study sessions described above have helped participants in finding valuable materials and sharing medical knowledge, based on experiences gained in their respective countries. Discussions on exam contents are extremely helpful which involve reviewing questions and answers by topic category, and providing 'tips and tricks.' They assist IMGs in passing the exams at a greater success level. As well, information about the accreditation process, training courses and materials is also being exchanged.

During group discussions with like-minded people who face similar predicaments, a positive atmosphere of togetherness and solidarity prevails. The sense of sharing and togetherness helps eliminate IMGs' feeling of loneliness. The support from within allows them to feel appreciated. It enhances individuals' motivation to study and proceed along the difficult path toward accreditation.

Group interactions help restoring confidence and self-identity, which appears to have been lost due to a major career setback. Characteristically, however, study groups offer different support than the support provided by one's own ethnic community.

By comparison, the former provides guidance and information on medical and accreditation issues, whereas the latter deals with social, cultural and spiritual aspects.

According to the assessment provided by the study participants, immigrant-serving agencies are neither particularly instrumental in passing the exams, nor helpful in navigating through the accreditation process. Albeit, some programs which focus on job skills (e.g., the aforementioned *Skills for Change*) appear to be helpful in preparing IMGs for interviews and 'marketing' their skills. As well, study participants have found certain organizations to be helpful in providing information about the accreditation process, focusing on IMG-related issues, and advocating on their behalf (e.g., AIPSO).

6.4. Opportunities

6.4.1. System Changes: Participant Perspectives

Mata (1999) points out that contrary to public belief, the problem of the non-accreditation of immigrant credentials in Canada is not just an 'immigrant-related problem.' As a standard practice, to become fully licensed and accredited, out-of-province professionals and immigrant professionals need to comply with specific occupational regulations and provincial requirements. Hence, as a first step, the removal of inter-provincial barriers is vital to properly and equitably dealing with the assessment of credentials and the dynamics of professional services.

As mentioned in the previous section, labour market inefficiencies created by the unemployment or underemployment of foreign-trained professionals result in revenue loss to individuals and to society (Mata, 1999; AIPSO, 2001). Opportunity lost may

be approximated as the aggregate value of foregone income, lost taxes, and income support (i.e., subsidy) given to unemployed professionals. Thus, the economic impact of not recognizing foreign credentials can be enormous.[79] In addition, the negative psychological impact on immigrant professionals can lead to mental-health problems (Kliewer and Jones, 1996; Aycan and Berry, 1996).

In the fragmented Canadian accreditation system, diversified stakeholder interests (and the assertion of independence by them as licensing bodies) necessitate a search for systemic solutions. In that context, when making policy decisions, it is important to consider IMG needs. At present, a few changes to improve the situation are being slowly implemented (Ontario Government website, 2001).

This research explores the perspectives of study participants on the changes needed to remedy the system. In the following section, participants have identified a number of areas that, in their view, require improvements.

6.4.2. Information Requirements

Providing updated and complete information on licensing requirements is regarded as a necessary element to help immigrant professionals navigate through the accreditation system (AIPSO, 2001). Since no single organization functions as an information 'clearing house,' details on applicable processes are unavailable or unclear. Study participants claim to have often needed to rely on different sources, including family networks and various organizations. Although basic information is

---

[79] Mata (1999) cites an Australian study, based on demographic, socioeconomic, cultural and immigration characteristics similar to Ontario. Australia estimated its economical loss in 1990 due to non-recognition of foreign degrees, as ranging from $100 to $300 million U.S.

available in other areas, regretfully this is not the case with the medical accreditation process. To increase efficiencies, reduce frustration (and save time and expenses), participants have recommended establishing one-stop information centre, specifically-targeted for dealing with licensure-related issues. The following are their perspectives on this issue:

> *Perhaps, having a general(ized) information base would help. ...Being able to know exactly what is expected (of one)..., being able to have more information of exactly what one need[s] to know, being able to know what the process is, how the process works, [is beneficial]. ...It takes time and money until one understand[s] how it works..., what is expected..., and how to (take) [prepare for] the exam[s].... [Knowledge about] all [of] this could (be) cut (in) time and expenses...; if it works in (the) [a] more orderly way....*

> *Yes, proper information..., aid information [is available], ...like how to get an apartment, how (do you) [to] apply for [a] social insurance number.... All these basic things are there. But, (not) as far as their profession(alism) is concerned, that is not properly looked after.*

6.4.3. Residency Training Positions — the Number Game

The total number of IMGs living in Ontario and seeking to obtain a medical licence is unknown. In February 2003, the number of AIPSO-registered members stood at twelve hundred. However, the total number of IMGs in the province is much higher. Nevertheless, as cited on the respective websites, the total number of positions available through OPIMG and APIMG, the two programs created for Ontario-based IMGs, is less than one hundred. (This is merely eight percent of total number of AIPSO-registered IMGs.) Referring to the manpower shortage in the context of limited access to the residency training program (which, in turn, negatively affect

IMGs' ability to obtain licensure in Ontario), study participants believe that the number of residency positions allocated to both programs should be increased. They have reemphasized that IMGs had already completed their training as doctors, and some had acquired training in specialties.

The shortage of physicians in Ontario is expected to worsen, and it is estimated to be about one thousand, according to McKendry (1999). Such a serious shortage requires that all available resources, including IMGs, be accounted for and given full consideration. Study participants maintain that with additional training and orientation, IMGs should be considered as ready, capable, and fully qualified physicians. At the same time, they express skepticism that in a politically-driven environment, rather than increasing the number of positions allocated to IMGs, governments had increased the general enrollment to medical schools:

> *[There] should be more [positions]..., I think, ...[in] residency [training]. (It) [currently, the aggregate number] is really (less) [smaller]..... But, ...can I expect it? I thought there will be more [positions] because they are short of (the) physicians right now... [and for the next few] years..... But, they still don't want to open more [spots] for foreign doctors. So, I think, it is easier... other than..., they..., of course, (they) will open more space[s in] (for the) medical schools..... Why do[n't] they use (the) foreign doctors that (are) [have] already (being) [been] trained (before)? They (just) have to give some information to [help these IMGs] adjust (with) [to] the Canadian system. It is like ready-made..... It is easier for them..., I think. Right! They have a lot of knowledge also.....*

6.4.4. Self-help Groups

The concept of self-help group has been widely applied in other societal aspects.[80] In self-help group gatherings, like-minded individuals share the same issues and support each other. Consistent with the experiences described in previous sections, ample evidence on self-help meetings clearly demonstrate the benefits of preparing for the exams in a group setting. However, since these groups are generally self-funded, participants express their desire to receiving due consideration for government or community funding to assist in addressing logistical challenges (e.g., providing space for meetings and sponsoring guest-lecturers):

> *...But in terms of (only) preparing [for] the exam[s], the best thing is the discussion group and, hopefully, there [are]... a lot of discussion groups (going on). And, maybe, ...the government may give some support (here)..., or.... I don't know some community support group will fund something like this. Because it is really helpful (and).... I think, in the future, if they support (the) foreign doctor[s] (to be like that to be able) to get into the system, they will (have the) benefit (also), in the long term.*

6.4.5. IMG Access Issues: Stakeholder Perceptions

Rising healthcare costs and the perception of physician oversupply have been cited as reasons for limiting the number of IMGs admitted into the system. Barer et al (1992) provide evidence to that effect. They recommended limiting the entry of IMGs to the system and, in particular, reducing the number of postgraduate training positions available to IMGs.

---

[80] For example, one of the best known self-help groups is Alcoholics Anonymous (AA).

In *Restriction of Physician immigration seen as method of curtailing health costs,* Korcok (1975) cites his interview with then Ontario Minister of Health, the late Frank Miller, who admittedly wanted to cut healthcares cost in Ontario by taking a tough stance and limiting the number of licensures involving foreign-trained MDs (i.e., IMGs). Concurrently, the number of entry positions to medical schools was also reduced. This cutback in entry to schools across Canada raised many concerns throughout the medical profession (Sullivan, 1986). Moreover, a public debate fueled arguments for 'self-sufficiency' of physician resources across Canada (Maudsley, 1994). The expressed concerns were that IMGs would take away training positions from Canadian graduates. The Canadian Association of Interns and Residents (CAIR) responded by issuing a position paper (1993) stating, among others, that IMG training must be carried out in a separate 'pool of positions' (Recommendation 7). Furthermore, IMG access to postgraduate medical training must not adversely affect the guaranteed access of Canadian Medical Graduates (CMGs) to those positions.

Concerns about IMGs threatening CMG positions have continuously raised to this day. The Professional Association of Interns and Residents of Ontario (PAIRO) issued a position paper (2003) stating that:

> *...the entry to residency training in Canada has generally and historically been understood as a necessary corollary flowing from successful completion of medical school. This is often referred to as the medical life cycle continuum.*
>
> *...access to postgraduate training opportunities within Canada must not be restricted for CMG. ... It is critical that CMGs be assured that they will receive residency training positions, before looking outside*

Canada to increase our supply of physicians and before making residency positions needed for CMGs available to IMGs.

