SOCIETY OF CANADIANS STUDYING MEDICINE ABROAD

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Canadian Medical Association

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Dear Dr. Buchman,

Re. CMA Policy on Equity and Diversity in Medicine

On May 4, 2020, Deputy Prime Minister Freeland stated:

> "*This is Canada and we don't discriminate on the basis of which country they come from and which country they studied; they all are treated the same and share the same platform once they are Canadian citizens. We don't discriminate. They are Canadians and Canadians only.*"

The awareness of discrimination in the medical profession and the development of a policy to define and address it by the CMA in its recently published CMA Policy on Equity and Diversity in Medicine brings tremendous hope to the international medical graduate community that there will be a change. The CMA policy sets out the most fundamental principles of what it means to be a Canadian. Highlights of the CMA policy include:

> "The principles of equity and diversity are grounded in the fundamental commitment of the medical profession to respect for [sic] persons. This commitment recognizes that everyone has equal and inherent worth, has the right to be valued and respected, and to be treated with dignity. When we address equity and diversity, we are opening the conversation to include the voices and knowledge of those who have historically been under-represented and/or marginalized."

> "Equity in the medical profession is achieved when every person has the opportunity to realize their full potential to create and sustain a career without being unfairly impeded by discrimination or any other characteristic-related bias or barrier. To achieve this, physicians must 1) recognize that structural inequities that privilege some at the expense of others exist in training and practice environments and 2) commit to reducing these by putting in place measures that make recruitment, retention, and advancement opportunities more accessible, desirable, and achievable."

We believe that the conversation the CMA invites should begin with point of entry jobs in the medical profession, i.e., access to resident physician positions, where international medical graduates have been historically, and continue to be under-represented and/or marginalized. Because Canadians who are international medical graduates are prohibited from competing for the majority of entry level jobs in medicine, the majority end up driving the metaphoric taxi instead of practicing in the field in which they were educated.

To examine whether access to residency training, and hence the medical profession, is equitable and meets the other hallmarks set out in the policy, let us objectively consider how the system is structured and its effects.

Resident physician jobs are separated

Access to residency training for citizens and permanent residents of Canada (Canadians) is separated into two streams based on place of education, not on individual competence:

a) The CMG Stream is for graduates of Canadian and American medical schools which are LCME accredited called "CMGs"; and

b) The IMG Stream is for immigrant physicians and Canadians who chose to study medicine abroad called "IMGs".

Proving Competency

To compete in the CMG Stream of CaRMS, a Canadian or American medical school student must simply be poised to graduate from medical school.

To compete in the IMG Stream of CaRMS a Canadian who is an internationally trained medical student or graduate must establish that (s)he has, in the words of the Medical Council of Canada, "the critical medical knowledge and clinical decision-making ability of a candidate at a level expected of a medical student who is completing his or her medical degree in Canada" by passing the Medical Council of Canada Qualifying Examination Part 1 (MCCQE1). In addition, he or she must pass the National Assessment Collaboration Objective Structured Clinical Examination (NAC OSCE) which is in the words of the Medical Council of Canada "designed to evaluate an IMG's clinical skill at the level of a Canadian medical graduate entering postgraduate training."

Thus, when an IMG passes these two exams, (s)he establishes that (s)he has the knowledge, clinical decision-making ability, and clinical skills expected of a graduate of a Canadian medical school. This demonstration of competency is required of IMGs prior to seeking a residency position.

To compete in the CMG stream, CMGs are not required to demonstrate they meet this expectation. CMGs never have to take the NAC OSCE. Their competency in clinical skills is assumed. CMGs do take the MCCQE1 at the end of medical school, by which time all but a few of these prospective CMG graduates have already secured a resident physician position.

In the 2020 Match only 25 CMGs did not secure a residency position[1]. There is no issue that the majority of CMGs are well trained. But the Medical Council of Canada's most recently publicly released data

[1] https://www.carms.ca/pdfs/2020-carms-forum.pdf Slide 38

indicates that approximately 5% of CMGs[2] (approximately 140 CMGs) fail the MCCQE1 each year.[3] When CMGs fail the MCCQE1, an objective conclusion would be that these CMGs do not have "the critical medical knowledge and clinical decision-making ability of a candidate at a level expected of a medical student who is completing his or her medical degree in Canada". Nevertheless, CMGs who fail the MCCQE1 are entitled to work as resident physicians.

