

**ROAD TO RETURN -
B.C. MEDICAL GRADUATES ABROAD**

Information and Position Paper
Society for Canadians Studying
Medicine Abroad (B.C.)
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CONTENTS

EXECUTIVE SUMMARY	3
BRINGING HOME B.C. DOCTORS	5
The Doctor Shortage	5
Bring Home B.C. Doctors	6
The Different Kinds of Medical Graduates	8
BECOMING A DOCTOR IN BRITISH COLUMBIA	10
Getting a Residency - the CaRMS Selection Process	10
CMG Residencies	12
IMG Residencies	12
The Clinical Assessment Program	15
Clinical Electives	16
The Second Iteration	17
Barriers, Disincentives and Obstacles	17
FUNDAMENTAL FAIRNESS - ALLOW CSA COMPETITION FOR CMG RESIDENCIES	18
No Good Reason to Bar CSAs	19
Is UBC in a Conflict of Interest?	23
Phasing CSAs into the CMG Stream	23
Recommendations	24
FIXING THE IMG STREAM	25
How the IMG Stream Blocks CSAs	26
Recommendations	29
COMMUNITY-SPONSORED MEDICAL RESIDENCIES	29
Meeting the Needs of Under-Served Communities	29
Recommendation	30
CONCLUSION	31

EXECUTIVE SUMMARY

B.C. badly needs doctors, and needs them now. Yet this province throws up needless barriers to the return of B.C. medical students who have graduated abroad. Close to 100 young men and women from British Columbia graduate each year with medical degrees from schools of medicine outside North America. They want to come home to practice medicine, and they can and do pass the examinations, set by the Medical Council of Canada, that ensure that their medical knowledge and clinical skills are at least equivalent to those of a graduate of a Canadian medical school. If the present artificial and unnecessary barriers are removed, these new Canadian doctors can become a significant and enduring solution to the health care needs of British Columbia.

This makes economic sense, too. The cost of bringing home these newly-graduated B.C. doctors would be modest - no more than funding additional medical residencies. During those residencies, while being supervised and mentored by experienced practitioners, these graduate physicians would be providing direct patient care. The social and economic return to British Columbia would be immediate. In the long term, British Columbia would receive the benefit of doctors, native to B.C., with a lifetime of medical practice ahead of them in this province. There would also be significant, immediate savings by being able to scale back less cost-effective taxpayer-supported attempts to address B.C.'s doctor shortage. These costly expenditures, present and projected, include between one and two million dollars a year for Health Match B.C.'s efforts to recruit physicians outside B.C., bonuses of \$100,000 each to induce doctors to move for just three years to rural communities, \$132.4 million for the "A GP for Me" and the "Inpatient Care" initiatives (which include \$40 million just for research and community plans). Millions more, which are sought by UBC to expand medical school facilities and class sizes, could be saved. Such medical school expansion produces graduates only after four years, historically results in many of the graduates going elsewhere in Canada, and still ultimately requires the same cost of residency funding after graduation for those graduates who do remain in this province.

In order to be able to bring back B.C. medical graduates abroad, present barriers and disincentives must be removed. To be fully trained and licensed, a graduate doctor must complete a medical residency of two to five years or more. In British Columbia, residency admission requirements are set by the University of British Columbia, and are presently structured so that Canadian medical graduates from abroad are barred from even applying for most residencies. Medical graduates abroad are also deterred from the small and limited quota of residencies that are available to "international medical graduates".

Despite an Action Plan to remedy this, proposed to the Minister of Health by M.L.A. Moira Stilwell in December 2011, the necessary changes have not been put in place. UBC remains adverse to change, unwilling to agree to competition for the many residencies reserved for its own graduates and for those of other Canadian universities.

Although the respective roles of UBC and the Ministry of Health remain obscure, few senior bureaucrats in the Ministry of Health are willing to acknowledge their responsibility to act independently of UBC. And above them, the Government of British Columbia has simply failed to act in the public interest.

To address these issues, this paper recommends:

1. Allow B.C. medical graduates abroad to compete for the B.C. residencies presently reserved only for graduates of Canadian and American medical schools. And fund additional residencies to accommodate the combined pool of applicants.

In the meantime:

2. Increase the number of specialist residencies available to Canadian medical students abroad as “international medical graduates”.

3. Implement a fair and workable selection process for those B.C. residencies that are available to Canadian medical students abroad as “international medical graduates”.

In addition:

4. Establish community-sponsored medical residencies, available to B.C. medical graduates abroad.

British Columbia must open a way for B.C. graduate doctors to return home to practice medicine. This must be done for their benefit, for the benefit of their families, friends and communities, and for the benefit of British Columbia.

BRINGING HOME B.C. DOCTORS

The Doctor Shortage

British Columbia desperately needs doctors, especially family physicians. In rural communities, this shortage is particularly acute. On March 15, 2013, Dr. Shelley Ross, President of the B.C. Medical Association, was quoted by *The Vancouver Sun* as noting that roughly 106,000 British Columbians, who want a family doctor, don't have one. "We haven't even seen the (real) shortage yet," she observed, referring to the expected retirement of older doctors in the next 10 to 15 years. She also noted that, "We have a different generation now, they don't want to work 24/7...they want to have a little bit more time for themselves, so it's going to take more doctors to do the work..." At the same time, an aging population in British Columbia will put even greater demands on health care.

The shortage persists despite aggressive (and expensive) recruitment of doctors from abroad. In *The Vancouver Sun* on February 25, 2013, Pamela Fayerman reported that Health Match B.C.'s website listed more than 400 vacancies for temporary and permanent positions at hospitals and health authorities, and this did not include vacancies in community-based private practices which were independently advertising for physicians. Health Match B.C., a provincial government agency, recruits doctors from outside British Columbia. In 2012, major source countries included the U.K./Ireland (24%) and South Africa (18%). John Mabbott, Health Match Executive Director, attributed recruiting success that year to a \$350,000 marketing campaign, over and above the \$1,400,000 annual Health Match budget. In 2013, however, South Africa will not be in the mix, due to changes in that country's medical education and the questionable ethics of poaching doctors from developing countries that desperately need them.

The shortage is so pronounced in British Columbia, particularly in rural communities, that costly initiatives have recently been announced, funded by the provincial government. In the Rural Physicians for British Columbia incentive program, doctors who commit to staying three years in one of 17 designated communities will get a special payment of \$100,000. In the "A GP for Me" and the "In-Patient Care" initiatives, \$132.4 million will be spent, because, according to the General Practice Services Committee (GPSC) website in February 2013 when the initiatives were first announced, "...there are approximately 400,000 British Columbians who either do not have a family doctor or they don't have a strong attachment to a family doctor". (The GPSC is a partnership between the B.C. Ministry of Health and the Canadian Medical Association). In these two initiatives, \$40 million will be spent on research and on developing community plans, \$60.5 million will go to increased family physician fees, and \$31.9 million will seek to enhance care by family physicians to patients in hospitals. None of this money goes directly to hiring additional family doctors or to training more graduate doctors by providing additional residencies. The "A GP for Me" program

confirms that, “currently there is no specific funding for the additional family residencies category.”

B.C. is not alone. In its May 10, 2012 brief, *A Doctor for Every Canadian - Better Planning for Canada's Health Human Resources*, the Canadian Medical Association told a House of Commons committee that between four and five million Canadians did not have a family doctor, and that one third of all Canadian physicians were over 55. South of the border, an article by Melinda Beck in *U.S. News*, March 13, 2013, reported that the *Affordable Care Act* (Obama Care) will mean 30 million more Americans will have access to health insurance. She cited the Association of American Medical Colleges' prediction of a shortage of 62,900 doctors by 2015 and 140,000 by 2025. And she further noted that about half of primary care doctors in the U.S. are graduates of foreign medical schools. This can only increase the potential drain of doctors from British Columbia to the United States.

Bring Home B.C. Doctors

At the same time, British Columbia is failing to take advantage of the most immediate and least expensive long-term solution to the doctor shortage in this province. Readily available, there is a continuing supply of young, newly-graduated B.C. doctors abroad, wanting to come home to practice medicine in British Columbia. They have completed their medical degrees (or are in medical school completing them), and need only residency training in British Columbia in order to qualify here for independent medical practice. Of these, a significant number have grown up in rural B.C. communities and would be only too happy to return to meet the needs of these communities.