The claim made by PAIRO for the above positions suggest that IMGs are perceived as 'threat,' which can undermine the preferred status enjoyed by CMGs. It should be noted, however, that in recent years, the situation of physicians supply in Canada has been different than in the early 1990s. The fluctuations of supply, on the one hand, and the intent to control the number of physicians as a measure of healthcare cost-containment, on the other hand, may have influenced the perceptions of IMGs by stakeholders. By contrast, study participants blatantly describe the negative attitude by stakeholders toward them.

In the following narrative, the participant perceives that the process of accreditation is an unfair, political game to protect Canadian graduates. He believes that limiting the number of residency positions available to IMG is purposeful, aiming to ensure training to Canadian graduates. Thus, under this scenario, IMGs are not totally prevented from gaining access to practice, but rather deterred from easily entering the system:

Actually, I think the problem is the (attitude) [principles] of the policy. Well, for example, in Ontario..., even [if] you pass[ed] (the) Part One, you couldn't get in[to] the residency program. You have to... have the chance to get [in] the second match. You have to go through the IMG program first, and you have... the chance to match. But, the other problem is (the) different.... If you pass the Qualify[ing exam] Part One, you also have the chance to practice.... [It] is really unfair. For example, even [if] you pass the Qualify[ing exam] Part Two, this mean[s that] you will have the chance get (the) [a] licence.... [Comparing to a] student [who] graduated here..., they can get (the) [a]

licence, but (the) [a] foreign doctor (couldn't) [cannot]. It's really unfair.... Yes, I think, [these] are the major barriers.... Maybe..., in Canada, they give such a (little) [small number of] spot[s] for (the) foreign doctor[s]. It looks like..., a political game. It's really serious.... They think, 'oh, (if) they have... so much (the) immigration to this country.' How many [foreign] doctor[s] should become... physician[s] here? We can calculate the... ratio.... If they totally shut down this door..., this mean, this political game(s) [is] not perfect. They have to give some (the little bit) spot[s, so] that we all... have a chance to get into the program. But the real thing [is..., it] looks like [there is lack of support for]... (the) foreign doctor[s] to get into the program.

Similar to the above, in the following two narratives, the participants express an opinion that barriers have been purposefully created to prevent IMGs from accessing practice in Canada:

You know..., I think the government wants Canadian physicians to practice in Canada. And they say that the communication skills of (the) international medical graduates are not as good as our (physician's) [physicians'] (have).... So, it is really hard for them to get into the system, and we have to spend a lot of money on that. They are encouraging their own Canadian physicians, and they are trying to increase the [number of] seats in their medical schools. They say that we should..., you know, increase the [number of] seats in medical schools, so more doctors (come out of) [graduate from] those (medical) schools.

I am thinking that all these barriers (sort of) [are] being made to become ...like this ...like the exam, (to) become more difficult, more competitive, so that not many foreign doctors will (not) be able to practice in this country. That is what I think. Maybe sometime, somehow, the requirement is..., like it does not really make sense to me....

A participant questioned on the reasons for the barriers responds that despite the common knowledge about physician shortage in Canada (and in Northern Ontario and rural communities, in particular), she feels that the government has been oblivious to IMGs' needs. She believes the government should reevaluate this position and remove the barriers faced by IMGs:

> *Yes, they (just) tell you (that) what kind of exam you are going to have. They don't tell you what is happening in Canada. (Because) the books there..., we are already reading those books in our countries. So, we need to know the system here. (And) that system..., we can know [find out about it] when we work here as physician[s]. That is very important, and that will really help (people) [applicants] and [the] government. (Because) I have heard that in Northern Ontario, and in other provinces of Canada, there is an acute shortage of physicians, and I have also heard that for [a single] physician-(only) visit once (in) a week, (and) [they] get paid for the whole week.... I don't know what is happening over there.... These things are seen in our rural areas. But, I was not expecting it to happen here in Canada. (But) ...you know, the government has closed their eyes because they don't want... [that] many other physicians should come here and (they should) be trained at the expense of (maybe) the government. [The government] has to pay a lot for their training.... I don't know, what's the catch behind it? They are not letting you enter (in)to the system. (Because...) when (even) an immigrant comes here, it take[s him or her] one or two years to settle down. And, then he starts thinking about writing the exams. He is not (put into) [a participant in] the medical system here..., right when he comes here. He is not allowed to [practice]. So, I think they should be considerate enough to look into these problems.*

In summary, study participants have been unaware of the 'historical' facts presented in this section. From their vantage point, the current shortage of physicians should

serve as a prime consideration for engaging more IMGs, who are fully trained physicians. At the same time, they acknowledge that they require orientation and some additional training to better understand and appreciate standard practices within the Canadian system. Given this 'simple' solution, study participants are bewildered as to why they have been prevented from fully accessing the system. They feel unwelcome and believe that the situation is inequitable and should be rectified immediately.

6.4.6. Standard Assessment

As part of their mandate, licensing bodies across Canada must ensure that before granting the privilege to assess and manage patients, practicing physicians present sufficient medical knowledge, experience and skills in the Canadian context. However, these licensing bodies do not perform their own assessment. Instead, they rely on other organizations, such as MCC, RCPSC and CFPC — organizations with varying mandates; none of which is coordinating the assessment process for IMGs. As pointed out by Mata (1999), the lack of national coordinating bodies to effectively manage and facilitate the accreditation of foreign professionals is no longer an option. As a direct result, IMGs experiences often overlap and duplications prevail throughout the system. In the area of examinations, for example, the similarities between the oral and clinical exams held by both the MCC and the OPIMG are clear and unwarranted.

Study participants have expressed a need for a single accreditation system capable of providing all IMGs with the necessary information on contextual issues, cultural

orientation, and the assessment of qualifications and experiences gained in the country of origin. As well, parallel to financial-aid programs available to university students, participants advocate for a financial support program for helping IMGs. Given the immediate need to individually deal with the various stages of the accreditation process, study participants have raised specific questions relating to the dissemination of information and study material relevant to the exams. With the objective to better orient IMGs and condition them towards meeting Canadian standards, it has been suggested to implement a streamlined process or a toolkit, designed to properly document and present qualifications, skills, experiences and support material. Study participants feel that with the proper support and orientation, they would be able to meet Canadian standards.

With the view to institute a coordinated process and provide all IMGs an equal opportunity, one participant expresses the need to have a standardized assessment system for IMGs, which will benefit all:

> *In regards to the accreditation for foreign medical students..., ...uh — once again..., ...perhaps (the) [a more] standardized system of (getting into) [acquiring] the [required] level of knowledge [...consistent with] the standard[s] of (what is...) [the] Canadian (medicine) [medical system] should be [in place]. ...Perhaps, [a] coordinated [effort], so that everyone has the same amount of time, (amount of) money, (amount of) [and equal] possibility of getting into the system. That will benefit both, themselves and the Canadian society.*

Interviewees suggest that before being assessed, IMGs should receive an orientation about the Canadian system. The following two narratives provide different

emphases. The first narrative emphasizes the need to improve knowledge regarding technological aspects of the profession, whereas the second focuses on the need to orientate IMGs on cultural aspects of the Canadian healthcare system:

> *...For example, they think (the) [that] many doctor[s] get the training.... [The process] for (the) qualifying [a physician is] not equal ...like, [across] Canada. They think, 'oh, maybe you [are] from [a] developing country; maybe your knowledge, maybe the technology is (the kind of the) different'.... But, I think, (the)...if (this) [a] physician move[s] to Canada, it's quite easy [for that IMG] to catch up.... (Because...) they are well educated, and it's pretty easy to (know) [acquire] all (those kinds of) [the required] knowledge... all those technologies. ...I think, [...this is] not a major problem. Just to (get the) [become a] doctor.... (Get) [take] a chance! ...Even to practice, or (do) [training through] observation... — they will catch up really quickly.*

> *But why don't they just give some orientation..., ...like one specific program for foreign doctors who want to practice (over) here. (And) they give some information about [the local] culture, the Canadian culture (over here); the social culture [and] how (are) things work (in the communities like in) here. So..., I am really sure that (the) foreign doctors will try to adjust to the culture (over) here.*

Interviewees have expressed unequivocal criticism about the Canadian system, stating that it should be better equipped to dealing with immigrant professionals.

To effectively and quickly learn about the Canadian healthcare system, participants expect that system to provide more information, specifically created to resolving IMG-related issues. In that context, time and again, they have mentioned improved access to learning centres, language training and exam preparation. With such

support mechanisms, they argue, IMGs would regard themselves as having been given a fair opportunity to contribute to society, and effectively use the knowledge and experience they bring to bear.

