**THE SOCASMA SEVEN**

**Society of Canadians Studying Medicine Abroad**

**7 REQUESTS for MOH CONSIDERATION in 2019**

**1)Equal access to compete for the same positions on the same terms** for all qualified medical graduates who are Canadian citizens or Permanent Residents, including Canadian Medical Graduates (CMGs), International Medical Graduates (IMGs) & United States Medical Graduates (USMGs), for **2020** onward.

The MOH can instruct CaRMs that Ontario will cease streaming positions by location of graduation for both the first and second iteration, and for positions added by the MOH, the Department of National Defense or other funding sources. (page 2 & 3)

**2) Uniform examination / evaluation and timing of evaluation** for all qualified candidates, including CMGs, IMGs and USMGs as well as Visa trainees, for **2021** onward.

The MOH can instruct Ontario Medical Schools as public institutions and CaRMS that Ontario will require this standard as of Fall 2021 and to begin preparations now. (page 4)

**3)** **Consistency and Fairness in Return of Service** (ROS) **Contracts**

The same contracts, if any, to be applied fairly and equally to CMGs, IMGs and USMGs by

ceasing to require ROS contract requirements for all groups, OR offering identical program-based ROS contracts for all candidates &/OR offer optional ROS contracts, available to all, that could be used to prioritize entry to certain programs. (page 4)

**4) Equal access to Medical Elective experiences** for all Canadian citizens and Permanent Residents regardless of location of medical school attended.

The MOH can instruct Ontario medical schools as public educators to ensure both a blinded University sponsored elective assignment lottery and privately arranged electives. Medical schools can provide electives for their students who fail to arrange placement. (page 4)

**5)**  **Increase the number of Residency positions** for Canadians and Permanent Residents

1. as funded by the MOH in targeted medical specialties of present and future need;

b) as funded by Department of National Defense;

c) as funded by municipalities, corporations, and community groups with particular needs

Attempting to reduce costs by containing physician numbers and limiting patients access has been determined to be a false economy. (page 5)

**6)** **Prioritize training resources for Canadians** and Permanent Residents in Ontario.

The MOH can direct Ontario Universities as public institutions to **suspend training of Visa Trainees** in Ontario Residency positions**.** (page 6)

**7)** **Establish a formally recognized and designated role of “Supportive Physician”** within Ontario’shospitals & community setting for unmatched CaRMS qualified candidates. (page 7)

**SOCASMA SEVEN- Additional Background information, Rationale and References**

***SOCASMA strongly suggests Ontario adopt a MERIT BASED***

***fair and transparent Residency selection process (items 1-4)***

***1) Equal access to compete for the same positions on the same terms*** *for all qualified medical graduates (CMGS, IMGs and USMGs) for* ***2020*** *onward.*

*The MOH can instruct CaRMs that Ontario will cease streaming positions by location of graduation for both the first and second iteration, and for positions added by the MOH, the Department of National Defense or other funding sources.*

**Embracing merit is not just the right thing to do; it will also secure the very best candidates for Ontario’s Residency programs to develop to be highly competent, progressive and resilient future physician leaders for Ontario.**

**The status quo is unfair** and must be changed. For several years a much greater number of Residency positions have been pre-designated for CMGs than IMGs in the first iteration of the CaRMS match.

In 2018 the Council of Ontario Faculties of Medicine (COFM) and MOH directed a change for the 2019 CaRMS match with the introduction of streaming of CMG and IMG positions in the second iteration, again with many more positions being assigned to CMGs than IMGs.

In 2018 new positions created by the MOH & DND were reserved for only CMGs with no positions offered to IMGs.

**Prioritizing positions for CMGs** is a deeply ingrained tradition in Canadian post graduate medical education. The **justification** provided is that Canadian taxpayers and governments have invested in the undergraduate medical education of CMGs and thus many feel we must continue to fund CMGs through residency training to become practicing physicians in order to capitalize on our investment.

This common but **illogical reasoning** is called the **Sunk Cost Fallacy** in the fields of Economics and Psychology. It is a very human gut feeling but it is wrong. Further investment in a previous less profitable investment does not maximize returns. It is best to evaluate all investment options and redirect resources to the most likely to succeed future investment.

Since entry to medical school some students will have thrived and proven themselves well suited to the demands of medicine and competent in their knowledge, while some will have failed to do so. The **CaRMS process represents an opportunity to objectively re-evaluate each candidate’s appropriateness for future investment based not on past investment but on demonstrated merit.**

A further consideration is the inequity and Human Rights, Charter, and administrative law implications of treating one group of Canadian citizens and Permanent Residents (CMGs) more favourably than another group of Canadian citizens and Permanent Residents (IMGs). This favourable treatment is based on place of education, not on any objective assessment of competence. As such, it is inconsistent with principles of administrative law and the Office of the Fairness Commissioner which requires entry to practice decisions be impartial, transparent, objective and fair. This practice also effectively creates a requirement for Canadian experience which is contrary to the Ontario Human Rights Commission's Policy on Requiring Canadian Experience.