These young men and women from British Columbia (and from other provinces), who have graduated abroad as doctors or who are still studying medicine abroad, are referred to as “Canadian Students Abroad” or “CSAs”. There is no registry that keeps count of their exact numbers, but a 2010 survey conducted by the Canadian Resident Matching Service (CaRMS), *Canadian Students Studying Medicine Abroad*, estimated that there were approximately 3,500 Canadian students enrolled in medical studies abroad, the largest numbers of whom were from Ontario and British Columbia. In December 2011, a report entitled “*Action Plan for Repatriating B.C. Medical Students Studying Abroad*” was prepared for the B.C. Minister of Health Services, the Honourable Mike de Jong, by Liberal MLA, Dr. Moira Stilwell. The *Stilwell Report* estimated that, “About 60 - 100 British Columbia medical students studying abroad graduate each year.” The report went on to point out that, “Most want to return to BC for a residency to complete their training and become licensed physicians and surgeons serving in this province.” The *Stilwell Report* describes barriers and restrictions facing CSAs seeking residencies in B.C., and makes recommendations to further fairness and to make it feasible for new B.C. doctors abroad to come home to practice medicine. The Stilwell Action Plan has not yet been implemented.

The University of British Columbia refuses to disclose the number of CSA applicants who do or do not obtain residencies in B.C., but the B.C. Society for Canadians Studying Medicine Abroad (SOCASMA) estimates that there are very few in any given year. As a result, in addition to current year graduates, there is a growing pool of past B.C. medical graduates from abroad who could also meet the medical needs of this province. Not everyone who graduates abroad remains available. Many B.C. graduates abroad are forced to commit themselves to alternatives outside B.C. Other provinces make it more feasible for CSAs to obtain residencies, especially in the same year they graduate. This means that a number of B.C. CSAs in fact seek and obtain residencies in other provinces where the process is more fair and less restrictive. Others obtain residencies in the United States which, ironically, is more welcoming than their own province. And because medical residents are at that time of their lives when they put down roots, many never return to practice medicine here and are lost permanently to British Columbia. Australia, for example, makes residencies available to CSAs, and many B.C. medical students who study medicine in Australia end up staying, thereby helping Australia to relieve its doctor shortage. Providing residencies is a far-sighted policy by Australia, opposite to that of British Columbia. And while some CSAs, by staying abroad, may be able to fulfill their dream of practicing medicine, it comes with real human cost in terms of family separation.

For a significant number of B.C. medical graduates abroad, however, the devastating reality is coming home, finding the door to medicine closed by the unavailability of residencies here, and their medical degrees going to waste.

It would seem to be a “no-brainer” to recognize that CSAs can be at least one important part of the solution to the health care needs of British Columbia, and therefore that the present obstacles facing CSAs should be eliminated.

- It would help reduce the chronic doctor shortage in British Columbia on a long-term basis by bringing back young doctors, with their professional lives ahead of them. Doctors who have neither language nor cultural barriers to overcome.
- By including CSAs in fair and open competition with domestic medical graduates, it would obtain for British Columbia the “best and the brightest,” from among not only Canadians who have studied in Canada, but also from among Canadians who have studied abroad.
- It would provide more doctors sooner and at much less cost than by expanding the taxpayer-subsidized four year undergraduate M.D. program at UBC. CSAs have already paid for their own medical education. But not surprisingly, it is UBC expansion that UBC favours.
- It would save on the millions of taxpayer dollars currently being poured into schemes and inducements to get doctors from other countries, from elsewhere in Canada and from urban to rural areas in B.C.
- It would extend basic justice to CSAs by allowing them an opportunity to compete on merit for residencies available in B.C.

- On a purely human level, it would give CSAs a reasonable chance to be reunited with their communities, friends and family in British Columbia, while fulfilling their dream of practicing medicine.

It is indeed a “no-brainer” to bring home CSAs to residencies in British Columbia. But this is prevented by the present positions taken by the University of British Columbia, and by the failure of the Government of British Columbia to ensure that the public interest is put first.

This paper addresses these issues. In doing so, it attempts to be both accurate and comprehensive, but only as of November, 2013. Some relevant information which would be useful has not been found to be available, or has not been disclosed to SOCASMA. As a word of caution, circumstances facing CSAs change. The IMG website of the UBC Faculty of Medicine has very recently been redone entirely, but it is still too early to assess the impact of what could be significant modifications. In order to ensure that information is current, CaRMS and Medical Council of Canada requirements and UBC program websites should always be checked.

The Different Kinds of Medical Graduates

This matters. What kind of graduate - IMG, CMG, CSA or even USMG - can make all the difference. Yet the terminology can be artificial and sometimes misleading. In *Canadian Students Studying Medicine Abroad*, CaRMS points out the difference between IMGs and CSAs:

“The definition of a Canadian studying abroad (CSA) recognizes that while these individuals are international medical graduates (IMGs), they are Canadians who left Canada to pursue their dream of medical education abroad. They are citizens born in Canada, or permanent residents. Almost all of them have done some of their earlier education in Canada, but choose to go abroad for medical education. This definition separates these individuals from other international physicians (IMGs) who graduate abroad prior to coming to Canada and becoming citizens or permanent residents.”

Defenders of present inequities prefer to lump CSAs with IMGs because this obscures their differences and distracts from the very real similarities between CSAs and CMGs. Reference is made, for example, to lower success rates for IMGs on examinations at the end of residencies. But as was noted by Walsh A, Banner S, Schabort I, Armson H, Bowmer I, and Granata B in *International Medical Graduates - Current Issues*, 2011 (page 12), this may be due in part to, “length of time since medical school graduation and clinical experience; financial and family obligations; traumatic experiences and different cultural beliefs about gender roles, as well as communication difficulties.” This may be the profile of an immigrant doctor, but not of a newly-graduated CSA who has grown up in Canada. It is deliberately misleading to imply that IMGs and CSAs are the same, and accordingly that CSA’s have the same challenges.

In this paper, “CSA” is used as distinct and different from an “IMG”. CSAs are not simply a subset of IMGs, but rather a subset of Canadian medical students, differing from other Canadian students in essence only by the location of their medical schools. With that in mind:

- Canadian Medical Graduate (CMG) refers to a medical graduate from a Canadian or an American University. Although the United States is not part of Canada, medical graduates of U.S. universities (USMGs) are given the right to compete for B.C. residencies on the same basis as CMGs, provided they are citizens or permanent residents of Canada. (The 2012 *National IMG Database Report*, published by the Canadian Post-M.D. Education Registry (CAPER), however, classes graduates of U.S. medical schools as IMGs.)
- Canadian Student Abroad (CSA) refers to a medical student graduating outside Canada or the United States, who was already a Canadian Citizen or permanent resident before enrolling in medical school. Typically this is a young man or woman who has grown up in Canada.
- International Medical Graduate (IMG) refers only to graduates of medical schools outside Canada and the U.S. who immigrated to Canada after having obtained their medical training, and often after having practiced medicine in their country of origin.

Visa Residents (sometimes called “sponsored applicants” by UBC) are a further category of medical graduates who obtain medical residencies in British Columbia. They are defined by CAPER as, “someone holding a visa permitting temporary employment in Canada as a post M.D. trainee.” Visa Residents are citizens of foreign countries on behalf of whom UBC is paid money, usually by a foreign government, to provide training in a medical residency or fellowship. During the year from July 1, 2012 to June 30, 2013, UBC sold the equivalent of 82 full-year residency positions to oil-rich Middle Eastern countries alone, receiving over \$7,000,000 (including money for student stipends). UBC generally charged these countries at the rate of \$75,000 per residency per year, and Saudi Arabia was the biggest customer. To enable these foreign residents to work in Canada, their employment authorizations are processed through the Dean’s Office. It is not known what material is submitted by UBC to prove to immigration authorities that there are no Canadians available to fill these residency jobs. To the contrary, there are hundreds of IMGs and CSAs able and wanting to do so. Although Visa Residents are entitled to provide care to B.C. patients on the same basis as Canadian residents, visa holders have no previous Canadian medical education or clinical training in Canada. They do not have to pass the Medical Council of Canada Equivalency Exam (MCCEE). Nor are their clinical skills assessed by the National Assessment Collaboration Objective Structured Clinical Examination (NAC OSCE) or by the Clinical Assessment Program.

BECOMING A DOCTOR IN BRITISH COLUMBIA

Medical education is a long process. It usually takes at least eight years in university to obtain an M.D. in Canada, four to obtain an undergraduate degree (often in the biological sciences), and then four more years of intensive study in medical school. And because it's so competitive to get into medical school, many applicants take on additional years of study in order to improve their chances of admission to medical school by earning advanced degrees before being accepted into medicine. There are 17 medical schools in Canada, but at present, UBC is the only medical school in British Columbia.

Graduation from medical school is a required milestone, but more training lies ahead. Graduate M.D.s must still complete a medical residency to provide essential on-the-job training under the supervision of experienced doctors who hold teaching appointments with the UBC Faculty of Medicine. A family medicine residency takes two years. Residencies for specialists are generally five years, and further sub-specialty training takes even longer.