6.4.7. Responsibility and Leadership

On a national scale, Canada has much to gain from allowing its immigrants to realize their full potential; conversely, society has much to lose from failing to do so (Brouwer, 1999). But, the primary issue in addressing the situation involves identification of policies and processes that can best achieve such goals. Except for the province of Québec, the federal government assumes responsibility for all immigration aspects, particularly for the process of selecting and approving new immigrants. The driving force behind immigration policies are factors such labour-market requirements, qualifications and skills, vocational and trade experience, and demographics. Federal immigration officers use a certain yardstick to assess potential immigrants of any and all of the categories included in the point system. However, regardless of the assessment made abroad, when it comes to professionals such as physicians and specialists, the regulating professional bodies are under provincial jurisdiction, and authority is delegated to the occupational and professional regulatory bodies (e.g., in Ontario — the College of Physicians and Surgeons of Ontario). Academic independence notwithstanding, by extension, universities deliver training programs that are accredited by the national bodies such as RCPSC, CFPC and LCME.

The accreditation system as a whole seems to be compartmentalized, with no one agency or institution assuming responsibility for IMG accreditation — an 'invisible hand' phenomenon.[81] As described earlier, the roles and responsibilities of stakeholders are reflective of the system's 'silo approach,' instituted by several agencies working in a parallel but uncoordinated fashion, and attempting to regulate processes and resolving issues, profoundly regarded by IMGs as unnecessarily complex.

While identifying duplications and gaps in the system, study participants have questioned who was really responsible for coordinating the activities of all the key players involved in the accreditation system. With uncertainty and no common opinion on this issue, as expected, a second-choice has been selected: …'the government!' However, participants remain unsure as to which level of government should take a leadership role in this matter. This indecisive position is rooted in the fact that provincial governments are responsible for the delivery of healthcare, while the federal government has a role in partially funding this system.

In the following narrative, a participant expresses his opinion about the College of Physicians and Surgeons. Unsure as to the feasibility and the timeliness of his proposal, he argues that as a licensing body, the college should take a leadership role in accrediting IMGs:

> *[The] College of Physicians could do it..., and (put) [set a] very high standard... and, then, select within (those people) [the group of applicants]*

---

81 A famous expression coined by renowned economist Adam Smith (1723 - 1790), who theorized that the nation's economy is seemingly run by an *invisible hand.*

> *who could pass, (and) taking into (the) account (either) their experience, or other factors, which might help select the right candidate[s]. I don't know if, ...as of this moment, ...this is [a] feasible process. Apparently, it has been working until now. But, is it the best? For both sides?...*

In the following narrative, the participant believes that the College of Physicians and Surgeons should collaborate with different levels of governments and 'open the door' to allow more IMGs into the system:

> *I am not really sure about the system (over) here. But..., I think the licensing body is the first thing that...; they have to open the door a little bit (bigger for) [wider to] people from foreign countries. So..., (if it comes from there...), maybe they will collaborate with (the) Health Canada or whatever (the) government or..., ...you know, (some) [an] (initiation) [institution] that [may be] involve[d] in that.*

In contrast to the above, one participant believes that the federal government should establish a program to help and support IMGs in preparing for the written exams and providing residency training:

> *(What) ...I think (is) that the Government of Canada should..., ...you know, step forward and... recruit (the) physicians..., (the) international medical graduates... into a program (that).... [They] can help them write their exams, plus (they can) get a[n] experience with that.... Because both things are a necessity, (and) if anyone of them is missing, you are nowhere.... So, there should be a program, in which we can get [the necessary] experience, as well as prepare (with) [for] the exams.*

A participant points out that the 'government' should take a lead role in establishing a well-coordinated accreditation system. However, she does not specify which level of government:

> *The government! The government, of course.... (Because) I see on the TV all the time that (there are) many doctors [are] needed in Ontario. I have many friends at work; and one guy (he) said that, in the area where his mom (lives) [lived], the physician (will) [was planning to] retire, and there (is) [would be] no one there [to replace that physician]. They are begging for [a] family physician. And he said: 'I hope that..., you know..., you can come there.' They need family physicians; and, yet, I don't know what the problem is. I think you need to (put in place) [select] (the) [that] person.... Give them [the IMGs] the exam, and allow(s) them in[to the system]. Make sure they (are of) [meet the] standard[s]; ...and, maybe, you can let them rotate in the hospital, (and) mark them, grade them; make sure they (are of) [meet the] standard[s]. Teach them, bring them up to that standard, and then allow them in....*

From the narratives presented above, there appears to be no agreement among participants in regard to the roles of the various stakeholders and their leadership in the accreditation of IMGs. This is likely due to participants' unfamiliarity with the accreditation system, and the lack of understanding on the roles and responsibilities of each stakeholder.

The view below passes a negative judgment toward politicians. However, as a remedy, the female interviewee proposes that instead of 'passing the responsibility to someone else,' all stakeholders cooperate and collaborate with the intent to address key issues, such as physician shortage and accelerated IMG access to practice. In addition, on a personal level, she raises a concern regarding lack of available residency positions in Ontario for IMGs, who have already passed the required exams, and subsequently are unable to obtain a licence to practice:

Well, I am not a politician. I know politicians (are) exploit(ed).... You know..., using diplomacy and passing the buck as, so to speak, passing the responsibility to someone else. But, if you have a (big) [serious] issue, ...(and) then, every one should come together and make sure that it is properly addressed. Because I am not so sure the provincial government (is), you know..., is hiring physician[s], or the federal government [is].... I am no politician, but I think something seriously has to be done. You can't have thousands of physicians in Ontario and Canada (and they), [who] can't get a place [to practice], even though they have completed the(se) exams (without entering into your institution). That means that they are good.... There is no help; (and) they studied..., and they (must) pass (the) practical (exam) and [the] theoretical exam[s]; (without) [...but, they are not] getting into (your) institution[s] as other Canadian-trained doctors are. That means that they have to be good....

6.5. Thematic Summary of Narrative Data

Primarily for the purpose of improving their own lives and the lives of their offspring, study participants have immigrated to Canada from a variety of countries. In search for safety and tranquility, some also left to escape political unrest.

At their prime age, study participants are eager and willing to contribute to the Canadian society. All have gone through a competitive process to entering medical school, and all have completed long years of intensive studies, including postgraduate medical training. In the countries of origin, participants were content with their successful medical practice. As practicing physicians, they felt needed in their communities. While planning to immigrate to Canada, they became aware of some of the difficulties involving the process of accreditation to practice in Canada. However, pre-arrival information was non-specific, and not detailed enough.

Upon arrival to Canada, study participants have quickly become aware of various barriers associated with the accreditation process. The level of difficulty has proven to be far greater and more complicated than originally anticipated. Quite rapidly, IMGs have learned about the different organizations involved in the accreditation process. They also recognize the lack of a uniform and reliable system to coordinate the dissemination of credible information. Interviewees have become aware of the requirement to pass a series of examinations, held by different organizations at a considerable cost. Without that, IMGs would have no access to residency training, which is a mandatory step toward obtaining a licence to practice in Ontario. Reluctantly, they learn to come to terms with reality, acknowledging that despite the critical physician shortage in Ontario, the annual allotment of residency positions available for IMGs in the province is limited. As a result, IMGs must go through a demanding selection-process, in which passing the required exams does not guarantee entry to a training program.

When seeking work to support themselves and their family, IMGs face difficulties in finding meaningful employment and, failing that, they assume a position (and remuneration) inconsistent with their skills and experience. At the same time, their unfavourable choice of employment is often made under duress and pressing needs to cover living expenses and accreditation costs. The ensuing result is an overwhelming sense of frustration among study participants, who feel guilty for not spending enough time with their immediate family members. For the unattached or childless, family planning is often temporarily set aside. With personal plans on hold, IMGs feel the need to 'fill in time,' until they are allowed to practice in their new country.

With the perception of being 'trapped,' IMGs cannot escape the thought of being unwelcome in Canada. To alleviate this problem, they seek support and encouragement from their family members. For a few study participants, their partners are in a position to support them financially; while their ethnic communities provide additional support. As well, they find self-help group-sessions very helpful.

When it comes to the accreditation process, in the absence of a single source of information, these self-help sessions have served as a key source of information. Moreover, IMGs feel that they are successful in generating sufficient mutual support and a 'critical mass' of likeminded people, who are no longer alone in their struggle to deal with common difficulties and barriers. Metaphorically, this 'negative charge' forces, which initially attract IMGs to their interest group, generate much needed positive energy through study sessions and exchange of information regarding exam contents and accreditation issues.

The IMGs interviewed for this study have emphasized the earnest need for a reliable information source, and a system capable of coordinating the various aspects of the accreditation process. Orientation to the Canadian healthcare system is but one of the main aspects that needs to be addressed. Other needs involve a financial support system, a transparent assessment process of skills, knowledge, and experience, and training opportunities to fill identified gaps. While study participants have remained indecisive in assigning responsibility to a particular agency for undertaking this insurmountable task, they believe that stakeholders from a public-sector entity; namely, the government, should be in charge.

