



PODIUM: DOCTORS SPEAK OUT LA PAROLE AUX MÉDICINS

Can international medical graduates help solve Canada's shortage of rural physicians?

*Naomi Dove, MD
Community Medicine
Resident, School of
Population and Public
Health, University of British
Columbia, Vancouver, BC*

*Correspondence to:
Dr. Naomi Dove, School of
Population and Public
Health, University of British
Columbia, 5804 Fairview
Ave., Vancouver BC
V6T 1Z5; fax 604 822-4994;
ndove@interchange.ubc.ca*

The shortage of health care professionals providing services to rural and remote regions has long been recognized as a significant problem in the delivery of Canadian health care. Rural Canada encompasses 99.8% of Canada's land mass and about 21% of the population, yet is served by only 16% of its general practitioners (GPs) and 2% of specialists.^{1,2} In 1998, the average Canadian ratio of patients per GP was 896:1 in urban settings, compared with a ratio of 1214:1 in rural settings.¹ These shortages are exacerbated by challenges in the delivery of care across vast and remote distances, and are likely to intensify in the future, with a projected 33% decrease in the overall supply of Canadian physicians, due to physician attrition and lack of adequate replacement by recent graduates.^{3,4}

Canada has historically relied on international medical graduates (IMGs) to augment its supply of physicians, particularly in rural areas. In the 1970s, 30%–35% of Canada's physicians were foreign-trained.⁵ Estimates in 2007 indicate that 21.9% of physicians were trained outside of Canada or the United States, with the highest proportions in provinces with predominantly rural populations, including Saskatchewan (54.8%) and Newfoundland (41.7%).⁶ A cross-sectional study of family physicians in southeastern Ontario found that IMGs, in comparison with medical graduates trained in Canada, were more likely to practise in small towns (32.9% v. 28.3%) or rural communities (20.0% v.

17.6%).⁷ Similarly, a US study found that IMGs were more likely than US graduates to practise in medically underserved locations.⁸

Increasing opportunities for IMGs to practise in the Canadian health care system has been suggested as a potential solution to help mitigate Canada's shortage of rural physicians.^{5,9} Important considerations include assessing the equivalency of medical training, ethics involved in recruiting physicians from developing countries, long-term retention rates of IMGs in rural communities and political barriers such as differing provincial licensing requirements, varying regional recruitment strategies and a lack of federal–provincial cooperation. This paper aims to address the following question: Will increased licensing of IMGs help solve Canada's rural physician shortage in a sustainable and ethical manner?

Obtaining a medical licence is a major barrier for IMGs wishing to practise medicine in Canada. Physician licensing falls under the jurisdiction of provincial regulatory authorities and there are wide variations across provinces with respect to access and granting of medical licences.¹⁰ Requirements for a full licence are similar across provinces, contingent on successful completion of Licentiate of the Medical Council of Canada evaluating and qualifying examinations and Canadian postgraduate training. However, because of the limited availability of residency positions, many IMGs are unable to obtain full medical licences.¹¹

A number of provinces have attempted to integrate IMGs into the provincial health care system by granting provisional (also known as “conditional,” “restricted” or “temporary”) medical licences. These enable IMGs to practise with restrictions until requirements for full licensure are completed, and are often coupled with rural contracts. Provinces with significant rural populations and problems with physician retention such as Newfoundland and Labrador, Saskatchewan and Manitoba have the greatest number of IMGs with provisional licences, and other provinces such as Quebec and Ontario grant few provisional licences.¹¹

ASSESSING MEDICAL TRAINING

Assessing the equivalency of medical training for physician licensing has become more controversial in recent years because of increasing physician immigration from countries in which the quality of medical education is less well known. In the 1970s, 30% to 35% of Canada’s physicians were foreign-trained, originating mainly from the United Kingdom, South Africa and Western Europe.⁵ In 2002, 72% of IMG applicants for Canadian residency positions received their degrees from Asia, the Middle East or Eastern Europe, reflecting increased mobility of individuals from these countries, a shift in Canada’s immigration policies and an increased number of foreign visa trainees from sponsoring countries.^{12,13} Before 1993, “category 1” countries such as Britain, South Africa and New Zealand were allowed to bypass internship licensing requirements, based on medical education standards that were perceived to be equivalent, and “category 2” countries required an additional year of training.¹⁴ In 1999, the BC Human Rights Commission ruled that the BC College of Physicians and Surgeons had discriminated against 5 IMGs, on the grounds that no individual should be prevented access to the training required for licensure based on the country of origin. The BC College Deputy Registrar responded by addressing the larger question of how to assess the quality of medical schools worldwide, expressing concern regarding “diploma mills” that produce graduates with little or no patient contact during their training.¹⁴