Residents are graduate physicians. They are paid for their work. In British Columbia, salaries start at about \$50,000 in the first year, rising in increments of approximately \$5,000 per year. Residents are worth this cost. They notoriously work long hours and undesirable shifts, doing much of the menial and routine work that would otherwise have to be done by fully-trained doctors. And under supervision, they in fact provide direct patient care which would otherwise not be available. It has been said that one resident would have to be replaced by two fully-licensed physicians working regular shifts, and at much greater cost.

While working at their residencies, resident physicians must also prepare for and pass examinations. The first is the Medical Council of Canada Qualifying Exam, Part I (MCCQE Part I), which tests the knowledge and clinical skills of candidates who have obtained their medical degree. Typically, this examination is taken in the first year of residency. The second examination is the Medical Council of Canada Qualifying Exam, Part II (MCCQE Part II), usually taken in the second year, which assesses competence (knowledge, skills and attitudes) essential to licensure. Residents must complete their required years of training, and in doing so, they must pass the further examinations which are required for certification by the College of Family Physicians of Canada (for family practice) or by the Royal College of Physicians and Surgeons (for practice as a specialist). The resident may then apply for full registration with the College of Physicians and Surgeons of British Columbia in order to obtain a license to practice medicine in British Columbia.

Getting a Residency - the CaRMS Selection Process

Residencies in Canada are awarded through the Canadian Resident Matching Service (CaRMS). CaRMS seeks to match applicants for residencies to positions in

residency programs throughout Canada, taking into account the preferences of both the applicants and the programs. Applicants must be Canadian citizens or permanent residents of Canada. Eligibility criteria for residencies in British Columbia are determined by UBC; they are not set by CaRMS, or by the provincial government, or by the B.C. College of Physicians and Surgeons. Most B.C. residencies, however, are funded entirely by the Government of British Columbia through the Ministry of Health. Each year, current fourth year graduating UBC medical students are registered automatically in the CaRMS match by UBC, but others who are not current year graduates of Canadian Medical schools, including all CSAs, must submit online requests to register, beginning in August. The match itself takes place the following spring, in time for CMG applicants to begin their residencies in July after graduation.

Guided by the CaRMS timeline, applicants for residencies in B.C. review UBC residency program descriptions of available residencies, and then apply for interviews with the programs that they want. Applicants also submit documents, including transcripts and letters of reference, which CaRMS forwards to the programs. After interviews (which may or may not be granted for a given program), applicants submit a “rank order list” (ROL) to CaRMS, in which they rank the programs that they want in order of preference. Likewise, each UBC residency program submits to CaRMS its rank order list, in which it ranks applicants according to the program’s preference. In British Columbia, ranking of the applicants for each program is done by UBC through the program’s selection committee and the program director. When the rank order lists are received by CaRMS, the CaRMS computer, using a mathematical algorithm to maximize student and program preferences, then matches the applicants to the positions available.

The CaRMS matching process proceeds in two stages or “iterations”. At present in British Columbia, the first iteration has two very separate streams, each having dedicated positions. No cross-over or transfer between the two streams is permitted. The CMG stream is open only to graduates from Canadian and American medical schools, and is further restricted to, “those who have no previous postgraduate training”. According to CaRMS statistics for the 2013 match, there were 308 residency positions in British Columbia, of which only 34 were available to IMGs and CSAs. All 34 were filled in the first iteration. Of the 274 residencies available to CMGs, all but 16 were filled in the first iteration. These 16 unfilled B.C. residency positions, together with unfilled positions elsewhere in Canada, are carried over to the second iteration, but no additional residencies are added for the second iteration.

Not all CMGs match to their own provinces. Some graduates from other provinces are matched to the CMG residences here in British Columbia and some B.C. graduates go elsewhere. In 2013, 101 UBC graduates (about 40%) applied for and obtained residencies outside British Columbia in the first CaRMS iteration.

In 2013, there were 252 UBC graduates listed by CaRMS as final participants in the first iteration for the CMG stream. Of these, 7 were prior year graduates, all of whom matched. Of the 245 current year UBC medical graduates, 11 were not matched in the

first iteration to CMG residencies. As for the IMG stream, neither the total number of B.C. applicants, nor the number left unmatched after the first iteration, is disclosed by UBC. Applicants in both streams who are not matched in the first iteration can then seek to be matched in the second iteration to any residencies that were not filled in the first iteration.

The second iteration matches only to the leftover residencies. In 2013, there were the 16 unfilled residency positions in B.C. (all from the CMG stream) plus 283 in other provinces (103 of which were in Quebec). In the second iteration, the CMG and IMG streams in British Columbia are no longer separate. Everyone competes together for the same few positions, including first iteration unmatched applicants who have been carried over from both the CMG stream and the IMG stream. Also competing in the second iteration are IMGs and CSAs who were deterred or prevented from competing in the first iteration. In addition, practicing B.C. physicians, wanting to retrain in a different field or specialty, can compete in the second iteration. The process is much the same as for the first iteration, with applicants ranking their preferences for the few remaining programs, and the programs ranking the applicants. The CaRMS computer does the second and final match in mid-April.

CMG Residencies

CSAs are simply prohibited from competing at all in the CMG stream in the first CaRMS iteration. Full stop. In 2013, there were 274 first iteration B.C. residency positions open only to CMGs (and USMGs). In 2014, there will be 286. This absolute bar against CSAs competing in the first iteration is mandated by UBC despite close similarities between CMGs and CSAs. Typically, CMGs and CSAs alike are young, they have grown up in Canada, and they are new medical school graduates who have never had a residency or any post-graduate medical training before. A CSA could well have attended the same B.C. high school as the CMG, and they may both have earned their pre-med degrees at the same university, often UBC.

Nor can this discrimination against CSAs be justified by university standings abroad. Under the present artificial division, a bottom-of-the-class graduate from any American medical school is entitled to apply in the CMG stream. At the other end of the spectrum, Oxford University is rated to be the best in the world by the 2013-2014 *Times Higher Education World University Rankings' Clinical, Pre-Clinical and Health table*. But a Canadian Rhodes Scholar, graduating in medicine at the top of his or her class at Oxford, would be barred from even applying for a residency in the CMG stream in British Columbia.

IMG Residencies

As for the IMG stream in the first iteration of CaRMS, barriers remain in place to discourage and prevent CSAs from obtaining residencies. Although technically available to CSAs, this stream is a very poor fit for Canadian medical students completing their studies abroad. Historically, the IMG stream arose from a need to

address language and cultural challenges and other barriers faced by immigrant doctors. These were doctors who had completed their medical training prior to immigrating, and who had already been practicing medicine in their home countries before coming to Canada. Because they could not be licensed in Canada, these doctors were forced (and continue to be forced) to work at unrelated or even menial jobs. Time went by and their medical training fell into disuse. They found that they had little opportunity to demonstrate their current medical skills in a Canadian setting or to obtain residencies in British Columbia. Ostensibly to remedy this, the IMG stream, with its dedicated residencies available only to IMGs, and the IMG Clinical Assessment Program (formerly the IMG-BC Program), are two aspects of an approach to the needs of immigrant IMG doctors. But this approach, created for immigrant doctors, does not address the very different circumstances of Canadian students abroad, the numbers of whom has increased substantially in recent years.

Up to and including the 2013 CaRMS match, UBC's approach to IMGs made it both very difficult and unlikely for a CSA to obtain a medical residency in British Columbia, and made it virtually impossible to obtain one the same year that the CSA graduated abroad. During the summer of 2013, the UBC Faculty of Medicine completely revamped its IMG website under what is now the "International Medical Graduate Office" of the Faculty of Medicine. The assessment program for IMGs, previously called the "IMG-BC Program", is now the "Clinical Assessment Program", operated by the International Graduate Office (the IMG Office). Some changes appear in the new website which may be of some benefit to CSAs in reducing obstacles to obtaining IMG residencies. It is too soon to determine whether, in practice, these changes will be implemented in a way that will result in more CSAs actually being placed. This assessment can only be made with time and with full and frank disclosure by UBC of the number of CSAs who receive residencies.

CaRMS statistics show that in 2013, 34 IMGs obtained residencies in the IMG Stream of the first iteration, (table 28), and 12 obtained residencies in the second iteration (table 52). But no breakdown of these figures is published by CaRMS as to how many of these are CSAs and how many are immigrant IMGs. Nor will UBC disclose how many CSAs, apart from IMGs, receive residencies. SOCASMA has doubted in the past that there are many more than one or two in any given year. Was 2013 any better? UBC will not provide the answer.

In 2013, as noted, there were 34 residencies in the IMG stream. According to the website of the International Medical Graduate Office of the UBC Faculty of Medicine, the number of these IMG residencies will increase to 58 by 2017. Of the 34 residencies available in 2013, 28 were in family medicine, and 6 in specialties: 3 in internal medicine, 2 in Psychiatry and 1 in pediatrics. For 2014, there will be 42 IMG residencies: 36 in family medicine, and the same 6 specialty positions.