**The present process** is as follows.

a) The Deans of each Ontario medical schools together form the COFM.

b) COFM **and the MOH *together* put forward to CaRMS each Spring their agreed policy for the next year’s CaRMS match of Ontario Residency positions.**

<https://www.carms.ca/match/r-1-main-residency-match/eligibility-criteria/ontario/>

**This process is problematic** on several levels.

**The Ontario Deans and COFM have by definition a conflict of interest** in making recommendations for CMGs that are distinct from other groups. The Deans have continued year after year to set policy that protects and prioritize their own CMGs to the detriment of IMGs.

It is problematic from a **human rights and equity** perspective to treat two different groups of Canadian citizens and permanent residents differently with no objective basis for doing so. This is also contrary to the **Ontario** office of the **Fairness Commission** who has informed all Regulated Health Colleges in Ontario that they are responsible for ensuring third parties delegated to evaluate entry to practice are operating in a fair, transparent, objective and impartial way. The CPSO has delegated entry to practice decisions for residency to the COFM who are not acting according to these principles. To ensure these principals the COFM should be told to endorse and abide by the University of Toronto’s Post Graduate Medical Education document entitled “Best Practices for Applications and Selection”. <https://pg.postmd.utoronto.ca/wp-content/uploads/2016/06/BPASDraftFinalReportPGMEACMay2013-1.pdf>

The **MOH as the objective representative of ALL Ontarians** including Ontario patients and all Canadian citizens or Permanent Resident medical students seeking to work in Ontario is obliged to demonstrate fairness and equality by calling for the end of all streaming in the 2020 CaRMS match.

***2) Uniform examination / evaluation and timing of evaluation*** *for all qualified candidates (including CMGs, IMGs, USMGs, as well as Visa trainees) for* ***2021*** *onward.*

*The MOH can instruct Ontario Medical Schools as public institutions and CaRMS that Ontario will require this standard as of Fall 2021 and to begin preparations now.*

This is the model adopted in the USA with the same series and timing of United States Medical Licensing Examinations (USMLE) required by all candidates regardless of location of training.

At present in Canada the **requirements are inconsistent among groups**.

**IMGs** seeking CaRMs participation must pass a knowledge examination called the Medical Council of Canada Qualifying Examination Part I (**MCCQE1**) & a clinical skills assessment called the National Assessment Collaboration Objective Structured Clinical Examination

(**NAC OSCE**).

IMGs must **take the MCCQE1 a year earlier than CMGs**, at the end of their second to last year (July) or beginning of their final year (September) and their **score is available for consideration *before* the CaRMS match.**

**CMGs** however, generally **take the MCCQEI 1 year later, at the end of their final year, after an *additional year* of education, and *after* the CaRMS match (with leeway for those who fail to rewrite before Residency begins**). **CMGs do *not* have to take the NAC OSCE**.

For CMGs, no scores are available for consideration in the CaRMS match, nor for direct comparison of program applicants much to the frustration of program directors who must select candidates without complete and comparable information.

**Visa Trainees are not required to take** **the NAC OSCE** and purchase positions outside of CaRMS.

***3)******Consistency and Fairness in Return of Service Contracts***

*The same contracts, if any, applied fairly and equally to CMGs, IMGs and USMGs by*

*ceasing to require ROS contract requirements for all groups, OR offer identical program-based ROS contracts for all candidates regardless of their location of graduation, &/OR offer optional ROS contracts, available to all, that could be used to prioritize entry to certain programs.*

It is unfair that the government imposes ROS contracts as a condition for access to the medical profession on Canadians who are IMGs. No similar requirement is imposed on CMGs whose education has been subsidized by taxpayers.

***4) Equal access to Medical Elective experiences*** *for all Canadian citizens and Permanent Residents regardless of location of medical school attended. The MOH can instruct Ontario medical schools as public educators to ensure both a blinded university sponsored elective assignment lottery and privately arranged electives. Medical schools can provide electives for their students who fail to arrange placement.*

Electives are a very useful tool for program directors to determine whether a particular student has the skills that examination may not reflect that are necessary to fit their program. In a competence/merit based system of access, electives are an important tool to ensure that the program directors have the widest possible experience to ensure that the best graduate is being selected.

Furthermore, the present day difficulty IMGs experience in obtaining reduced medical electives positions effectively creates a Canadian experience requirement contrary to the Ontario Human Rights Commission's Policy on Canadian Experience Requirements.

***5)*** ***Increase the number of Residency positions*** *for Canadians and permanent residents*

1. *as funded by the MOH in targeted medical specialties of present and future need;*

*b) as funded by Department of National Defense;*

*c) as funded by municipalities, corporations, and community groups with particular needs*

*Attempting to reduce costs by containing physician numbers and limiting patients access has been determined to be a false economy.*

Past governments have incorrectly assumed paying fewer doctors will help contain costs, and thus have been very hesitant to increase training positions.

We now know delays in accessing care impacts the population's health and our economy with overall higher cost to government.

<https://www.fraserinstitute.org/categories/health-care-wait-times>

The Ontario government can be a leader in evidence-based changes and provide citizens *more* upfront health care with *less* cost in the long run.