THE ETHICS OF USING IMGs

The recruitment of physicians from developing countries has also sparked additional ethical debate. This was illustrated vividly in 2001 when the South

African High Commissioner to Canada criticized Canada for recruiting a relatively high number of South African physicians at a time when South Africa’s own health care system was struggling.¹⁵ Ethical dilemmas exist between an individual physician’s right to self-determination and migration versus the rights of citizens of developing countries to have access to health care professionals in whose training they have invested.¹⁵ Recommendations for national recruitment guidelines for health care professionals include countries from which recruiting would be unethical, a focus on passive instead of active recruiting, and the implementation of a national monitoring process.¹⁵

RETENTION ISSUES

The effectiveness of provisional licensing in generating long-term retention of IMGs in rural communities has not been clearly established. Evidence suggests that IMGs tend to migrate disproportionately to urban settings following completion of their mandatory rural terms, resulting in rapid physician turn-over and compromised continuity of care in rural settings.^{8,11,16} Concern has also been expressed that IMGs may use rural placements as an expeditious route to full licensure, effectively using it as a screening mechanism for the rest of the country.¹⁶⁻¹⁸ A retrospective cohort study¹⁶ conducted in Newfoundland and Labrador between 1995 and 2006 found that the proportion of provisionally licensed IMGs remaining in the province dropped to 55% after 2 years, coinciding with the end of the standard rural contract term. After 5 years, only 20% of provisionally licensed IMGs remained in the province. Close to 90% of IMGs who migrated to other provinces moved to urban centres, particularly in Ontario, which is thought to be related to increased financial compensation as well as ethnic diversity. A similar study¹⁷ found that both provisionally licensed IMGs and graduates of other Canadian medical schools remained in Newfoundland and Labrador for a significantly shorter period (median 24 mo) than local Memorial University graduates (median 40 mo), suggesting a benefit in recruiting local graduates. The overall retention rate after 8 years for all graduates in this study was 13.7%.

This highlights the importance of considering long-term IMG retention within the larger context of recruitment and retention of rural physicians. General barriers to the retention of rural physicians in Canada include the heavy workload, breadth of

skills required, professional isolation, preferences for urban lifestyles and career options, and a lack of interest in rural lifestyles.^{4,18} A study of foreign-trained doctors in Australia¹⁹ found that important predictors of rural retention were a supportive community environment, the potential to maintain cultural and religious ties, opportunities for spouses and children, and professional support mechanisms. Not surprisingly, discrimination and racism were inversely correlated with rural adaptation. Another study²⁰ found that Australian graduates and IMGs identified similar training, professional support and financial priorities, indicating a need to address the broader systemic determinants of physician distribution.

LIMITED COOPERATION AMONG JURISDICTIONS

Although all Canadian provinces and territories face similar issues and challenges related to rural physician shortages, there has been limited cooperation in attempting to solve common issues.¹⁸ A lack of coordination between provincial medical licensing bodies and federal immigration authorities, as well as divergent regional recruitment and retention strategies, have resulted in inconsistent policies and a lack of cohesion at the national level.¹⁸ This has likely contributed to increased interprovincial migration, exacerbating shortages in some of Canada's most underserved provinces.^{16,17} Encouraging greater cooperation at the national level will be an important aspect of reducing rural inequities in the long term.

In conclusion, the problem of physician distribution in rural Canada is a complex and enduring issue that is unlikely to be solved exclusively through licensing more IMGs. International medical graduates clearly have an important role in alleviating acute shortages and providing temporary relief for Canada's overworked and overextended rural physician workforce. However, increased IMG licensing is unlikely to lead to long-term retention in rural communities without being part of a broader strategy to increase domestic rural physician supply and retention rates, a position supported by the Canadian Medical Association and Society of Rural Physicians of Canada.^{21,22} More research will be needed to establish a national picture of rural IMG recruitment and retention rates, to gain a better appreciation of the overall contribution of IMGs to the delivery of rural Canadian health service and to identify factors that contribute to increased rates of IMG retention specific to the rural Canadian context. Additional factors that will

need to be considered include the establishment of Canadian guidelines for ethical recruitment and methods of improving coordination between provincial licensing bodies, federal immigration authorities and regional recruitment and retention strategies at a national level.

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