To qualify and obtain a residency, an applicant must:

- Be a Canadian Citizen or permanent resident, or have refugee status. To obtain a medical residency in B.C., it is not necessary to be living in B.C. or to be a resident of B.C. (although residency in B.C. is required for admission to the Clinical Assessment Program);
- Have a medical degree (already or to be obtained by July 1 of the match year) from a medical school listed by the Foundation for Advancement of International Medical Education and Research (FAIMER):
- Register (as an international medical student or graduate) with the Physicians Central Registry of Canada (PCRC), a division of the Medical Council of Canada which reviews credentials and provides a central repository for core medical credentials. This is necessary before taking Canadian medical examinations, including the MCCEE.
- Pass the Medical Council of Canada Evaluating Exam (MCCEE), a computer-based examination, “designed to assess the skills and knowledge required at the level of a new medical graduate who is about to enter their first year of postgraduate training”. This exam may be taken at more than 500 locations in 80 countries worldwide. The fee is \$1,645. Passing the MCCEE is a prerequisite to taking the NAC OSCE. As a word of caution, careful preparation for the MCCEE is important because a simple pass will not be good enough. Almost all matches are in the 90+ percentile range, and a passing exam cannot be retaken.
- Pass the National Assessment Collaboration Objective Structured Clinical Exam (NAC OSCE), administered by the Medical Council of Canada to, “assess the readiness of an IMG for entrance into a Canadian residency program.” It tests “knowledge, skills and attitudes essential for entrance into postgraduate training in Canada,” such as taking a patient’s history, performing a physical examination, communicating with the patient, and diagnosing and managing the patient’s complaint or presentation. Scoring is, “at the level of a graduating student from a Canadian medical school”. In the past there has been a limit to the number of NAC OSCE seats available to IMGs (and CSAs) in British Columbia, but commencing in 2014, all qualified applicants will be accommodated, (although not necessarily at their location of choice). There are a number of locations across Canada where the examinations are administered, and in order to maximize the chances of getting a desired location, applicants are advised to apply as early as possible. The cost of the NAC OSCE is \$2,190. In a recent development, UBC now requires the NAC OSCE not only for IMG residencies in the first iteration, but also in the second iteration for any unfilled CMG residencies which may become available.
- Fulfill English language proficiency requirements. Applicants must pass an English proficiency exam, either the Test of English as a Foreign Language (TOEFL) or the International English Language Testing System (IELTS). However, English language proficiency is considered to be met if, (1) the language of instruction at medical school was English, and (2) the primary language of patient care was English, and (3) the first and native language of the country where the applicant was trained was English. UBC advises that this comes from the by-laws of the College of Physicians and Surgeons of B.C., and

notes that the College has a link listing the acceptable countries which satisfy these criteria. Training in English is not necessarily enough - applicants should check this link.

- Submit an online application to CaRMS, which will require supporting documents and payment of fees.

All of the positions available in the IMG stream in the first iteration are subject to a “return of service” obligation. Successful applicants must sign a legally binding Return of Service Contract to work full time, for up to three years after their residency, in a community of medical need determined by the province. Should the resident fail to do so, or if the resident fails to complete the residency, he or she may be liable to repay the cost of the residency. (Clause 3.1 of the 2013 Return of Service Contract states that the repayment amount (what the Ministry of Health pays UBC as the cost of providing the residency) is to be \$108,000 per year.) It is only residencies in the IMG stream that carry a return of service requirement, not residencies in the CMG stream. Some CSAs are deterred from the IMG stream by this legal commitment. Others, some with roots in these very same rural B.C. communities, welcome such residencies. It is incongruous and unfair that a UBC Medicine graduate, whose medical education is heavily subsidized by the B.C. taxpayer, contributes nothing back by way of return of service; but a CSA, who has cost the taxpayer nothing, must shoulder this obligation.

The Clinical Assessment Program

It is important to keep distinct the Clinical Assessment Program and the CaRMS IMG “stream”. The Clinical Assessment Program is a specific program funded by the B.C. Ministry of Health. It offers only assessment, not training or teaching, and presently has 60 positions available each year. There is a one-week orientation to Canadian medical administration and computer systems, followed by eight weeks of assessment during which participants, under the supervision of licensed physicians, spend four weeks in a Family Practice setting, two weeks in a hospital Emergency Room and two weeks of geriatric medicine in an elder care setting. At the conclusion of the Program, a written evaluation is prepared and sent directly to CaRMS.

To apply for the Clinical Assessment Program, according to their website, an applicant must:

- have passed the Medical Council of Canada Evaluating Exam (MCCEE);
- have passed the Medical Council of Canada’s National Assessment Collaboration Objective Structured Clinical Exam (NAC OSCE). UBC advises that selection for the Assessment Program is based on NAC OSCE scores.
- be a resident of British Columbia. Applicants will be considered to be B.C. residents if they hold a current BC Care Card or BC Services Card. (Although the website states only that “preference” is given to B.C. residents, UBC advises that B.C. residence is required.)

-fulfill the English Language Proficiency requirements of the College of Physicians and Surgeons of B.C.

How essential is successful completion of the Clinical Assessment Program to obtaining a residency in B.C.? Up to 2013, UBC websites, for the IMG family medicine programs at least, have referred to the Assessment Program as a prerequisite. Now, however, the program is simply described as, “key to increasing your probability of a successful match to a medical residency position at UBC.” The website points out with respect to IMG Stream residencies, that in 2013, 28 of the 34 successful CaRMS candidates were graduates of the Clinical Assessment course, but does not disclose if any of them six without the Assessment Program were family residencies. One enquiry was told that “technically” a family residency can be obtained without going through the Clinical Assessment Program, implying that in reality it doesn’t happen. Under *FAQ for IMG applicants*, the UBC Family Medicine website states that completing the Assessment program, “increases your chance of getting a residency spot”, but acknowledges that, “current medical students cannot access this assessment so will be assessed on the basis of their NAC-OSCE score, MCCQE 1 score (if available), academic performance, and references.” The unavailability of the Assessment Program to current year CSAs means that this all-but-essential route to a residency is blocked to them in the year that they graduate.

Clinical Electives

In order for a CSA to obtain a medical residency in Canada, the importance of demonstrating clinical competence in a North American setting, preferably in Canada, cannot be over-emphasized. The UBC International Medical Graduate Office notes that clinical electives are, “one of the resources available to help you demonstrate clinical experience in Canada.” To that end, CSAs who will be in their final year of medical school can apply for the Visiting Student Elective Program, but only if they are in accredited schools in the U.K., Ireland, Australia, New Zealand, or South Africa. Non-Canadian medical students in these countries and in the U.S. can also apply. The visiting electives, which are part of the official UBC year 4 curriculum, are of 2 and 4 weeks duration. Of several hundred visiting electives in a given year, the Program estimates, as a rough approximation, that about 60% go to applicants from medical schools elsewhere in Canada, and the remaining electives go to both CSAs and foreign students, with CSAs accounting for somewhat over half of these. Visiting electives are awarded on a “first come, first choice” basis, based on when online applications are received by UBC, but the process is structured to ensure that priority is given to UBC students, followed by students attending other Canadian medical schools, and then students from approved international medical schools. After UBC students have chosen their electives, applications are taken from students at other medical schools in Canada, who can apply as early as 9 months before the elective start date. International students must wait until 7 months before the start date, at the earliest, to submit an application, and not all electives are open to them. UBC points out that applicants should, “apply and pay as close to the 7/9 mark as possible.” At the conclusion of the

visiting elective, an evaluation can be obtained for the student's medical school, and possibly letters of reference.

In addition, observerships and shadowing by CSAs may be arranged directly with Canadian doctors for the purpose of furthering educational experience in Canada, and to obtain possible letters of reference. In B.C., to be present with a patient requires license and registration by the B.C. College of Physicians and Surgeons. Accordingly, CSAs should contact the College well in advance to ensure that necessary material can be submitted in time.

The Second Iteration

It is also an option for a CSA to enter the second iteration of the CaRMS match, either following participation in the first iteration or by entering the second iteration separately. There is no return of service obligation attached to an unfilled CMG residency obtained by an IMG in the second iteration. But there are many applicants - unmatched CMGs, IMGs and CSAs, CSAs who are entering only the second iteration, and B.C. doctors seeking retraining. The breakdown for B.C. (UBC) is not disclosed, but for Canada as a whole in 2013, there were 1,335 IMGs who participated in the second iteration, only 127 of whom matched. (31 of these were current year graduates, presumably CSAs, but the 127 may also include additional prior-year CSAs). 80 out of 160 CMGs applicants in the second iteration were matched, but none of the 9 participating USMGs matched. In B.C., there were only 16 positions left over from the first iteration, all of which were from the CMG stream. Of these, IMGs obtained 12 of them. (UBC has not disclosed how many of these were CSAs.) CMGs (not necessarily from UBC) obtained only 3, and one remained vacant. Five current year UBC graduates did not obtain residencies anywhere, and this may explain why UBC has posted, but only with late notice, that for the second iteration of 2014, CSAs must now pass the NAC OSCE. The effect of this is that graduating CSAs cannot take the MCCCE in time to take the fall NAC OSCE, thereby eliminating them from competition in the 2014 second iteration match in their year of graduation, as was previously possible. (See CaRMS statistics, tables 1-6, 45, 46, 51 52, 55.)