Chapter Seven: Discussion and Recommendations

7.1. Study Limitations

Since this is qualitative research based on a small sample size, the level of applicability of the conclusions drawn herein to the general IMG population, especially in other provinces, may be limited. As related by study participants, narrative descriptions of experiences (and subsequent attempts to achieve licensure), may not necessarily reflect the prevailing opinions within the larger IMG population. However, on several dimensions the informants are representative of that population.

The researcher has gathered ample evidence to conclusively ascertain that general themes generated by the study provide insightful and credible descriptions of the key issues involving IMGs. It is hoped that decision-makers at the institution and government levels will be in a position to use this study as reference material to better understand the impact on the lives of IMGs, caused by inundated policies.[82]

7.2. Provision of Information

The evidence collected by this study underscores the need for better information at the pre- and post-migration stages; a need that has been documented in other reports, (e.g., Brouwer, 1999).

In the pre-migration stage, face-to-face (or telephone) contacts with federal immigration officials, as well as official publications are usually the first encounter with potential migrants. Being at the 'front line,' it is incumbent upon the federal

---

[82] This study may, no doubt, lead to further quantitative or qualitative research.

immigration authorities to ensure the provision of accurate and reliable information. This information must be detailed enough to allow IMGs to make an informed decision about the prospects of immigration and practice in Canada. Taking advantage of current information technology, dissemination of information should be done through parallel avenues, using primarily Internet-based resources. Having an on-line web portal will allow site managers to accurately post and update its contents in a timely fashion, and address issues brought to light by immigrants (physicians and others), with the end result of a more 'realistic picture' of licensure in Canada.

After arrival in Canada, IMGs need a single 'clearinghouse,' where they can access and obtain consistent and dependable information on licensure.[83] All immigrant-serving agencies and community agencies should network and liaise with this 'information broker.' Being in charge of posting proper and current information, a web-master will, no doubt, serve the needs of IMGs in the pre-migration phase.

7.3. Assessment of Skills, Knowledge and Experience

The study findings highlight the weaknesses inherent in the accreditation system. The system is fragmented to the extent that assessment of IMGs can never be carried out in a consistent and uniform manner. Often it is quite confusing. Many organizations and institutions are involved in the accreditation process. The provision of access involves a number of complex steps and sequential exams, which IMGs must pass in a prescribed time frame. Lack of knowledge by Canadian licensing

---

[83] In 2003, the Ontario Government provided AIPSO funding to establish a web-based 'clearinghouse' for IMG information. Efforts are currently underway to set up this entity.

bodies about medical training in the countries of origin is a grave problem. As a result of this deficiency, in terms of time and money, IMGs are heavily taxed.

Most study participants and this researcher recommend implementing a single assessment process, for reviewing and assessing IMG credentials and their clinical-management skills. The objective of the assessment should be to identify the strengths and weaknesses of one's clinical knowledge, therapeutic and management skills. Moreover, a pre-assessment orientation would familiarize IMGs with the assessment process and the exam formats. Subsequently, post-assessment training aimed to fill-in knowledge and skill gaps (as identified by the assessment) would be of benefit. To a certain extent, the recently-implemented APIMG program in Ontario uses this concept; albeit, further improvements are still required.[84]

7.4. Residency Training Positions

Study findings underline participants' frustration with the inadequate number of residency positions available to IMGs. Despite the increase in capacity over the last four years, the end result is far from addressing the needs of IMGs seeking licensure in Ontario. This also holds true with respect to the overall physician supply vis-à-vis resource requirements in Ontario and elsewhere. In addition, there is a need to increase the number of specialty positions (e.g., ophthalmology, unattainable via IMG programs in Ontario) available to IMGs. However, the increase in the number of positions will increase the resource requirement for post-graduated medical training.

---

[84] For example, one improvement should involve the provision of pre-assessment orientation; another improvement will focus on credential review, as this process is insufficiently transparent.

The condition requiring IMGs to fully complete residency-training must be reexamined. The majority of IMGs have completed some postgraduate medical training before their arrival in Canada, and many of them have years of experience in their areas of specialization. However, they may need to be 'reintroduced' to the healthcare system and to clinical practice. It has been argued that, for some IMGs, the entire residency training may not be necessary. The following comment from a study participant supports this argument:

> *Well, for me, (the) residency [training] should not be ...like (the) repetition of that.... (The one that) I already have [done that] before. (The) family doctors here are specialist[s], whereas over there, (the) general practitioners are family doctors. We already are doing the same thing..., ...I think. So, I don't know why we have to go through residency and all the programs again. Eventually, probably the program may be useful; but, not for nine months; [it is] too long....*

The APIMG program has dealt with this issue. However, it is important to note that the program is intrinsically tied to physician distribution issues and underserviced areas. When accepted into the program, an IMG undertakes to serve in an under-serviced area for a number of years. Since different rules seem to apply under varying pressures, it stands to reason that the assessment of IMGs needs be done on the basis of knowledge, skills and experience, and it should not be tied to physician resource and distribution issues. Upon meeting the required standards, the assessment process should result in giving IMGs clear access to medical practice.

7.5. Self-help

Group study helps participants prepare for the exams and provides much needed moral support and information related to the accreditation process. Admittedly, study participants have benefited from the results of the work performed by self-help groups. Consistent with this view, some funding opportunities should be considered. Public (or corporate) backing by way of space, logistics and in-kind support will guarantee the stability and continuity of these sessions, and reduce dependency on donations. For example, with proper financial support, an organized lecture series can be provided to upgrade and update participants' clinical knowledge. Funding these self-help study-groups will be a valuable investment for skilled immigrants.

7.6. An Integrated Accreditation System

Fragmentation of the accreditation process is unhelpful to immigrant professionals and, in particular, the non-recognition of immigrant skills could be costly to the Canadian economy (Mata, 1999). As a group, IMGs can be a useful resource to the current crisis in physician shortages across Canada. Currently, there is a slow moving process to improve the situation, but there is no end in sight.

Recent changes in Canadian immigration laws are indicative of a more focused approach to recruiting skilled workers with transferable skills. Given this official stance, supporting the stated objectives is imminent. Without a coordinated accreditation process, bringing in skilled immigrants ostensibly sets those newcomers up for failure. As a result, many immigrants end up being underemployed. The following comments from study participants reflect this reality:

> *I was saying that (what is) the trick behind that [lies with] the Canadian Government.... [It] (is) only invite[s] highly-educated people from all over the world.... They come here and they are doing (the labour) [laborious] jobs. If they have to put them in labor[ious] job[s]..., why don't they bring (the) skilled people (but) who are not highly-educated? (Because...) a person who is highly educated is already doing well in his country. ...But, the problem is with the social unrest in their countries; that is why they moved to Canada. But, they don't move to Canada just because they want to be in agony.... See..., I don't know what to do with.... If they say 'why do you come?'... (But,) I will say, 'why do you invite people? Stop immigration!'*
>
> *Yes, that is the problem. Why did you come? ...But, I have a question – why Canada invite[s] people? Why Canada only want[s] highly-educated people? If there is an(y) answer to this question, I would be very happy to know. Because what I have seen is that Canada is inviting highly-educated people (for their) [to perform] labor[ious] job[s]. (Because...) they want labor[ious] jobs to be done by highly-educated people....*

The federal government should take a more active and directive role in developing a national accreditation program. Current shortages in physician supply have led to decreasing barriers for IMGs in Ontario. Initiatives such as the APIMG program reflect this situation. However, once the physician supply becomes less problematic, barriers — as outlined in *Zero Point Immigration Plan,* (Korock, 1975) — are expected to be reintroduced, thereby re-limiting IMG access to medical practice. As history would have it, IMG barriers to medical practice were raised in the past due to the perception of physician oversupply and increasing healthcare costs. A critical

literature review suggests that the underlying policy decision had little to do, if at all, with the efforts to maintain medical practice standards.[85]

With no doubt, Canada is set on a course of continual acceptance of immigrants, and this resource strategy is not about to be changed in the foreseeable future. Economic and demographic imperatives will continue to drive a proactive immigration policy of welcoming immigrants with knowledge, skills, hopes, and aspirations. In a reciprocal fashion, it is also in society's best interest to allow those immigrants, who have chosen Canada as their new homeland, to fulfill their dreams and realize their full potential.

The notion of 'self sufficiency'[86] advocates for reliance on primarily Canadian Medical Graduates and, to a lesser degree, on the labour potential that IMGs bring to bear. Given their skills and knowledge, ample evidence convincingly demonstrates IMGs' potential contribution to the Canadian healthcare system. This has been the case for many years and will continue in the future, especially in northern and rural areas.[87]

Treating IMGs fairly and equitably should be the 'new normal,' as these immigrants are part of the Canadian society and many have already acquired Canadian citizenship (but not a licence to practice). Recent changes in social behaviours have affected the progress in human rights and equalities. As individual's rights are being evolved,

---

85 This issue is discussed in Barer et al (1992), Korock (1975), Maudsley (1994).

86 Self-sufficiency is raised by Barer et al (1991, 1992), Maudsley (1994), Korock (1975), Adams (1982, 1986), Ezekiel (1994), Waugh (1993), Peterson (1978), Watanabe et al (1995).

