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. Ministries of Health can instruct CaRMs that provinces will cease streaming positions by location of graduation for both the first and second iteration, and for positions added by Ministries of Health, 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.
Ministries of Health can instruct Medical Schools as public institutions and CaRMS that they 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.
Ministries of Health can instruct 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.

5) Increase the number of Residency positions for Canadian citizens and Permanent Residents

a) as funded by the Ministries of Health 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.

6) Prioritize training resources for Canadian citizens and Permanent Residents.
Ministries of Health can direct Universities as public institutions to **suspend training of Visa Trainees** in Residency positions**.**

7) Establish a formally recognized and designated role of "Supportive Physician" within hospitals & community settings for unmatched CaRMS qualified candidates.

SOCASMA SEVEN- Additional Background information, Rationale and References

SOCASMA strongly suggests provinces 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.*
Ministries of Health can instruct CaRMs that provinces will cease streaming positions by location of graduation for both the first and second iteration, and for positions added by the Ministry of Health, 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 Residency programs to develop to be highly competent, progressive and resilient future physician leaders.

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

For example, 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. Other provinces such as Manitoba did the same.

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 human gut reaction 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 favorably than another group of Canadian citizens and Permanent Residents (IMGs). This favorable 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's objective 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 national policy of inclusion as exemplified by the Ontario Human Rights Commission's Policy on Requiring Canadian Experience.

The present process is as follows:

a) The Deans of each medical schools together form the Provincial Councils of Faculties of Medicine.
b) Provincial Council of Faculties of Medicine **and Provincial Ministries of Health *together* put forward to CaRMS each Spring their agreed policy for the next year's CaRMS match of Provincial Residency positions.**

c) See for example, the following eligibility criteria for Ontario:
https://www.carms.ca/match/r-1-main-residency-match/eligibility-criteria/ontario/

This process is problematic on several levels.

The Deans and Provincial Councils of Faculties of Medicine 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 graduates 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 without a fair basis for doing so. This is also contrary to the objective of inclusion of the legislation relevant to regulation of entry into the medical profession and contrary to specific fairness legislation in a number of provinces. For instance, 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 Council of Physicians and Surgeons of Canada has delegated entry to practice decisions for residency to Provincial Councils of Faculties of Medicine who are not acting according to these principles.

To ensure these principles all selection committees for all Faculties of Medicine should be told to endorse and abide by the Recommendations set out at pages 9 to 12 of the University of Toronto's Post Graduate Medical Education report entitled "Best Practices for Applications and Selection". https://pg.postmd.utoronto.ca/wp-content/uploads/2016/06/BPASDraftFinalReportPGMEACMay2013-1.pdf

Ministries of Health as the objective representative of ALL citizens in their province including their patients and all Canadian citizens or Permanent Resident medical students seeking to work in their province are 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.*
Ministries of Health can instruct Medical Schools as public institutions and CaRMS that provinces 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, or in some provinces after, 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. In some provinces they need not even take the MCCQE1.

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

Additional Examination Conditions that are Specific to Certain Provinces

Alberta imposes a provincial residency requirement on IMGs. It does not impose this same restriction on CMGs. Fairness requires the same positions on the same conditions for IMGs and CMGs including provincial residency requirements.

The **BC Clinical Assessment Program (CAP)** creates another level of discrimination against IMGs. The CAP is mandatory for IMGs. It is not required for CMGs. The purpose of this CAP is not to weed out the unqualified, but to restrict the number of IMGs who can apply. Only 300 CAP assessments are available for over 1000 IMGs who typically apply to BC, preventing more than 700 IMGs who have the necessary qualifications from competing for residency training. BC does not block any of the almost 2000 CMGs who typically apply to BC, even if they just barely scraped through medical school.

To apply for residency, **the College of Physicians of Québec** currently require applicants to have completed their medical diploma and the necessary examinations. This deters applications by CSAs at it means that they cannot apply in the fourth year of medical school as is the case with other CaRMS programs across Canada. This is a major source of frustration for CSAs who would like to practice medicine in Quebec.

***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 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 inclusion policies of the federal and provincial governments including the Ontario Human Rights Commission's Policy on Canadian Experience Requirements.

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

a) *funded by Ministries of Health in targeted medical specialties of present and future need;*
b) *funded by Department of National Defense;*
c) *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

Provincial governments can be leaders 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 Canadian citizens** and Permanent Residents. Ministries of Health can direct Universities as public institutions to **suspend training of Visa Trainees in Residency positions.

In August 2018 Canadians became aware that 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. Patients are also well aware that Canadian physicians who have studied abroad (CSAs) must emigrate to other countries to complete their training despite patients waiting for long periods for medical care. Apart from running contrary to nationalism, the loss of CSAs has other social and economic repercussions, not the least of which is reduced support to patients and increased pressure on Canadian healthcare resources.

Canada'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/

An additional concern is that Residency positions purchased by Visa trainees consume 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 to a small number.

It appears positions and resources instead go to the higher bidder as SOCASMA understands 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 positions for Canadians as some believe.

This practice does NOT offer long term solutions to Canada.

7) Establish a formally recognized and designated role of "Supportive Physician" *within hospitals and community health care systems for unmatched CaRMS qualified candidates.*

Canada 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. 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.