Barriers, Disincentives and Obstacles

As a result of the barriers and structural disincentives taken together, few CSAs enter the CaRMS match for residency positions in this province, although a significant number of CSAs from British Columbia apply and are matched to residencies in other provinces. The IMG stream in British Columbia is not viable for most CSAs. There are too few residency positions in this stream for both IMGs and CSAs, even with the increase promised by the provincial government to a total of 58 by 2017. And of these, just a fraction will be specialty positions, only six in total. As outlined already, the IMG stream requires applicants to have passed the NAC OSCE. Most CSAs accept this independent evaluation of their clinical skills, despite its cost (\$2,190), the cost of coming home from abroad to take it, and the disruption to their studies caused by having to return to B.C. for the examination. One of the biggest deterrents is the

Clinical Assessment Program, which remains virtually a prerequisite, at least for family residencies. It makes timing unworkable for most CSAs. Although it could be possible for a CSA to complete all of the other steps in time to be matched to a residency in his or her year of graduation, the eight-week IMG-BC Program makes this impossible for any CSA graduating in the northern hemisphere, resulting in a lost year for the CSA.

FUNDAMENTAL FAIRNESS - ALLOW CSA COMPETITION FOR CMG RESIDENCIES

At present, as already noted, the CMG stream is completely blocked to CSAs. In 2013, there were 274 residency positions offered in the CMG stream, but CSAs were not allowed to compete for a single one of them in the first iteration. This is the way in which UBC reserves for itself, and for other Canadian universities, the large majority of family medicine residencies in British Columbia, and almost all of the specialist residencies. Exclusion from the CMG stream is a major reason why CSAs are compelled to go elsewhere, or end up without any residency at all.

No more is sought than an opportunity to compete. B.C. medical graduates abroad aren't asking for any guarantee of a residency, just a fair and level playing field, which allows competition on merit, shared with their contemporaries from Canadian and U.S. medical schools.

The arguments in favour of fair and open competition are cogent:

- Improved quality of health care. It would provide British Columbia with the “best and the brightest” graduating doctors from a greater pool of talent, including not only Canadians who have studied medicine in Canada, but also Canadians who have studied medicine abroad, and who have proved their excellence in open competition.
- Long-term solution. Adding CMG stream residencies to include successful CSA applicants would reduce the chronic doctor shortage in British Columbia, on a long-term basis, by bringing back young doctors with their professional lives ahead of them in B.C.
- Timely solution. CSAs have already completed medical school, and are ready to immediately begin practice as resident physicians where, under supervision, they can provide direct patient care. This saves four years over increasing UBC medical school enrollment, where in any event, a large proportion of the graduating students leave B.C. for residencies elsewhere.
- Fairness and equality. CMGs and CSAs should be treated alike. CSAs, like CMGs, have grown up in Canada, have been educated in Canada, are fluent in English and know the culture of this country. Both could equally have been, “the kid next door.” Like CMGs, CSAs in the CMG stream would be new graduates, who have not already done their residency training, and who have not already practiced medicine. The one and only difference between CSAs and CMGs is the place where they studied medicine. To discriminate against

CSAs on this basis is unsupportable. Its arbitrariness is illustrated by an actual case in B.C. where one sibling studied medicine in Canada and the other sibling studied medicine abroad. The same family - one was allowed to compete, the other was arbitrarily barred, just because of the location of her medical school.

- Cost effectiveness. There would indeed be a cost to providing more residencies for the increased pool of applicants including CSAs. This cost, however, is offset by the medical services provided by the residents. And this would be a quicker and more cost-effective way of meeting the doctor shortage in British Columbia than by paying the cost of increasing UBC's four-year medical program, because those UBC graduates would still need the additional residencies four years down the road. Furthermore, in 2013, 40% of UBC's medical graduates left the province anyway. Putting CSAs in the CMG stream could immediately increase the number of doctors doing residencies in B.C., and would do so on a long-term basis. It would also be more cost effective than paying doctors \$100,000 each to move (for three years) from one B.C. community to another lesser-served community.
- Fairness and justice. It does justice not only to CSAs, but also to British Columbia, by giving to all new British Columbia doctors, the right and the opportunity to compete for a future in medicine in this province.
- Family, friends and community. CSAs would be reunited with their communities, their friends and their families, rather than remaining exiled professionally. Family is an important British Columbia value. Yet excluding CSAs from competition for most residencies in B.C. separates families by forcing CSAs from British Columbia to make their homes away from B.C., often on other continents, in order to practice medicine.

No Good Reason to Bar CSAs

Those who do not want to share CMG stream residencies put forward various arguments. None of these justify prohibiting CSAs from proving their qualifications in the CMG stream. The following concerns have been raised:

Equivalency. An understandable concern is whether training in medical schools abroad is equivalent to medical training at U.B.C. and elsewhere in Canada. Some schools abroad have, in fact, better training. UBC has excellent medical training, and is ranked number 30 (down from 27) in the 2013-2014 *Times Higher Education World University Rankings'* Clinical, Pre-Clinical and Health table. In Canada, only McMaster University (27), McGill University (18), and the University of Toronto (15) ranked higher. Surveys are by no means conclusive, but several universities abroad also ranked higher than UBC - six in the U.K., two in Australia and one in Sweden. The three top-ranked schools were Oxford (1), Harvard (2) and Cambridge (3). Five American schools, in addition to Harvard, were in the top ten. There are, of course, medical schools in Canada, the United States and abroad, that rank lower.

But for the purposes of CMG stream residencies in British Columbia, medical schools in both Canada and the U.S. are simply assumed to be sufficiently equivalent,

no matter how they might rank. In Canada, no independent, standard testing is used for medical graduates seeking residencies, as it is in the U.S. for Americans and IMGs alike - the United States Medical Licensing Examinations (USMLEs). Graduates of Canadian medical schools do not take the NAC OSCE to test their clinical skills. Perhaps they should. Canada's approach (the absence of standardized testing and assumed equivalency) is said to be justified on the basis of accreditation by the Liaison Committee on Medical Education (LCME) which accredits M.D. Programs in the U.S., and which, in cooperation with the Committee on Accreditation of Canadian Medical Schools (CACMS), accredits M.D. programs in Canada. But in the United States, accreditation is not enough. American residency selection relies on the USMLEs. In the United States, simple LMCE or CACMS accreditation is not used, like in B.C., to block or discriminate against graduates from medical schools abroad. In the American process that corresponds to CaRMS in Canada, graduate M.D.s from the U.S., Canada and abroad all apply together for residencies to the National Resident Matching Program (NRMP) through the Electronic Residency Application Service (ERAS), and are judged on their merits. Ironically, it is more feasible for a B.C. CSA to obtain a residency in the U.S. than at home in B.C.

In any event, concerns about equivalency of training can be met by testing, and that testing is currently in place. Equivalency concerns do not justify the present total and arbitrary ban against even applying. The need for testing and evaluation is accepted by SOCASMA. As described already, both the Medical Council of Canada Evaluating Exam (MCCEE) and the National Assessment Collaborative Objective Structured Clinical Examination (NAC OSCE) test knowledge and skill at the level of a Canadian medical graduate entering postgraduate training. This is the level of a CMG, except that CMGs don't have to take the tests and are just assumed to have the requisite knowledge and skills simply by virtue of having passed medical school. It should be an applicant's own individual ability that counts, not just the location of his or her medical Alma Mater. This requires and justifies open competition.

These tests ensure equivalency. And they are just a threshold which would allow a CSA to apply and compete. Still further evaluation is inherent in the application process itself, which requires submission of transcripts, evaluations and letters of reference (often from doctors who have supervised clinical experience in Canada). For shortlisted applicants, a personal interview by UBC program faculty is also required. There is little danger or likelihood that a CSA would ultimately be chosen by a UBC selection committee, unless the committee could be certain that the CSA was at least equivalent to, or better than the competing CMG applicants.