87 IMGs' contribution to the Canadian healthcare system is discussed by Barer et al (1991, 1992), Adams (1986), McKendry (1999), CAIR (1993), Health and Welfare Canada (1986), Canadian Association of Foreign Medical Schools (1985).

refined, and legally entrenched — distinctions of rights and credentials based on country of origin may become an impetus for dispute and, possibly, grounds for a lawsuit alleging discriminatory practices.

In a society which comprises of mostly 'new' and 'old' immigrants, and which prides itself on multiculturalism and equality policies; this practice is uncalled for and should be immediately corrected. By and large, Canadian professionals should welcome their new immigrant colleagues, and refrain from treating them as competitors who are about to take away a share of their 'pie.' This sentiment is reflected in the following comment made by one study participant:

> *Well, I think, first of all..., (that) Canada should be a little more equipped in dealing with immigrant professionals. I think..., Canada is a beautiful country once you have a good job. You will live a comfortable life. I am grateful for allowing me the opportunity to come to Canada. But, I think, they need to be a little more equipped to (be able to in) deal(ing) with immigrant professionals. Professionals are not (the one that come and be) satisfied with mediocre jobs. They are 'pushy' people; they come with a lot(s) of knowledge and skills. (And) they come and they want to (be utilized) [utilize their skills]. You know..., they want to feel needed and they want to contribute to (the government of) Canada. I think..., they should be given that opportunity. ...If there is any problem with the standard of (the) qualification[s] from (some) [countries] where they come from, then Canada needs to put in place [a] mechanism to ensure that they are at that level of a Canadian in a similar profession, and then utilize them.... ...Instead of just having a professional go from job to job... (and), ...you know, becoming frustrated....*

7.7. Next Steps

Upon arrival, immigrant professionals should be oriented, assessed, and trained to meet the standards set by Canadian licensing bodies. This process should be coordinated through various levels of government. Since the economic impact of non-accreditation of IMGs (and others) affects all Canadians, it is for the common good to rectify this matter quickly. The principles of the accreditation process should be fair and transparent. By the same token, reference should be made to the integration of immigrant professionals into the Canadian workforce. Non-accreditation of immigrant credentials is not just an 'immigrant problem.' As related to this researcher, study participants have been frustrated, but are not about to lose their hope:

> *No, I just think that I just want to reiterate that I love Canada, and I don't want you to think that I don't.... I just think that you need to address the issue, and stop passing the buck to someone [else].*
>
> *Yes, I wish (that) the system gets better. And I am looking forward to a time when I will be working here.... And, it should be short[ly]. (And) when(ever) I pass(ed) my exams, I should not be asked to bring [to bear] any Canadian experience.*

IMGs is but one group among many other immigrant professionals who are part of the Canadian society. Helping them keep their hopes alive, reduce the effect of barriers, and promote their full integration into our society is a *shared responsibility.* As with other groups, maximizing IMGs' contribution to society will assist us in our

'nation building' efforts and maintain Canada as the best country on this planet.

Vive le Canada!

References

1. Abramson J.: Emotional Disorder, Status Inconsistency and Migration, A Health Questionnaire Survey in Jerusalem, Milbank Memorial Fund Quarterly; vol. 44, pp. 23-48.

2. Adams O.: Canada's Doctors — Who They Are and What They Do: Lessons from the CMA's Manpower Survey; 1986.

3. Adams O.: Canada One Country Among Many Grappling with MD — Oversupply Issue; Canadian Medical Association Journal, vol. 140, pp. 68-69; January 1, 1989.

4. AIPSO; Weighting the Balance, Submission to the Review of the Regulated Health Professions Act of Ontario by the Association of International Physicians & Surgeons of Ontario; 30 December 1999.

5. AIPSO; Barriers to Licensing in Ontario for International Physicians; June 2000.

6. AIPSO; Survey Report (unpublished); 2000.

7. AIPSO; Brief to the Standing Committee on Citizenship and Immigration Regarding Bill C-11; April 23, 2001.

8. Aizenman A.I.: Platform: The Oncoming Hordes — Physicians in Canada; Canadian Medical Association Journal, vol. 127, pp. 1177-1179; December 15, 1982.

9. Aycan Z. and Berry J.W.: Impact of Employment-Related Experiences on Immigrants' Psychological Well-Being and Adaptation to Canada, by the Canadian Journal of Behavioural Science, vol. 28; July 1996.

10. Baergen E.H. : South African Doctors Flock to Saskatchewan: Canadian Medical Association Journal, vol. 138, p. 786; May 1, 1988.

11. Bailey G.A. : Immigration of Physicians; Canadian Medical Association Journal, vol. 145(11), p. 1428; December 1, 1991.

12. Barer M.L., Stoddart G.L.: Toward Integrated Medical Resource Policies for Canada: Background Document; Report Prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health; final report; June 1991.

13. Barer M.L., Stoddart G.L.: Toward Integrated Medical Resource Policies for Canada: Graduates of Foreign Medical Schools; Canadian Medical Association Journal, 146 (9), pp. 1549-1554; 1992.

14. Barnett J.R.: Geographical Implication of Restricting Foreign Medical Immigration: A New Zealand Case Study, 1976-87; Social Science Medicine, vol. 33(4), pp. 459-470; 1991.

15. Bharwani N. : Graduates of Foreign Medical Schools: False Hope; Canadian Medical Association Journal, vol. 132., pp. 1107-1108; May 15, 1985.

16. Blacket R.B.: Foreign Medical Graduates; The Medical Journal of Australia, vol. 153, pp. 125-132; August 6, 1990.

17. Blair L.: Foreign Doctors, Wasted Resources? Canadian Family Physicians, vol. 40, pp. 831-834; April 1994.

18. Bose B. : Medical Apartheid in Canada: Canadian Medical Association Journal, vol. 138, p. 995; June 1, 1988.

19. Bowen S., Simbandumwe L.: *Alternate Careers Project,* final report; University of Manitoba and Red River Community College; January 30, 1998.

20. Bowman B., Edwards M.: The Indochinese Refugee: An Overview; Australian and New Zealand Journal of Psychiatry, vol. 18, pp. 40-52; 1984.

21. Brookstone A.J. : Where Should Our New Doctors Come From? Canadian Medical Association Journal, vol. 148(7). p. 1114; April 1, 1993.

22. Brouwer A.: Immigrants Need Not Apply; Caledon Institute of Social Policy; October 1999.

23. CAIR Position Paper on International Medical Graduates; Canadian Association of Interns and Residents; February 25, 1993.

24. Canadian Task Force on Mental Health; *After the Door has been Opened* – Mental Health Issues Affecting Immigrants and Refugees in Canada; Report of the Task Force on Mental Health Issues Affecting Immigrants and Refugees; 1988.

25. Chan E.S.: Career Focused Interview with a Foreign Medical Graduate; report submitted to J. Kaufert and P Kaufert (assignment II); winter 1997.

26. Chang P.: Xenophobia and the Ordeal of Foreign Medical Graduates; Canadian Medical Association Journal, vol. 111. p. 1183; December 7, 1974.

27. Chen J., Ng, E., Wilkins R.: The Health of Canada's Immigrants in 1994-95, Health Report: Statistic Canada, vol.7, No. 4; spring 1996.

28. Chouinard J.L. : Graduates of Foreign Medical Schools: False Hope; Canadian Medical Association Journal, vol. 132. p. 231; February 1, 1985.

29. Citrome L. : Medical Training in the United States: Canadian Medical Association Journal, vol. 146, p. 99; January 15, 1992.

30. Clarke I.M.C. : Canada is Unfair to Medical Immigrants: Canadian Medical Association Journal, vol. 145(2). pp. 98-99; July 15, 1991.

The symbol (in superscripted font) indicates 'letter to editor.'

31. Cohen R. et al.: A Comprehensive Assessment of Graduates of Foreign Medical Schools; Annals RCPSC; vol. 21(7), pp. 505-509; November 1988.

32. Dixon M.E. : Where Should Our New Doctors Come From? Canadian Medical Association Journal, vol. 148(7), p. 1113; April 1, 1993.

33. Doan R. J. : Immigration of Physicians; Canadian Medical Association Journal, vol. 145(11). pp. 1427-1428; December 1, 1991.

34. Emson H.E. : Where Should Our New Doctors Come From? Canadian Medical Association Journal, vol. 148(7), p. 1115; April 1, 1993.

35. Ezekiel D. : Licensed Physician Denied Further Training: Canadian Medical Association Journal, vol. 151(7). p. 912; October 1, 1994.

36. Federoff P. : Royal College Policies Questioned; Canadian Journal of Psychiatry, vol. 35(6), p. 570; August 1990.

37. Giri N.M.: South Asian Women Physicians' Working Experiences in Canada by Canadian Woman Studies, vol. 18, No. 1, pp. 61-64; 1998.