CMGs must pass the MCCQE1, not as a condition of competing for a residency position as is the case for IMGs, nor as a condition of working as resident physicians. CMGs need only pass the MCCQE1 prior to becoming licensed for independent practice.

While CMGs generally take the MCCQE1 just prior to graduation after the Match, Canadians who study medicine abroad must take the MCCQE1 in September of their final year of medical school, when they are only 75% of the way through medical school, to be eligible to compete in the Match. Similarly, with the NAC OSCE.

In order to avoid being electronically eliminated from competition without an interview, IMGs must not just pass, but must excel in their MCCQE1 and NAC OSCE scores.

To add context to the issue of different standards for CMGs versus IMGs as a condition of entering residency training and working as resident physicians, Canadian medical schools mark pass/fail while international medical schools grade and rank their students; Canadian and American medical schools provide substantial support to weak students which is provided in some international medical schools but not in others; and Canadian and American medical schools almost never fail anyone while most international schools do not hesitate to fail students.

The advancement and protection of weak students who graduate from Canadian and American medical schools is increasingly a source of professional concern. The *New England Journal of Medicine* in December of 2019 sets out the various factors that push graduation of weak medical students in Canada and the United States. The authors summarize the problem in the following terms:

> "Every spring, U.S. medical schools graduate some students who should not be allowed to become doctors. Despite multiple incentives for promoting, and barriers to dismissing, problematic students, medical schools have a responsibility to patients and the profession."
> "Kicking the Can Down the Road — When Medical Schools Fail to Self-Regulate", Santen, Christner, Mejicano, and Hemphill, N Engl J Med 2019; 381:2287-2289

Unlike Canada, in the United States, all medical students regardless of place of education must take the same medical licensing examinations at the same time to be eligible to compete for residency training positions. This is to ensure that the minimum standard expected of an American medical school graduate is indeed met before the graduate is matched to a residency position to ensure public safety. This universal system of examinations in the United States also provides an objective standard upon which programs can evaluate individuals instead of relying on assumptions based on place of graduation, colour of one's skin, and race. Universal testing helps the process of combatting the prevalent prejudice that IMGs are inferior.

The primary goal of the system of residency selection in Canada is not to choose the most competent Canadian who is a medical graduate for residency training and advancement to the medical profession;

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[2] MCC Annual report https://mcc.ca/media/2018-2019-Annual-Report.pdf p. 23