There are further cost savings to government in increasing IMGs specifically. A 2004 University of Calgary Economics report concluded “for the same resources needed to train 1 medical student to enter Residency the Alberta IMG program identified 10 ‘residency-ready’ IMGs. The rate of return to Albertans from licensing an IMG to practice as a family physician was between 9% and 3% which is clearly a desirable and socially accountable use of public resources”

<https://www.semanticscholar.org/paper/Social-rates-of-return-to-investment-in-skills-and-Emery-Crutcher/9207dcf2a0c175142abbe05ed2ae6793efaeb0a1>

The “Canadian Medical Association recommends that a ratio of 120 postgraduate training positions per 100 medical graduates be reestablished and maintained. Canadians studying medicine abroad and other IMGs who are permanent residents or citizens of Canada must be explicitly factored into the planning for the capacity of the post-MD training system. CMA supports measures to facilitate the acculturation of IMGs” <https://policybase.cma.ca/documents/policypdf/PD15-07.pdf>

***6)******Prioritize training resources for Canadians*** *and Permanent Residents in Ontario. The MOH can direct Ontario Universities as public institutions to* ***suspend training of Visa Trainees in Ontario Residency positions.***

In August 2018 everyday Ontarians became aware that Ontario Universities are training hundreds of physicians from Middle East countries, primarily Saudi Arabia. The Universities payment for the use of publicly funded resources, practicing Canadian physicians, to train visa trainees who under contract to leave Canada at the end of the training is now common knowledge and people feel it is wrong. Ontario patients are also well aware that Canadian physicians who have studied abroad (CSAs) must emigrate to other countries to complete their training despite Ontario patients waiting for long periods for medical care. Apart from running contrary to nationalism, the loss of CSAs has other social and economic repercussions to Ontario, not the least of which is reduced support to patients and increased pressure on Ontario healthcare resources.

Ontario’s health care delivery has inadvertently become susceptible to foreign government decisions. Last year’s Saudis government threat to suddenly withdraw their residents and fellows highlighted that in some teaching centre departments the majority of Residents and Fellows are Saudi, which meant these departments would not have the staff needed to treat patients. A number of healthcare administrators have expressed concern about the vulnerability this crisis unmasked and urged that Canada become independent of foreign government in healthcare delivery.

Ontario health care is particularly at risk for Saudi withdrawal of service given the highest proportion of Saudi residents in the country: numbering 216 in Toronto, 156 in Hamilton, 91 in London and additional in Ottawa in 2018-2019. [theglobeandmail.com/canada/article-canadian-hospitals-scrambling-as-saudi-medical-students-withdraw-from/](https://www.theglobeandmail.com/canada/article-canadian-hospitals-scrambling-as-saudi-medical-students-withdraw-from/)

An additional concern is thatResidency positions purchased by Visa trainees consume Ontario clinical training resources. These resources could instead be used to support increased training positions in specialties of need for CaRMs applicants and those funded by the Ministry of Defense or community groups.

Canadian organizations have been prepared to fund residency positions because of need in their community. The Ministry of Defense has agreed to fund training to enable deployment to regions where there may be violence which requires physicians in the ranks. Universities have declined both groups stating they do not have the human resources to train more residents.

In 2018, the Ministry of Defense announced it would fund 50 Family Medicine training positions, however only a few Universities agreed to train these Surge Residents, citing training resources at capacity.

Further, the Universities would only agree to train CMGs. As a result, only about 5 positions were filled. In 2019 the Universities will train some IMGs in addition to CMGs but again the number of positions is limited and well below 50.

It appears positions and resources instead go to the higher bidder as SOCASMA understands Ontario Universities continue to welcome new Visa Trainees in 2019.

Income from the Visa Trainee’s home governments such as Saudi Arabia and other Middle Eastern countries is NOT used to fund more Residency positons for Canadians as some believe.

An Ontario Post Graduate Medical Dean acknowledged to SOCASMA and Freedom of Information documents similarly show that the money goes to the University’s Faculty of Medicine including the Post Graduate Dean’s offices. This practice does NOT offer long term solutions to Canada and Ontario.

***7)******Establish a formally recognized and designated role of “Supportive Physician”*** *within Ontario’s**hospital and community health care systems for unmatched CaRMS qualified candidates.*

Ontario can use the opportunity of healthcare reform to **stop the brain drain** and benefit from this highly educated and qualified group of Canadians who want to serve patients in Ontario. A creative **win-win-win** approach benefitting **government, unmatched physicians & patients**!

SOCASMA hears this role has informally emerged in community settings with variable supervision levels and patient awareness of their doctor’s level of education.

SOCASMA suggests a pay scale similar to PYG1-5 based on level of experience for those unmatched but qualified CaRMS applicants, CMGs and IMGs alike.

The “Supportive Physician” role would be both community and/or hospital based with private and publicly funded positions similar to the present Nurse Practitioner and Physician's Assistant roles.

***We wish to sincerely thank Dr. Rueben Devlin and Ms. Fredrika Scarth of the Premier’s Council on Improving Healthcare and Ending Hallway Medicine for meeting with SOCASMA and agreeing to discuss with the Ontario MOH the need for and development of a merit-based residency selection process for Ontario.***

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