38. Godley E.: Foreign Medical Graduates Face an Uphill Struggle for Coveted Canadian Internships; Canadian Medical Association Journal, vol. 147(1), pp. 94-96; July 1, 1992.

39. Government of Manitoba; Information for International Medical Graduates in Manitoba; Manitoba Labour, final draft; January 2000.

40. Graduates of Foreign Medical Schools; A paper by the Canadian Association of Interns and Residents; August 6, 1985.

41. Gregory B. W. : Who Should Practice Where? Canadian Medical Association Journal, vol. 150(7), pp. 1055-1056; April 1, 1994.

42. Isaacson B. : Foreign Medical Schools; Canadian Medical Association Journal, vol. 120, p. 632; March 22, 1980.

43. Janes C.R.: Migration, Social Change and Health: A Samoan Community in Urban California, 1990.

44. Jones I.E.T.: Medical Brain Drain; Canadian Medical Association Journal, vol. 111, p. 312; August 17, 1974.

45. Judek S.: University of Ottawa; Medical Manpower in Canada; Royal Commission on Health Services by Hall E.M. et al; 1964.

46. Khanna S.K. : Where Should Our New Doctors Come From? Canadian Medical Association Journal, vol. 148(7), pp. 1113-1114; April 1, 1993.

The symbol (in superscripted font) indicates 'letter to editor.'

47. Klass D.: Program for Refugee Physicians; Canadian Medical Association Journal, vol. 139, pp. 847-848; November 1, 1988.

48. Kliewer E., Jones R.: Migrant Health and the Use of Health Services: A Report from the Longitudinal Survey of Immigrants to Australia (LSIA), First Wave; Research and Statistics Section, Department of Immigration and Multicultural Affairs; Canberra, October 1996.

49. Korcok M.: Restriction of Physician Immigration Seen as Method of Curtailing Health Costs: Canadian Medical Association Journal, vol. 112, pp. 509-513; February 22, 1975.

50. Korcok M.: We Want to Plug Hop-skip-jump Routine; Canadian Medical Association Journal, vol. 112, pp. 513-514; February 22, 1975.

51. Korcok M.: Zero Points Immigration Plan Shows No Effect on Inflow of Physicians; Canadian Medical Association Journal; September 20, 1975, 113. pp. 585-586.

52. Korcok M.: Will Offshore Medical Schools Graduate Quality Physicians? Canadian Medical Association Journal, vol. 124, pp. 461-468; February 15, 1981.

53. Korcok M.: Foreign Medical Graduates: Screening-out the Poorly Trained; Canadian Medical Association Journal, vol. 124, pp. 626-630; March 1, 1981.

54. Korcok M.: Horizons Bleak for Offshore Medical Graduates; Canadian Medical Association Journal, vol. 132, pp. 951-954; April 15, 1985.

55. Knox M.C. : Where Should Our New Doctors Come From? Canadian Medical Association Journal, vol. 148(7), pp. 1114-1115; April 1, 1993.

56. Kuo W.: Theories of Migration and Mental Health an Empirical Testing on Chinese-Americans; Social Science and Medicine, vol. 10, pp. 297-306.

57. Lakhani Z.M.: Graduates of Foreign Medical Schools: False Hope: Canadian Medical Association Journal, vol. 133, pp. 550-551; September 15, 1985.

58. Lowry F.: Quebec's Hunger-striking MDs: Do FMGs Automatically Have Right to Practise? Canadian Medical Association Journal, vol. 140, pp. 1341-1405; June 1, 1989.

59. Mador M.L. : Canada is Unfair to Medical Immigrants: Canadian Medical Association Journal, vol. 145(2), p. 99; July 15, 1991.

60. Manitoba Health: Reply to the Complaint of Discrimination of the Association of Foreign Medical Graduates in Manitoba under Section 25 of the Human Rights Code (Manitoba); January 31, 2000.

61. Mata F.: The Non-Accreditation of Immigrant Professionals in Canada: Social Dimensions of the Problem by Multiculturalism Program Citizenship and Canadian Identity; Department of Canadian Heritage; September 21, 1999.

The symbol (in superscripted font) indicates 'letter to editor.'

62. Maudsley R.F.: Canadian Self-Sufficiency in Physician Resources: Canadian Medical Association Journal, vol. 150, pp. 21-22; January 1, 1994.

63. McAuley R.G. : Physician Licensing Requirements: Canadian Medical Association Journal, vol. 107, pp. 17-19; July 8, 1972.

64. McCaffrey D.C. : South African Doctors Flock to Saskatchewan: Canadian Medical Association Journal, vol. 138, p. 300; February 15, 1988.

65. McCaffrey D.C. : Canada is Unfair to Medical Immigrants: Canadian Medical Association Journal, vol. 145(2), p. 99; July 15, 1991.

66. McGregor M.: Migration of Medical Manpower; Can. Papers from International Macy Conference; by Bowers J.Z. and Professor Lord Rosenheim; The Josiah Macy, Jr. Foundation, pp. 31-42; New York, 1971.

67. McKendry R.: Report of a Fact-Finding Commissioner; Ontario's Ministry of Health and Long-Term Care; 1999.

68. McWhinnie L.M.: Beyond the Threshold: A look at four international medical graduates successful experience of becoming licensed to practice medicine in Ontario; A thesis submitted to the Faculty of Graduate Studies and Research in Partial fulfillment of the requirements for the degree of Master of Arts in Education; 2001.

69. Morse J.M., Field P.A.: Qualitative Research Methods for Health Professionals, Second Edition by Chapman & Hall; 1995.

70. Mueller B.C.: Some Effects of Health Insurance in Canada, From Private Enterprise toward Public Accountability; The New England Journal of Medicine, vol. 298(10), pp. 535-539; March 9, 1978.

71. Nasmith L.: Programs for International Medical Graduates; Canadian Family Physician, vol. 39, pp. 2549-2553; December 1993.

72. National Action Plan for Physician Resource Management: Graduates of Foreign Medical Schools; Report of the Advisory Committee on Health Human Resources to the Conference of Deputy Ministers of Health; June 22, 1993

73. Paine D.T.H. : Immigration of Physicians; Canadian Medical Association Journal, vol. 145(11), p. 1428; December 1, 1991.

74. Peterson O.L.: A Lesson from Canada: Ontario's Health Insurance; The New England Journal of Medicine, vol. 298(10), pp. 566-567; March 9, 1978.

75. Politzer R.M. et al.: The Hidden Future Supply of Foreign Medical Graduates; Medical Care, vol. 27(11), pp. 1046-1057; November 1989.

The symbol (in superscripted font) indicates 'letter to editor.'

76. Professional Association of Interns and Residents of Ontario, International Medical Graduate (IMG) Position Paper; June 6, 2003.

77. Rafuse J.: Strategies Outlined for Balancing Growth of MD, Patient Populations; Canadian Medical Association Journal, vol. 148(7), pp. 1203-1205; April 1, 1993.

78. Report of the Joint Working Group on Graduates of Foreign Medical Schools to the Federal/Provincial Advisory Committee on Health Human Resources; by Secretariat of the Federal/Provincial Advisory Committee on Health Human Resources, Health Human Resources Division, Health Services and Promotion Branch, Health and Welfare Canada; October 1986.

79. Rossmann C. : Medical Apartheid in Canada: Canadian Medical Association Journal, vol. 138, p. 492; March 15, 1988.

80. Satkauskas R., Pavilanis A.: The Plight of Immigrant Physicians in Canada: Canadian Family Physician; vol. 36, pp. 119-127; January 1990.

81. Singleton F.B. : Canada is Unfair to Medical Immigrants: Canadian Medical Association Journal; vol. 145(2), p. 99; July 15, 1991.

82. Stasiulis D.K.: Multiculturalism and the Economic Agenda in Australia: Adult E.S.L., Overseas Recognition and Anti-Racist Strategies, Ottawa; DPAR Publication, Multiculturalism and Citizenship Canada.

83. Stewart C.B. : Immigrant Physicians: Canadian Medical Association Journal; vol. 107, pp. 109-111; July 22, 1972.

84. Sullivan P.: Medical School Cutbacks would be Unfair to Young Canadians, Conference Told; Canadian Medical Association Journal, vol. 135, pp. 1299-1301; December 1, 1986.

85. Sullivan R.B. et al.: The Evolution of Divergences in Physician Supply Policy in Canada and the United States; JAMA, vol. 276(9). pp. 704-709; September 4, 1996.

86. Sweatman E., Gagne C. (BDO Dunwoody & Associates): "Study to Determine the Feasibility of Establishing a Bridging Program for Foreign Medical Graduates and Underserviced Communities;" Report prepared for the Association of Foreign Medical Graduates in Manitoba Inc.; January 1996.