[3] https://www.carms.ca/pdfs/2019-CaRMS-Forum-data.pdf Slide 2

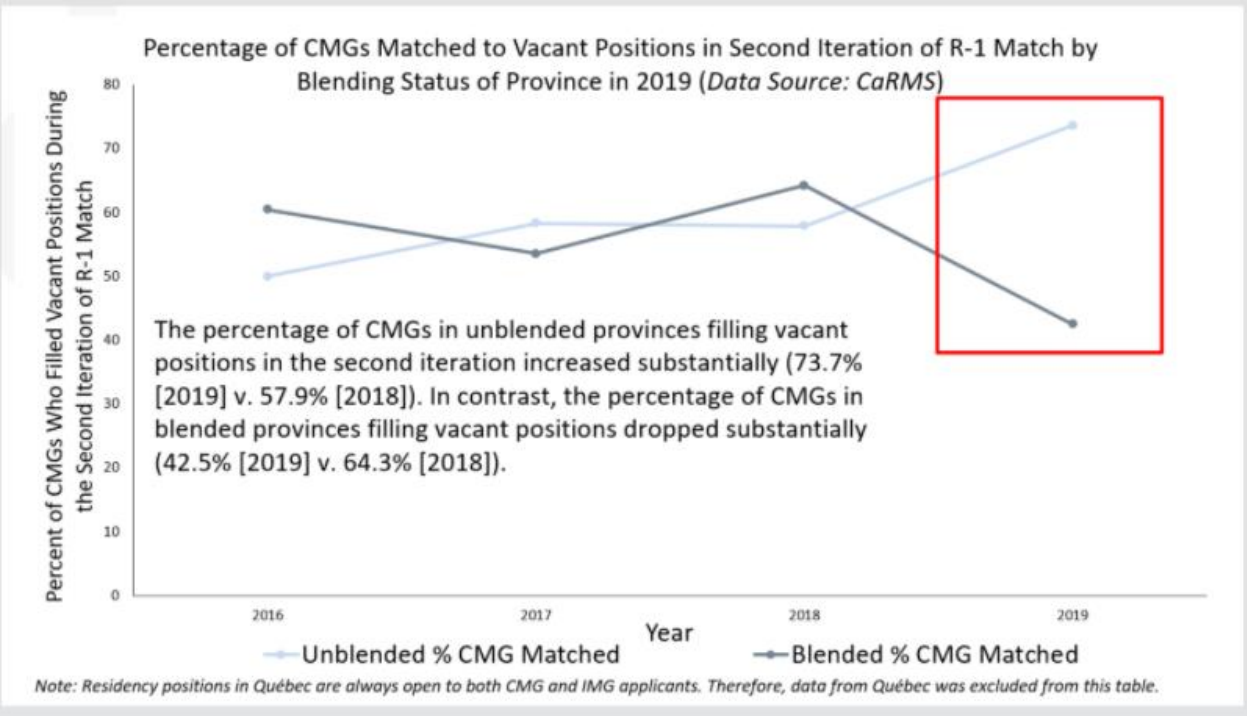
the goal is to protect CMGs from competition with other Canadians for residency positions to ensure CMGs work as resident physicians so they can become fully licensed. The Association of Faculties of Medicine of Canada (AFMC) resolved and the medical regulators and profession through their actions agreed that it is paramount "That all graduates of Canadian medical schools be assured access to a residency position in Canada to complete training necessary to enter practice" as stated in the AFMC resolution.[4]

In 2018 the AFMC and most of the profession involved in residency training determined that despite the significant protection CMGs were given, there were still too many unmatched CMGs. CMGs were being displaced in the second iteration by IMGs when IMGs are allowed to compete on the basis of individual merit. Thus, the AFMC lobbied for an "unblended" second iteration of CaRMS in 2019 to prevent CMGs from facing competition from Canadians who are IMGs in the first and second iteration. Ontario, Manitoba, and Alberta acceded to this request. In provinces where CMGs were protected from competition in the second iteration, the CMG match rate went up. In provinces where CMGs were not protected in the second iteration and were forced to compete with IMGs, the rate of CMGs matching dropped from 64.3% in 2018 to 42.5% in 2019 while the IMG match rate went up. Below is an excerpt from the AFMC newsletter.

The Impacts of Unblending during the R1 Match

In 2018, AFMC released a report with recommendations to address the increasing number of unmatched Canadian medical school graduates. AFMC advocated that provincial governments keep funding streams for Canadian medical graduate (CMG) and International medical graduate (IMG) streams separate during the second iteration of the match (unblending). For the 2019 R-1 Match, Ontario, Manitoba and Alberta changed their policy. As a result, the percentage of CMGs in unblended provinces filling vacant positions in the second iteration increased substantially. For this reason, AFMC will continue to recommend that all provincial governments unblend the second iteration of the R1 match to reduce the number of unmatched CMGs.

[4] The AFMC motion is posted on CaRMS https://www.carms.ca/match/r-1-main-residency-match/eligibility-criteria/



Access to Residency Positions

Both the CMG and IMG Streams are subject to what CaRMS calls a "quota".

The CMG Stream has more positions than there are CMG applicants. In the 2020 Match, the number of positions for CMGs was increased by 52 positions from the previous year to 3072[5] for 3011 CMG applicants[6]. This is an increase of 69 positions since 2013. Only 25 (0.9%) students expected to graduate in 2020 did not get a residency position[7].

The IMG Stream has a small ratio of positions per applicant. In 2020, there were 1822 IMG applicants[8] and 325 residency positions in the IMG Stream[9], a reduction of 1 residency position from the year before and a reduction of 23 positions since 2013. Over 1,400 IMGs (77%) did not get a residency position.

Canadians who graduated from international medical schools and who demonstrated objectively that they had the knowledge, clinical decision-making ability, and clinical skills expected of a graduate of a Canadian medical school were refused the opportunity to compete for 90% of entry level jobs to the medical profession. "A Canadian is a Canadian" does not apply to the medical profession.