Capability. Some opponents of CSA participation in the CMG stream imply that CSAs go abroad simply because they aren't good enough to get into UBC or another Canadian medical school. They are "rejects" who couldn't get into medicine at UBC. This innuendo is fallacious. The reality is that only a small proportion of all applicants (either CMGs or CSAs) are ever accepted the first time they apply to UBC. Accordingly, knowing how hard it is to get into medical school, many pre-med students apply to more than one school. Some, who are more adventurous or more free to do so, include

medical schools abroad. If offered admission to a medical school abroad, they may elect to take the opportunity at hand, rather than putting their lives on hold for multiple re-applications in Canada. The 2010 CaRMS survey *Canadian Students Studying Medicine Abroad* found (page 17) that, “Canadian students studying medicine abroad on average applied to Canadian medical schools 1.76 times prior to enrolling in a foreign medical school. In contrast, Canadian students studying at Canadian medical schools apply, on average, 2.95 times prior to being admitted.” This means that by the time they are accepted in Canada, the average CMG is more likely to be a “reject”, and indeed a multiple reject, than the average CSA. But this whole argument misses the point. Selection processes are notoriously imperfect, and even the best applicant may have to apply more than once. Not everyone chooses to wait. The bottom line is that the overwhelming majority of both CMGs and CSAs are intelligent, highly capable and hard-working, and it is often just chance or personal circumstance that decides their medical school.

If there are CSA applicants who are less than capable, opening the CMG stream to fair competition does not mean that these applicants get residency positions. The UBC residency selection process will identify the best applicants from among both CSAs and CMGs, and will weed out those not suitable. It must also be remembered that successful applicants, both CMGs and CSAs, still have the benefit ahead of them of two to five or more years of residency training by doctors holding appointments to the UBC Faculty of Medicine. And at the end of this, the residents will still have to pass the examinations necessary for licensure. Those who may be weak to begin with, both CMGs and CSAs alike, will be brought up to speed, and anyone who can't pass muster will be identified. Concerns about capability can be met. They do not justify an outright bar against all CSAs from even competing in the CMG stream.

In any event, it is implicitly acknowledged that CSAs are qualified to compete for CMG stream residencies. This is because CMG residencies that are not filled in the first CaRMS iteration go over to the second iteration, where all unmatched applicants, including CSAs, are then allowed to compete for them. Excluding CSAs from the CMG stream in the first iteration is not about capability or competence. It's about privilege and preference. It's about reserving the most and the best residencies for CMGs, while CSAs may take the scraps left over. UBC residency program selection committees will choose the best applicants, and they can be counted upon to ensure that no CSA will get a residency unless he or she is equally or better qualified than the competing CMGs. There is no need to simply and arbitrarily block all CSA applications at the outset. The real fear is not that CSAs are not good enough, but that they are too good. As a result, if fair competition is allowed, some UBC medical graduates might be displaced, or they might not get their preferred choice of residency.

Discrimination. In the broad, obvious and moral meaning of the word, it's the exclusion of CSAs from competition that constitutes discrimination. UBC, however, takes the position that it would amount to discrimination to allow CSAs to compete in the CMG stream because that would discriminate against immigrant IMGs. Although UBC advises that it has received a legal opinion to this effect, it has not disclosed this opinion

to public or independent scrutiny. The university appears to have failed to grasp what is actually proposed, and any legal opinion based on such a failure to understand would be equally flawed. If a distinction was to be based upon where a medical graduate was born, or upon being an immigrant to Canada, that could be discrimination. But SOCASMA does not advocate or endorse such a distinction. Although most CSAs are born in Canada, some have immigrated to Canada with their families. They have become permanent residents or Canadian citizens in due course, and have then only subsequently gone to medical school abroad. Although they are immigrants to Canada, they are CSAs, rather than IMGs, because they obtained their medical degrees after becoming a permanent resident or a citizen. And unlike most, but not all IMGs, they have no postgraduate training before coming to Canada. Possible distinctions proposed by SOCASMA are based not upon country of origin or upon immigration, or upon simply being a CSA, but solely upon whether the IMG or CSA has previous postgraduate medical training.

This is the very same basis upon which newly graduating CMGs are presently differentiated from practicing Canadian doctors who want to retrain. The CaRMS website states that the R-1 Main Residency Match is open to both the CMGs and IMGs, but that, “only applicants without previous Canadian or U.S. postgraduate training are eligible to attain a position through CaRMS in the first iteration.” IMGs (including CSAs) and CMGs are treated alike by CaRMS, and there would be no discrimination if the two streams were merged so that everyone who met this criteria could apply together. It is UBC that imposes additional criteria in the form of two separate streams in which IMGs and CMGs are segregated. As noted, simply ending this segregation would end the discrimination. Alternatively, if this approach would disadvantage IMGs or overwhelm CMGs, a modified approach could be undertaken in which the IMG stream was kept for those IMGs with previous postgraduate training, and the CMG stream would be open to CMGs, CSAs and IMGs, but only to those with no previous postgraduate training anywhere. SOCASMA is open to either of these two approaches, or a modification of them, subject to input from IMGs. Both approaches would be consistent and fair. Neither would be impermissible discrimination on the basis of country of origin or immigration. The second option would extend an element of permissible affirmative action to IMG doctors, previously in practice, who need retraining after coming to Canada.

Cost. It stands to reason that if CSAs are added to the pool of applicants in the CMG stream, additional residencies should be added in order to reduce the risk that UBC medical graduates will be displaced in a competition for too few residency positions. The Province of British Columbia has invested large amounts of money in training UBC medical graduates, and having them go without residencies is neither desired nor intended. This need not happen if the Ministry of Health funds additional residencies. Although residencies “cost” money, the analysis must also take into account the fact that resident physicians provide medical services which may more than offset this cost. Further, the *Stilwell Report* identified how B.C. can reap the benefit of such additional medical services without cost to the provincial government, by facilitating funding from other sources, including willing B.C. municipalities. And even if

directly funded by the province, the cost of additional residencies would be only a small fraction of the many millions announced for the “A G.P. for Me” and other initiatives. It would also be more cost effective than expanding taxpayer-subsidized medical classes at UBC, which requires four years of funding these classes, and then still requires the funding of the additional residencies.

Availability of teaching resources. More residencies require more teaching resources, and this is sometimes put forward as an obstacle. Resources can be found, however, as is illustrated by the significant expansion of residencies to accommodate the large increases of UBC medical class sizes in recent years. If necessary, UBC’s plans to further expand medical school enrollment, with its need of more residencies, could be deferred. There are resources available. After six months of discussions with interested parties, the *Stilwell Report* concluded that, “There are physicians and surgeons in health authorities across the province eager to train the next generation of doctors.” In addition, the selling of residencies by UBC to foreign visa students could be discontinued or scaled back, making that teaching capacity available for Canadians.

Is UBC in a Conflict of Interest?

It comes as no surprise that UBC wants to ensure that its own medical graduates get residencies, and that they get a full and first choice of residencies. And it is natural that UBC will want to protect and expand its Faculty of Medicine. But allowing CSAs to train by working as resident physicians in B.C. would bring more doctors into practice faster, and would thereby lessen or eliminate the need for UBC expansion. And allowing CSAs to participate in the CMG stream runs against the interests of UBC for the simple reason that some CSAs may out-compete UBC medical graduates for residencies.

At the same time, UBC is entrusted with control of the criteria for participation in the CMG stream of the first CaRMS iteration. Residencies are publicly funded, and the public interest requires not only more doctors, and soon, but also the best and the brightest from among all British Columbians who graduate from medical schools, not just from UBC. Blocking CSAs from residencies is clearly contrary to this public interest.

Phasing CSAs into the CMG Stream

Although self-interest may be an underlying reason for UBC blocking CSAs from participating in the first iteration CMG stream, UBC’s concern that some CMGs could be displaced is understandable. Because CMGs have the advantage of competing on home ground, and because only a small proportion of CSAs are able to get clinical experience in Canada during medical school, it is doubtful that many CMGs would be displaced from obtaining a residency. But to avoid this risk, additional residencies must be funded by the Ministry of Health or by other sources to accommodate the larger combined pool of CMG and CSA applicants.

The size of the combined pool of applicants (and the number of necessary additional residencies) will depend upon the extent of CSA and IMG participation allowed in the CMG stream, which in turn will depend upon how the eligibility criteria are defined. Because eligibility must not discriminate against IMGs on the basis of country of origin or immigration, IMGs, or some IMGs, may well qualify and participate in the CMG stream. There are alternative approaches, the evaluation of which would properly involve input not only from UBC, but also from SOCASMA and from IMGs, whose interests are represented by the Association of International Medical Doctors of BC (AIMD BC). Approaches to the criteria for expanded IMG/CSA participation in the CMG stream of the first CaRMS iteration could include the following:

Applicants with no prior residency experience anywhere. This alternative recognizes that the CMG stream is intended for new medical graduates without previous residency training, a feature shared by CSAs. Because most IMGs have already done their residencies and have practiced medicine in their countries of origin, few would be eligible under this definition. (It would also exclude, from the first iteration, CSAs who take residency training in countries such as Australia or the U.S. in order to improve their competitiveness for residencies in B.C, or simply to ensure that they have a residency somewhere.) This more restrictive criteria would result in a smaller combined pool of applicants, and would be less threatening to UBC graduates. By moving CSAs into the CMG stream, it would also leave IMGs with the benefit of the IMG stream.