87. The College of Physicians & Surgeons of Manitoba: Response of the College of Physicians & Surgeons of Manitoba (Re: The Complaint of Discrimination of the Association of Foreign Medical Graduates in Manitoba under Section 25 of the Human Rights Code of Manitoba); 2000.

88. The Medical Council of Canada: Letter to the Honourable Lucienne Robillard, MP, Minister of Citizenship and Immigration, Government of Canada; February 19, 1999.

The symbol (in superscripted font) indicates 'letter to editor.'

89. Thomas D.: Evolving Family Living Arrangements of Canada's Immigrants; Canadian Social Trends by Statistics Canada, Catalogue No. 11-008, pp. 16-22; summer 2001.

90. Thomson M.J.C. ; Medical Licensing: Canadian Medical Association Journal, vol. 113, p. 182-185; August 9, 1975.

91. Thong Y.H.: Editorial; Medical Immigration and the Medical Workforce; The Medical Journal of Australia, vol. 153, pp. 124-125; August 6, 1990.

92. University of Manitoba: Response of the University of Manitoba, (Re: The Complaint of Discrimination of the Association of Foreign Medical Graduates in Manitoba under Section 25 of the Human Rights Code of Manitoba), 2000.

93. Viel B.: Migration of Medical Manpower: General Observations; Papers from International Macy Conference by Bowers J.Z. and Professor Lord Rosenheim; The Josiah Macy Jr. Foundation, pp. 157-161; New York, 1971.

94. Voysey M. : Graduates of Foreign Medical Schools — False Hope; Canadian Medical Association Journal, vol. 132, p. 1108; May 15, 1985.

95. Wallace J.D.: The Horns of the Medical Manpower Dilemma; Canadian Medical Association Journal, vol. 112, p. 489; February 22, 1975.

96. Watanabe M., Fick G.H.: Influence of Undergraduate and Postgraduate Education on Recruitment and Retention of Physicians in Rural Alberta: Clinical Invest. Med., vol. 18(3), pp. 217-228; 1995.

97. Waugh D.: Where Should Our New Doctors Come From? Canadian Medical Association Journal, vol. 148(1), p. 81; January 1, 1993.

98. Waugh D. : Where Should Our New Doctors Come From? Canadian Medical Association Journal, vol. 148(7), pp. 1115-1116; April 1, 1993.

99. Webber W.A.: Residency Choice Blocked for IMG; Canadian Medical Association Journal, vol. 152(11), p. 1743; June 1, 1995.

100. Williams B., Conner M.: A Complaint of Discrimination Under the Human Rights Code of Manitoba by the Association of Foreign Medical Graduates in Manitoba Inc.; September 27, 1999.

101. Woods D.: Billing-Number Law Makes Them Second-class Citizens, BC Doctors Say; Canadian Medical Association Journal, vol. 137, pp. 329-330; August 15, 1987.

Websites:

102. About the Royal College: http://repsc.medical.org/english/about/

The symbol (in superscripted font) indicates 'letter to editor.'

103. Assessment Program for International Medical Graduates (APIMG); http://www.cou.on.ca/Health/HOME/IMG/IMGHomePage.htm

104. Canada's Immigration Law: http://www.cic.gc.ca/english/pub/immlaw.html http://www.cic.gc.ca/english/pub/imm-law.html#highlights

105. Canadian Resident Matching Services Website; http://www.carms.ca/main.htm

106. Citizenship and Immigration Canada Website: Immigrating to Canada; Introduction; http://www.cic.gc.ca/english/immigr/index2.html; http://www.cic.gc.ca/english/monitor/issue03/02-immigrants.html

107. Decision by British Columbia Human Rights Commission; *Reason for Decision* by Bitonti's et al; 1999. http://www.bchrt.gov.bc.ca/bitonti1.htm

108. Education Commission for Foreign Medical Graduates; http://www.ecfmg.org/

109. Facts and Figures 2000, Immigration Overview; http://www.cic.gc.ca/english/pub/facts2000/index.html http://www.cic.gc.ca/english/pub/immigration2003.html Annual Report to Parliament on Immigration 2003.

110. Harris government more than doubles foreign-trained doctors to work in Ontario, Government of Ontario Press Release, June 2001; http://www.newswire.ca/government/ontario/english/releases/June2001/14/c4167.html

111. Human Development Index; http://www.undp.org/hdr2003/indicator/indic_1_1_1.html

112. Human Development Indicators by UNDP The Human Development Indicator Report; http://hdr.undp.org/reports/global/2000/en/pdf/hdr_2000_back1.pdf

113. IMG Initiatives; Ontario Ministry of Health and Long Term Care; http://www.health.gov.on.ca/english/providers/project/img/strategy.html

114. Immigrating to Canada: How are Immigrants Chosen? http://www.cic.gcca/english/immigr/ihow-e.html

115. Medical Council of Canada Website: http://www.mcc.ca/ Medical Council of Canada Evaluating Examination: http://www.mcc.ca/pdf/2004ee/ee_pamphlet_2004.pdf Medical Council of Canada Qualifying Examination Part I: http://www.mcc.ca/english/examinations/qualifying_e1_sched.html Medical Council of Canada Qualifying Examination Part II: http://www.mcc.ca/english/examinations/qualifying_e2_sched.html

116. Ontario International Medical Graduate Program Website; http://www.library.utoronto.ca/medicine/oimg/

117. Ontario International Medical Graduates Program; http://www.library.utoronto.ca/medicine/oimg/

118. Provincial Restrictions for CaRMS match; http://www.carms.ca/procedure/provrule.htm

119. Test of English as a Foreign Language web site; http://www.toefl.org/educator/edresults.html

120. Test of Spoken Language web site; http://www.toefl.org/tse/tsegetscr.html

121. The College of Family Physicians of Canada website; http://www.cfpc.ca/toc.htm

122. The College of Physicians and Surgeons of Ontario web site; http://www.cpso.on.ca/Info_physicians/applicants/regist.htmcians/applicants/regist.htm

123. http://www.oimgc.utoronto.ca/phase1_infobook.pdf

124. http://ogov.newswire.ca/ontario/GPOE/2004/06/23/c7848.html

125. Liaison Committee on the Medical Education (LCME): http://www.leme.org/

The symbol (in superscripted font) indicates 'letter to editor.'

Table of Acronyms

AFMGM	Association of Foreign Medical Graduates in Manitoba Inc.
AIPSO	Association of International Physicians and Surgeons of Ontario
APIMG	Assessment Program for International Medical Graduates
BNA	British North America Act
CAIR	Canadian Association of Interns and Residents
CaRMS	Canadian Resident Matching Service
CFPC	College of Family Physicians of Canada
CIC	Citizenship and Immigration Canada
CMGs	Canadian Medical Graduates
CPSO	College of Physicians and Surgeons of Ontario
ECFMG	Educational Commission for Foreign Medical Graduates
HRDC	Human Resources Development Canada
IMGs	International Medical Graduates
IRPA	Immigration and Refugee Protection Act
LCME	Liaison Committee on the Medical Education
LMCC	Licentiate of the Medical Council of Canada
MCC	Medical Council of Canada
MCCEE	Medical Council of Canada Evaluating Examination
MCCQE I & II	MCC Qualifying Examination Part I & II
MLPIMG	Medical Licensure Program for International Medical Graduates
OIMG	Ontario International Medical Graduates Program
OIMGC	Ontario International Medical Graduates Clearinghouse
OSCE	Objective Structured Clinical Exam
PAIRO	Professional Association of Interns and Residents of Ontario
RCPSC	Royal College of Physicians and Surgeons of Canada
TOEFL	Test of English as Foreign Language
TSE	Test of Spoken English
USMLE	United States Medical Licensing Examinations
WHO	World Health Organization

Appendix A

Letter of Invitation

A Study on Narrative Descriptions of Access to Practice Among International Medical Graduates In Manitoba and Ontario

Date: March 12, 2002

Dear Doctor,

My name is Eng-Soon Chan and I am physician from Myanmar formally known as Burma. I am currently a graduate student completing my thesis in the Master Program at the Department of Community Health Sciences, Faculty of Medicine, University of Manitoba. I would like to invite you to participate in my thesis study.

The topic of my thesis is "Narrative Descriptions of Access to Practice among International Medical Graduates (IMGs) in Manitoba and Ontario." The study is intended to increase the understanding of barriers faced by IMGs in their attempts to access licensure with the hope that the study findings will contribute toward a better policy decision making related to IMGs in the future. The objectives of study are: *to describe the types of barriers described by International Medical Graduates (IMGs) in their attempts to access practice or obtain meaningful employment in Canada, to identify their coping strategies in encountering these barriers, to describe the IMGs' perspectives of changing policy toward improving the current situation.*

Data collection for my thesis required at least one interview and a possible follow up interview with people like you who are International Medical Graduates. The interview will take about one and a half-hour. During the interview, questions will be asked on your personal profile such as approximate age (decade of age) and the country of origin, your experience in Canada while you attempt to gain access to licensure, the types of barriers that you faced, the impact of these barriers on you and how you are coping with them and how you think can improve your situation.