In the CMG Stream, CMGs have complete mobility. They are eligible to compete for positions in the province or program of their choice all across Canada. This is not the case for IMGs who face a potpourri of additional requirements which limit their ability to compete even further. Some provinces like

[5] https://www.carms.ca/pdfs/2020-carms-forum.pdf Slide 9
[6] https://www.carms.ca/pdfs/2020-carms-forum.pdf Slide 1
[7] https://www.carms.ca/pdfs/2020-carms-forum.pdf Slide 38
[8] https://www.carms.ca/pdfs/2020-carms-forum.pdf Slide 1
[9] https://www.carms.ca/pdfs/2020-carms-forum.pdf Slide 8

Alberta and Quebec only allow IMGs who are residents of that province to compete for residency positions in that province. Other provinces impose additional examinations on IMGs. For instance, British Columbia mandates an additional assessment but limits the number of assessments to less than 30% of IMGs who have proved equivalency. In addition, half of those assessments are reserved for residents of British Columbia. Some programs will only allow IMGs to apply to their program if the IMG has done an elective in that program which is difficult for Canadians who study medicine abroad and virtually impossible for immigrant physicians. Almost all programs have a cut off point well above a passing grade for scores on the NAC OSCE and MCCQE1 such that if that score is not reached, the IMG is eliminated from competition. When all additional restrictions placed on IMG applicants are taken into account, an individual IMG has only a small fraction of the 325 IMG positions across Canada available to him or her.

While data is collected as to how CMGs fare in ultimately matching to a residency position (over 99% match within 3 years[10]), there is no tracking of how Canadians who are IMGs fare.

Choice of Area of Practice

In the CMG Stream, all base specialties are available. A CMG has the opportunity to obtain a residency position that will lead to all of the more than 70 disciplines recognized by the provincial Colleges of Physicians and Surgeons across Canada.

The IMG Stream does not have positions in all the base disciplines. There were 37 disciplines available to CMGs and only 23 to IMGs. For example, in all of Canada there are no IMG residency positions for otolaryngology. If an immigrant physician is an otolaryngologist or a Canadian studying medicine abroad wishes to become an otolaryngologist, it is impossible for him to become qualified as such in Canada—not because entry training jobs do not exist in Canada (there are 29 for CMGs) but because he is prohibited from competing for such because he is an IMG. In most provinces IMGs are restricted to the general disciplines: family medicine, with a few positions in specialties, mostly in psychiatry, pediatrics, and internal medicine[11]. CMGs are provided with a complete selection of recognized disciplines.[12] Some provinces, like British Columbia, do not allow IMGs to subspecialize if they match in the first iteration. In British Columbia, IMGs are realistically limited to 4 of more than 70 recognized medical disciplines.

Freedom of Practice

The CMG Stream has no restrictions or obligations after a CMG becomes certified. CMGs are free to train and then work if and where they want after becoming certified.

Matching in the IMG Stream is conditional. Even after overcoming significant odds, IMGs who match to a residency position will only be allowed to keep that position if they "agree" to sign a "return of service" contract in most provinces. The contract obligates IMGs to work where the Ministry of Health directs them to work for up to 5 years upon being certified. If an IMG wants to subspecialize, it is not allowed in some provinces or another return of service contract may be required by other provinces.

Return of service contracts impose hardship on IMGs. These contracts, which IMGs have no choice but to sign to become licensed in the medical profession, cause financial and emotional hardship (especially if the IMG's spouse and children cannot move with the IMG); interferes with cultural and religious

[10] https://www.carms.ca/pdfs/2020-carms-forum.pdf Slide 39

[11] https://www.carms.ca/wp-content/uploads/2019/05/2019_r1_tbl44e.pdf Table 44

[12] https://www.carms.ca/wp-content/uploads/2019/05/2019_r1_tbl12e.pdf Table 12

association (for example, Muslim and Jewish people may not have a place of worship or people of their religion in rural communities); interferes with access to services (especially in the case of family members with special needs, exceptional abilities, or disabilities); separates IMGs from their extended family; and interferes basically with a person's ability to control his or her life.