Applicants with no prior postgraduate training in Canada or the United States. This alternative, which tracks present CaRMS wording for the first iteration, would result in a larger pool of combined applicants, as it would include all CSAs, and most IMGs as IMGs have usually had their previous residency training only outside North America.

These proposals could also be modified to enable some or all IMG or CSA applicants to elect which stream in which they would apply.

If immediate, full implementation of CSA participation in the CMG stream would be too sudden or difficult for UBC, it could be phased in by an initial pilot project limiting applicants to those from British Columbia who score on the MCCEE and NAC OSCE examinations at specified levels, set higher than a simple “pass”.

Recommendations

Concerns, if they have substance, can be addressed as outlined above. They do not justify completely blocking CSAs from fair and open competition in the CMG stream of the first CaRMS iteration. Accordingly, SOCASMA recommends:

That the Minister of Health require, as a condition of funding, that all ministry-funded residencies in the CMG stream of the first CaRMS iteration be open to CSA medical graduates who have passed the MCCEE and the NAC OSCE examinations.

This, in essence, is what the *Stilwell Report* recommended to the Minister of Health Services:

“Align policies and regulations for Canadian students studying abroad to be identical to those currently in place for Canadian and American trained medical school graduates applying for BC residency positions.”

SOCASMA further recommends:

That additional residencies be funded in the CMG Stream of the first iteration of CaRMS in order to accommodate the combined pool of CMG and CSA applicants.

FIXING THE IMG STREAM

The primary recommendation, above, is to allow CSAs to compete in the CMG stream of the first iteration of CaRMS, rather than in the IMG stream. But until that happens, CSAs have only the IMG stream, and it must be fixed in the interim.

Although barred from the CMG stream, CSAs can in theory obtain residencies from the IMG stream. As a matter of reality, however, this doesn't happen. This is proved by the fact that very few CSAs match to residencies in B.C., due directly to the obstacles and disincentives embedded in the requirements for the IMG stream. As noted earlier, UBC will not disclose how many CSAs get residencies in B.C., or even how many obtain residencies in the IMG stream. SOCASMA doubts this to be much more than one or two in any given year, and can only conclude that this poor result explains UBC's lack of transparency and accountability. By contrast in Ontario, according to the Findings and Recommendations (volume 1, page 9) of *IMG Selection: Independent Review of Access to Postgraduate Programs by International Medical Graduates in Ontario (The Thomson Report)*, no less than 112 CSAs (98 in the first iteration and 14 in the second) matched into first year residency positions in 2011. 109 immigrant IMGs also matched. Ontario is viable for CSAs (including CSAs from B.C. who obtain residencies in Ontario). B.C. simply doesn't work for B.C. CSAs.

Likewise, even though the necessary information is obtained from applicants, the UBC IMG Office does not disclose the number of CSAs that go through their Clinical

Assessment Program. The number would be very few, and it would show how that program fails CSAs. The overwhelming majority of CSAs study medicine in Ireland, Australia, the U.K., the Caribbean, and more recently, Poland. Yet according to CAPER's 2012 *Database Report* (table 3, page 53), for the five years from 2007 to 2011, only a total of five people who had earned their medical degrees in these countries went through the IMG-BC assessment program as the Clinical Assessment Program was then called. Three from Australia, one each from Grenada and Poland, and none from the U.K. or Ireland. The fact that CSAs (including some from British Columbia) are successful in obtaining IMG stream residencies in other provinces, but not in B.C., demonstrates a fundamental failure in the B.C. approach.

How the IMG Stream Blocks CSAs

Too few residencies. This is particularly true for specialty positions. In the 2013 match, there were only 34 seats for IMGs, all of which were filled in the first iteration. 28 of these were in family medicine. Expansion has been promised, to 52 family positions by 2017, but the number of specialty residencies will remain at only 6, for a total of 58. By contrast, *The Thomson Report* (page 7) documents that in 2011, Ontario had 191 designated IMG first year residency positions. Of those, no less than 111 were for specialty positions. There are just too few IMG residencies for the many potential CSA and IMG applicants combined.

Absence of specialty residencies. The few specialty residencies in the IMG stream in British Columbia (only 6), and the fact that most specialties aren't available at all, mean that British Columbia CSAs, who aim to be specialists, simply have to try to find their residencies elsewhere. There are 65 specialties recognized by the College of Physicians and Surgeons of B.C., but only 3 of these are available to CSAs and IMGs in the IMG stream.

The Clinical Assessment Program - a Hindrance, not a Help. By making the Clinical Assessment Program a de facto necessary step in the IMG stream process, UBC stacks the deck against CSAs. All the program offers (apart from a one-week orientation) is yet more assessment - no training. The MCCEE and the NAC OSCE have already tested both medical knowledge and clinical skills at the Canadian medical school graduate level. More assessment may be helpful to some IMGs, as a further opportunity to show the current state of their medical knowledge, clinical skills, English language proficiency and cultural climatization. CSAs, however, grew up in Canada and have just finished four years of medical education. The clinical component of their medical education is recent, and can be made available to selection committees. Many CSAs also have clinical experience in North America, obtained through clinical electives during their studies. Letters of reference from B.C. doctors, often known to Canadian postgraduate program directors, or from doctors elsewhere in Canada and the U.S., can provide a good basis for assessment. The website of the IMG Office now appears to recognize this by noting that clinical electives are, "one of the resources available to

help you demonstrate clinical experience in Canada.” But whether this is just lip-service, or whether more IMG residencies will go to applicants without the Assessment Program remains to be seen. And unless UBC becomes transparent and accountable on these numbers, it will not be able to be seen.

Requirements for the IMG stream should be structured to give weight to North American clinical experience as an alternative to the Clinical Assessment Program. Ontario, for example, does not force its applicants into extra assessment delays such as the B.C. Clinical Assessment Program, but gives weight to recent clinical electives in North America. This is one reason why Ontario gets BC CSAs and B.C. doesn't. In a February 22, 2013 article in *The Prince George Citizen* by Peter James, Dr. Shelley Ross, president of the B.C. Medical Association, acknowledged that CSAs, “don't apply [in B.C.] because they have to waste a year to even try for a residency spot.” Dr. Ross observed that, “They know the culture, they speak the language and they have roots, often, in rural areas.” Dr. Ross also pointed out that working with local physicians could help determine who is ready for a residency, “Let them do some elective time with physicians back here in B.C., evaluate them, and let them apply...” To this end, it is essential that UBC makes available sufficient electives to CSAs during their studies abroad.

Unworkable timing. Timing for CSAs is crucial. Having to be assessed by the Clinical Assessment Program imposes a delay of at least one year, making it impossible for a CSA to enter the CaRMS match for a B.C. residency the same year that he or she graduates from medical school. This results in a lost year, with unsustainable consequences to the CSA. In reality, delays are longer. The May 7, 2013 article on the UBC Medicine website, entitled, “Different Journeys, Same Destination: B.C. Expands Opportunities for International Medical Graduates”, profiles Suzanne, a CSA who studied medicine in Germany. After graduation, it took Suzanne two-and-a-half years to complete the required exams and assessments before beginning residency training in 2010. No other province or territory imposes a delay of a year or more, and this, together with the lack of specialty positions, is one of the biggest reasons why CSAs must go elsewhere in Canada to find a residency. Ontario recognizes the importance of timing. With respect to the NAC OSCE, the *Thomson Report* (page 13) stated unequivocally, “Ontario must accommodate CSAs in their final year of medical school to ensure they can take the exam without losing a year.” Timing works elsewhere. CSAs from British Columbia can and do obtain residencies in Ontario, in other provinces. They do so the same year, right after graduation. Delay in British Columbia means lost opportunity to practice newly-acquired medical skills. It also means returning home to no job, having to find work (probably low-paying), and trying to service student debt. The 2010 CaRMS report, *Canadian Students Studying Medicine Abroad* (page 23) found that the median debt of CSAs was \$160,000. For students in Ireland and Australia, it was \$200,000. Most CSAs simply cannot afford to put their life on hold for a year. As a consequence, if they have any other option, they do not enter the B.C. process.

As outlined, CSAs face a chain of prerequisites (unlike CMGs at UBC who are automatically enrolled in CaRMS in the year they graduate). CSAs must:

- Register with the Physicians Central Registry of Canada
- Pass the MCCEE
- Pass the NAC OSCE (which means a trip back to B.C.)
- Go through the eight-week Clinical Assessment Program which, if not formally a prerequisite for the IMG stream, may remain a prerequisite in reality.

Although timing will be tight, a CSA will, at least in the future, be able to do the first three steps in time to be included in the CaRMS IMG stream match in his or her year of graduation. But having to spend eight weeks in the Clinical Assessment Program makes this impossible.