The interviews will be recorded by audio-tape and transcribed into text afterward. Initial (such as Dr. A or B) will be used during the interview and in the transcript instead of the actual names. Your name **will not** be identified on the tapes, forms or in any verbal or written reports. The data will be analyzed by coding the common themes that emerged from these interviews and comparing these themes with existing literature. The draft analysis will be made available to you for your input and clarification before it is finalized.

All information collected will be kept confidential. In the final report, only anonymous quotations will be included. If necessary, personal identifiers the country of origin will be altered in order to maintain the anonymity. Interview tapes will not be shared with anyone except you (for your interview only) and the individual who transcribe the tape. However, it may not be possible to guarantee complete confidentiality and anonymity.

There may be no direct benefit to you and you will not be paid as a participant of the study but there may be more awareness of barriers faced by IMGs among decision makers. There are no cost nor health risks by participating in this study.

Your participation in this study is completely voluntary. You may refuse to answer any questions during the interview or stop the interview at any point if you do not want to continue.

Please feel free to ask any questions you might have before deciding if you will participate.

I will be calling you to provide more information and to follow up if you agree to participate. If you agreed to participate after you read this letter or you would like to have more information on the study please feel free to contact me at:

Phone: (416) 208-5997 (H)
(416) 327-9252 (O)
Or email me at engsoon@globility.com

Thank you for your consideration.

Sincerely,

Eng-Soon Chan, MBBS, FRCPC
1212-430 McLevin Avenue
Toronto, Ontario
M1B 5P1
Canada

Appendix B

University of Manitoba
Participant Information and Consent Form

(Version 3, May 8, 2002)

Project Title: Narrative Descriptions of Access to Practice among International Medical Graduates (IMGs) in Manitoba and Ontario

Investigator: Dr. Eng-Soon Chan
1212-430 McLevin Ave, Toronto, Ontario, M1B 5P1
Phone: 416-208-5997 (H)
416-327-9252 (W)

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the investigator (Dr. Eng-Soon Chan). You may take your time to make your decision about participating in this study and you may discuss it with your friends or family before you make your decision. This consent form may contain words that you do not understand. Please ask the investigator (Dr. Eng-Soon Chan) to explain any words or information that you do not clearly understand.

Purpose of the Study

The purpose of the study is to increase understanding of the barriers that IMGs faced as they attempt to access practice in Canada. It is with hope that the study findings will contribute toward better policy-making decisions related to IMGs in the future.

Objectives of the study

1. To describe the types of barriers faced by IMGs in their attempts to access practice or obtain meaningful employment in Canada
2. To identify their coping strategies in encountering these barriers
3. To describe the IMGs' perspectives of changing policy toward improving the current situation

Procedures

- At least one interview with a possible follow up interview will be conducted on IMGs who agreed to participate in the study. Each interview will last approximately one and half-hour. Interviews can be conducted in a quiet place at your choice.
- During the interview, questions will be asked on your personal profile such as approximate age (decade of age) and the country of origin, your experience in Canada

while you attempt to gain access to licensure, the types of barriers that you faced, the impact of these barriers on you and how you are coping with them and how you think improvements can be made to better your situation.

- The interviews will be recorded by audiotape and transcribed into text afterward. Initials (such as Dr.A or B) will be used during the interview and in the transcript rather than the actual names.
- Coding the common themes that emerged from these interviews and comparing these themes with existing literature will analyze the data. The draft analysis will be made available to you for your input and clarification before it is finalized.

Benefit

- There may be no direct benefit to you and you will not be paid as a participant of the study but there may be more awareness of barriers faced by IMGs among decision makers.

Risks

- Participation in this study will not affect future access to training or practice in Canada either positively or negatively.
- There are no health risks by participating in this study.

Cost

- There is no cost for participating in this study.

Payment for participation

There will be **NO** payment to you by participating in this study.

Confidentiality

- All information collected will be kept confidential. In the final report, only anonymous quotations will be included. If necessary, personal identifiers such as age and the country of origin will be altered in order to maintain the anonymity.
- Interview tapes will not be shared with anyone except you (for your interview only) and the individual who transcribe the tape.
- The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes. However, this is only for the quality assurance purposes of the study and **will not** in anyway affecting your future access to the residency program at the University of Manitoba.

- However, it may not be possible to guarantee complete confidentiality and anonymity.

Voluntary Participation/Withdrawal from the Study

- **Your decision to participate in this study is completely voluntary. You may refuse to answer any questions during the interview or stop the interview at any point if you do not want to continue.**

Questions

- You are free to ask any questions you might have before deciding your participation.
- For questions about your rights as a research participant, you may contact the University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.
- Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Statement of Consent

- I have read this consent form. I have had the opportunity to discuss this research study with Dr. Eng-Soon Chan. I have had my questions answered by him in language I understand. The risks and benefits have been explained to me. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.
- I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Participant Signature _____ **Date** _____

Participant's printed name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given his or her consent.

Printed Name: _____

Signature: _____ **Date** _____

Role in the study: Principal Investigator

Appendix C

Questionnaire

Personal Profile of IMG

- Please tell me the decade of your age (e.g., thirties, forties, fifties or sixties)
- Where did you come from?
- How long have you been in Canada?
- Are you living with your family now? Tell me briefly about your family.

Experience in the country of origin

- Tell me briefly about your country's political and economical situations from what you understand.
- How are you educated as a physician?
- What is your experience as a physician in your country of origin?
- Why did you want to be a doctor?

Experience in Canada

- Before you came to Canada, what did you know about Canada?
- What was your expectation when you arrive in Canada?
  - Why did you come to Canada?
  - Did you plan to work as a doctor in Canada?
  - Were you aware that it is difficult for an IMG to become a physician in Canada?
- Tell me your experience in Canada?
  - Are you able to find a job? How?
  - Tell me in your understanding the process for IMG to re-qualify as a physician in Canada.
  - Are you trying to become re-qualify as a physician in Canada and what is your experience?

Barriers

- What do you think are the major barriers that you face in finding a meaningful employment or re-qualifying as a physician in Canada?
- What are your perspectives on these barriers?

Coping Strategies

- What are you doing to overcome the barriers you have identified or how are you dealing with the barriers you have identified?
- How does this experience you described affect your life?

How to improve the situation

- Do you think current support available to you is good enough to overcome these barriers?
- From your perspective what do you think needs to be changed to improve the current situation? Who should be doing these changes? And how?

Appendix D:

A Study on Narrative Descriptions of Access to Practice Among International Medical Graduates In Manitoba and Ontario

Each year Canada receives many thousands of immigrants from countries all over the world including many professionals such as medical doctors, engineers and others who carry with them skills, knowledge, and years of experience. It is important that Canada utilizes these readily available skills, knowledge and experience. However, immigrants often have trouble having their academic or occupational credentials recognized. As such, they may be forced to work in lower status occupations. Little literature exists to describe the experience of these immigrant professionals, especially in the area of obtaining meaningful employment, re-qualifying in their profession, what difficulties they face and their coping strategies.

The objectives of this study are:

- ✓ To describe the types of barriers described by International Medical Graduates (IMGs) in their attempts to access practice or obtain meaningful employment in Canada.
- ✓ To identify their coping strategies in encountering these barriers.
- ✓ To describe the IMGs' perspectives of changing policy toward improving the current situation.

The study will focus on the population of the IMGs who are landed immigrants or Canadian citizens in Ontario and Manitoba, trained in medical schools outside of Canada and who have been unable to become licensed to practice medicine in Canada. The study will use qualitative methodology to document and describe in depth, the IMGs' experience and identify common themes from the personal experiences. It will also identify the individual perspective of IMGs on the necessary policy changes for more effective integration of IMGs into Canadian society.

The researcher will formally request two IMGs organizations in Manitoba and Ontario to send out information of the study and the letter of request on behalf of the researcher to their members to participate in the study. The researcher will follow up by telephone. Data will be collected from at least one interview with IMGs after the consent is granted. The interviews will be recorded by audio-tape and transcribed into text afterward. The data will be analyzed by coding the common themes that emerged from these interviews and comparing these themes with existing literature. Final analysis will be done to identify issues that are commonly perceived as barriers by IMGs, the impact of these barriers and their coping strategies and finally, from IMGs' perspective, what will be useful to improve the situation. All information collected will be kept confidential. In the final report, only anonymous quotations will be included. If necessary, personal identifiers like the country of origin will be altered in order to maintain the anonymity.

Since this is qualitative research based on a small sample size, the generalizability of the study may be limited. However, the researcher believes that general themes that are generated from the study will provide some insightful knowledge especially for decision-makers at both institutional and governmental levels.

If the goal of Canadian immigration policy is to import more highly skilled and educated professionals, it is important to ensure successful integration of these immigrant professionals into Canadian society. It is in the best economic interest of Canada to utilize these ready trained immigrant professionals as well as it can.