When the government of British Columbia tried to restrict where newly graduated CMGs practiced, the profession stood behind the graduates in opposition to this incursion of freedom by filing a legal challenge. When this restriction was struck down by the courts, the government tried two more times to impose place of practice restrictions. Each time the profession rallied behind the new graduates by providing funding for lawyers and other support. Each time the courts struck down the mobility restriction. [13] The profession has not rallied with support or funding for IMGs who have had these restrictions imposed on them as a condition of accessing the medical profession.

Representation and Recognition

Although we often hear the Ministry of Health, Faculties of Medicine, and other professional organizations state that they have collaborated or engaged with stakeholders, and although decisions made by these bodies regarding postgraduate medical education affect IMGs, there is little evidence of consultation with organizations that represent IMGs during the process. In the last several years the Society for Canadians Studying Medicine Abroad which represents Canadians who study medicine abroad has repeatedly requested representation on various committees and organizations that make decisions affecting them. Even though the Canadian Federation of Medical Students has representation on multiple organizations related to postgraduate medical training, Canadians who study medicine abroad have been denied representation on these same committees and boards. The 2019 response of CaRMS gets to the point:

> "The CaRMS Board of Directors reviewed your request, and has determined that its current Board composition is satisfactorily meeting the organization's governance needs. Your request has therefore been declined."

When the AFMC has reported that it has been "collaborating with stakeholders", Canadians who study medicine abroad have written advising that they are stakeholders who are affected by the particular issue and requested a voice at the table when decisions related to access to postgraduate medical training is involved. AFMC has never acknowledged or responded to such correspondence. Nor are immigrant physicians treated as stakeholders.

The voices of Canadians who are international medical graduates, whether immigrant physicians or CSAs, appear to be considered unnecessary when decisions which affect them are made.

Conclusion

[13] Mia v. Medical Services Commission of British Columbia, 1985 CanLII 148 (BC SC)
Wilson v. Medical Services Commission of British Columbia, 1988 CanLII 177 (BC CA) (Leave to Supreme Court of Canada denied 1988] 2 S.C.R. viii)
Waldman et al. v. The Medical Services of British Columbia et al., 1999 BCCA 508 (CanLII)

Two comments to a Vancouver Sun article written in support of IMGs being recruited to fight COVID 19 aptly demonstrate the effect of the climate created by systemic segregation and discrimination of Canadians which has the characteristics described above:

> Leic Youcuss: "they are poorly trained and dangerous letting them loose now is like letting cats into Australia…"
>
> Karen Smith: "Great post Leic. BC government and Canadians governments have valid reasons for what they do to keep us all safe and quality care insured."

In fact IMGs must prove that they have the medical knowledge, decision-making ability, and clinical skills expected of a Canadian medical school graduate before they are allowed to apply to work as resident physicians. CMGs are free to apply without objective, standardized testing, and are free to work as resident physicians even after 5% of them have failed the MCCQE1.

Since confederation, Canada has espoused that it is based on principles of equity and equality. But equity is defined through the lenses of those in power. In the 1800s equity was defined as women being subordinate to men. The Chinese Exclusion Act was in force until 1947. Restrictive covenants on land which prohibited sale to "Jews", "people of colour", and "other undesirable groups" were not unusual into the 1960s. It is only relatively recently that homosexuals have been "accepted" as having rights equal to heterosexuals.

Imagine that the segregation of access to residency training was based on characteristics such as: Caucasian/Coloured; Christian/Jewish or Muslim; or Heterosexual/Homosexual instead of CMG/IMG. Compare the differences in opportunity to enter or advance in a career available to these two sectors of Canadian society. Does this system of treating two different groups of Canadians meet the goals set out in the CMA Policy on Equity and Diversity in Medicine? Can access to the entry level jobs in medicine be characterized as "equitable" or "Free of bias and discrimination"? Does the system reflect that "everyone has equal and inherent worth, has the right to be valued and respected, and to be treated with dignity"?

Do the facts presented above disclose "structural inequities that privilege some at the expense of others exist in training and practice environments"?

Is 2020 the year that international medical graduates will be looked at with a different lens?

We ask that the CMA allow us, Canadians who are international medical graduates—CSAs and immigrant physicians, to publish these concerns in the CMAJ to begin the conversation. Would you please advise us the best route to go about this including any word limit restrictions?

Sincerely yours,

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Rosemary Pawliuk

President of Society for Canadians Studying Medicine Abroad