Residence requirements. Being a resident of British Columbia is no longer a prerequisite for an IMG stream residency in B.C., but it remains a requirement for the Clinical Assessment Program. According to the new guideline, an applicant is considered to be a B.C. resident if he or she holds a current BC Care Card or BC Services Card. This imposes on CSAs the uncertain prospect of having to maintain their B.C. cards while studying outside Canada, and must do so in the face of requirements abroad that may impact on entitlement to B.C. health care coverage, or other B.C. services. In fairness to CSAs, the residency requirement should be modified to include not only current B.C. card holders, but also applicants who held a valid BC Care Card, B.C. Driver's License or BC Services Card prior to commencing their medical studies abroad.

Return of Service. This legal obligation does deter some CSAs from applying for IMG stream residencies. But as noted already, some CSAs are from these rural or remote communities and would be happy to return home to practice medicine in these communities. And despite the onerous return of service conditions, many CSAs would be quite prepared to accept return of service if they thought the IMG stream was a realistic way of coming back to British Columbia to practice medicine. In fairness, to help with the rural doctor shortage, and to acknowledge taxpayer subsidization of the medical education of UBC CMGs, it would be appropriate to add return of service to an equal number of CMG stream residencies.

Although B.C. CSAs, having grown up here, are familiar with the medical system in this province, it may still be useful to have some orientation to B.C. procedures. This would be equally true of USMGs and CMGs from other provinces (who aren't forced into clinical assessment), and is doubtlessly provided already in the residency programs themselves. The Clinical Assessment Program offers no training, just assessment. As an alternative, implementation of pre-residency training should be considered. Pre-residency training is in place in Ontario, and is recommended by the *Thomson Report* (page 31). These programs are for both CMGs and IMGs after they are accepted into residencies, and can include a clinical component as well as orientation.

SOCASMA does not advocate the elimination of the Clinical Assessment Program. It was designed for immigrant physicians, and although it does not appear to offer much, if anything, to help improve language and cultural competencies in a medical context, it does provide an opportunity for immigrant physicians to show current clinical skills, cultural climatization, and English and communication proficiency. The CaRMS IMG stream, however, should be independent of the Clinical Assessment Program, so that the Program and its staff play no direct part in the CaRMS selection process. This would help to address the perception that the Program makes itself essential in order to justify itself, and that the Assessment Program and IMG residencies are too closely linked within the IMG Office. The selection decision for residencies should be made by each residency program, not by anyone connected to the Assessment Program. It must be made clear to program selection committees that a Program assessment is but one of a candidate's possible qualifications, to be considered along with other recent clinical education and experience. Assessment in the Clinical Assessment Program must no longer be a de facto prerequisite for any IMG stream residency, and this must be demonstrated, in a transparent and accountable way, by the disclosure by UBC of the number of CSAs who receive or do not receive IMG stream residencies. Unless all of this is done, a full and independent external review may be required.

Recommendations

That the number of specialty residencies in the IMG stream of CaRMS be increased to at least equal the number of IMG stream family medicine residencies, both presently available, and promised.

That the Ministry of Health require, as a condition of continued funding, that the relationship between CaRMS and the Clinical Assessment Program be restructured to ensure that the CaRMS selection process is independent of the Assessment Program, and that the Assessment Program does not remain a de facto prerequisite to any CaRMS IMG stream residency positions.

COMMUNITY-SPONSORED MEDICAL RESIDENCIES

Meeting the Needs of Under-Served B.C. Communities

The shortage of doctors in British Columbia is particularly acute in communities outside Vancouver and Victoria. Circumstances in rural and remote B.C. communities are so serious that the provincial government has proposed the "A GP for Me" program and other multi-million dollar initiatives. Not a dollar of this money is earmarked for the creation of additional medical residencies. At the same time, CSAs who come from these communities would gladly return to them to practice medicine. And many more

CSAs would willingly accept return of service in these communities as a way to come home to British Columbia. But for now, as outlined already, they can't.

This is illustrated by Carla, whose circumstances were referred to in the *Stilwell Report*. Carla grew up in a B.C. First Nations community. She studied medicine abroad, but the policies set by UBC made it almost certain that Carla would not get a residency in B.C., even though she had done electives and clinical placements in this province, and even though she had passed all the necessary qualifying examinations. She wanted to apply for a family medicine position in Terrace, where her family resides, but this was not allowed because that position was in the CMG stream. Carla did ultimately match in Canada, but in Nunavut to a 3 year rural family medicine residency. With a return of service contract to fulfill, Carla will be there for several additional years, separated from her family. The consequence to B.C. is that Northern Coastal Health, which is desperately short of doctors, lost a fine candidate who in all likelihood would have made a lifetime commitment to northern B.C.

In preparing the *Stilwell Report*, conversations were held in 2011 with mayors from across British Columbia. The Report points out that, "mayors from communities around the province expressed their desire to have residents training in their cities and towns. In addition, several mayors are prepared to commit fiscal support to help fund the cost of a residency position estimated at \$100,000/year." Municipal contributions would be invaluable, especially if they trigger support from the provincial government. If Saudi Arabia can buy residencies in British Columbia, why not British Columbia communities? There is also precedent for the Canadian Forces sponsoring residencies for personnel training in medicine. It would not be fair, however, to have small communities fund the entire cost of a sponsored residency. Rather than spend all of the \$40 million announced to "conduct research" and to "develop a community plan", the "A GP for Me" initiative should direct money to fund, at least in part, the establishment and operation of Community-Sponsored Medical Residencies. And this should be done now.

Recommendation

In consultation with the funding community, community-sponsored medical residencies should be implemented to reflect the specific needs and circumstances of the funding community. To increase the likelihood of selecting candidates who will remain in the community, these residencies could be structured to give preference to qualified applicants with roots or family in the community. A return of service contract in that community could be required. A representative of the community could be allowed to sit on the selection committee for the residency. And to maximize the likelihood of finding the best applicant with roots in the community, the residencies should be open to CSAs, either through a broadened CMG stream or through an IMG stream that has been changed to actually function for CSAs. Accordingly, SOCASMA recommends:

That the Provincial Government, in consultation with UBC and with Mayors of communities experiencing physician shortages, establish additional

residencies, available to CSAs, jointly funded by the communities and by the Provincial Government.

CONCLUSION

The *Stilwell Report* pointed out that the obstacles faced by B.C. medical graduates abroad still remained in 2011, “despite commitments made in the 2008 and 2010 Throne speeches to make changes to the way all BC medical undergraduate residency applications are treated.” The *Stilwell Report* was an “Action Plan.” After the report, on May 16, 2012, the proceedings in *Hansard* record that MLAs Mike Farnworth and Bruce Ralston questioned the Minister of Health, the Hon. M. de Jong, about what was being done to implement the Stilwell recommendations. Their questions showed a perceptive understanding of the problem. In his reply, Minister de Jong endorsed, “wholeheartedly the proposition that there is more that we must do to tap into the talent that is represented in the international medical graduates”. But the *Stilwell Report* has not been implemented, and the obstacles still remain. CSAs still have no access to the CMG stream. And although an increase in the number of IMG stream family practice residencies has been promised, the increase does little to help CSAs because of the obstacles and disincentives still in place.

The Ministry of Health has not come to grips with the problem. In discussions with that ministry, SOCASMA has found many senior bureaucrats to be unable or unwilling to act independently of the University of British Columbia.

Nor has SOCASMA found UBC willing to adopt necessary changes to make residencies accessible to CSAs. In an interview with UBC Medical School Associate Dean, Dr. D. Snadden, reported by Pamela Fayerman on June 19, 2012, in *The Vancouver Sun*, Dr. Snadden told the *Sun* that UBC had started to work with high school and university counsellors to give students a “reality check” regarding their future prospects for residency slots upon graduation if they studied medicine abroad. It may well be appropriate to warn prospective medical students about present obstacles to getting residencies in to British Columbia. That, however, is no basis for failing to remove those obstacles.

UBC presently holds a monopoly on medical education and post-graduate residency training in British Columbia. In Alberta there are two medical schools, and in Ontario there are six. Hopefully, UBC will be responsive to implementing fair procedures for CSAs, but if not, the Ministry of Health and the B.C. College of Physicians and Surgeons should mandate them. It may even be necessary to enable

the University of Victoria or Simon Fraser University to establish independent medical schools, and to operate residency programs which are responsive to fairness for CSAs.

British Columbia needs its doctors who graduate abroad. It will be a challenge to overcome those interests opposed to medical residency access in B.C. for CSAs, but this challenge must be faced in the public interest. For the benefit of CSAs, their families, their friends and their communities, and for the benefit of British Columbia, the way must be cleared to enable British Columbia to bring home B.C. medical graduates.