

# *Proceedings*

*Assessment Programs Workshop:  
Contributing to the National IMG Database  
“tracking the acquisition of Canadian credentials  
and access to practice”*

*9 February 2006  
8:30 a.m to 3:30 p.m.  
Lord Elgin, MacDonald Room, Ottawa ON*

## Attendees

Caroline Abrahams	Ministry of Health and Long-Term Care
Jason Kur	CAIR
Helga Loechel	Health Canada
Patty Brady	HRSDC
Chris Bolland	HRSDC
David Blackmore	MCC
Dale Dauphinee	MCC
Brent Barber	CIHI
Elspeth Gullen	CIHI
Howard Wright	Alberta Assessment Program
Penny Davis	Saskatchewan Assessment Program
Gisèle Bourgeois-Law	Manitoba Assessment Program
Radu Vestemean	Knowledge4You (IMG-Ontario Contractor)
Gwen MacPherson	Nova Scotia Assessment Program
Robert Maudsley	Nova Scotia Assessment Program
Carl Sparrow	Newfoundland and Labrador Assessment Program
Rod Andrew	British Columbia Assessment Program
Nick Busing	AFMC
Hélène LeBlanc	CAPER
Dianne Thurber	CAPER
Rita Forte	CAPER

## Background

CAPER is now developing the International Medical Graduates database. This initiative was one of the recommendations of the Canadian Taskforce on Licensure of International Medical Graduates. This national longitudinal database project will track International Medical Graduates from the time they enter the Canadian medical assessment, training and licensure pathways until they begin practice in one of the Canadian provinces. The objective is to track any individual who has engaged with the Canadian medical evaluation and/or education systems, and with licensing authorities to identify the entry routes and the contribution of IMG's to the Canadian physician workforce. In view of the assessment centres' role for evaluating the individual on the path to licensure, their contribution to providing a complete picture of the physician workforce is important.

As part of the National IMG Database, assessment programs were invited to a one-day workshop in Ottawa held on 9 February 2006. We envisioned the following objectives and received input about items that individuals wanted addressed, discussed, or information about from an expert in the field.

Objectives included the following:

- Providing a description of the whole IMG database and the important contribution of assessment centres for the data.
- What is already known, from CAPER's perspective, about IMG's and what the IMG database adds to the knowledge base of IMG's and the physician workforce in Canada.
- Presentations from each assessment centre relating to the highlights of activities from the past year and the role of the deputy minister of health in each province for IMG assessment centres.
- Origin, description, and intended use of the MINC#NIMC.
- Case study of how a non-profit organization which provides health information has introduced provincial and federal privacy policies.
- Through the assistance of a facilitator we would like to address the issue of transparency and portability.

These proceedings provide a summary of the presentations and the discussion which resulted from the workshop. The agenda is divided into three parts: Presentations from local experts, Presentations from CAPER, and a facilitated inside look at each of the assessment programs.

## **Welcome: Chris Bolland, Assistant Director - Policy/Foreign Workers and Immigrants, Workplace Skills Branch, HRSDC**

Chris Bolland introduced the workshop by providing an overview of foreign credentials and its relevance/importance to HRSDC and the Canadian government. Additionally, he provided an introduction as to how the IMG Database project fits into the whole picture of foreign credentials recognition at HRSDC.

Objectives:

- ❖ Why the issues that the IMG Database project is connected to are important
- ❖ Some of the changes with the new government

The Government of Canada is committed to building a more globally competitive and sustainable economy. One of the key pieces of that is investing in people. It is going to be the quality of our people and how well we have people doing what they were trained to do that is going to help Canada as a country be competitive in the global marketplace. Accelerating and enhancing the capacity of internationally educated workers to work in their fields remains a priority of the Government of Canada.

### **Immigration**

There have been changes to how we bring people to Canada in the recent years. The selection criteria were changed in 2002 to select less on occupation and more on a human capital model. Under the old criteria many of the health occupations were excluded. The new human capital model selects based on education level, work experience, and language adaptability factors. Although the new criteria were introduced in 2002, there were a lot of applicants on the former criteria. The effects of the new criteria are being experienced in the next couple of years. In the next 10-12 years, immigration will likely account for 100% of the net labour force growth although the labour force is not expected to grow enormously.

### **International Medical Graduates**

Physician Workforce

- The physician workforce is aging.
- The composition of the physician workforce is changing.
- Shortages in family medicine and in certain specialties.
- Historically IMG's have made up 20-30% of the physician workforce.
- IMG's are not seen as the solution to the physician workforce, but they are seen as a significant part of the solution.

The purpose is to enhance opportunities for qualified IMG's to become part of the Canadian physician workforce.

As a result of the Taskforce on the Licensure on International Medical Graduates, the National IMG Database is designed to give us a moving picture of how IMG's come in contact with the Canadian medical system. The database will track individuals as they

move through the Canadian system towards licensure. This will help us complete the comprehensive picture of the physician workforce in Canada. Additionally, this will help inform policy development and future initiatives to facilitate qualified IMG's entry to the Canadian physician workforce.

### **Other HRSDC Projects**

Other related projects include the National Credential Verification Agency and Physician Registry and an on-line self-assessment for IMG's. Eventually the MCCEE will be on-line so individuals can begin the examination process in their home country. Additional projects are being funded in other health occupations such as nursing, pharmacy, occupational therapy, physiotherapy, medical radiation technology, medical laboratory technology.

### **Context within the Government**

In April 2005, the government announced the Internationally Trained Workers Initiative. What are our priorities? What initiatives are we implementing?

Five key components

- Foreign Credential Recognition Program
- Enhanced Language Training – Being completed bilaterally with provinces to look at initiatives training individuals in the higher levels (Benchmarks 7-10)
- Labour Market Information – Consolidate the labour market information in Canada about what are the economic opportunities and put that information on a web portal called “Going to Canada”
- Bridge to Work and Overseas – Being developed to try and help people more actively before coming to Canada, e.g. have some opportunities for people to acquire work experience when they come
- Research – What are the determinants of good labour market outcomes?

The aim is to see foreign credential recognition processes that are fair, accessible, transparent, and coherent, but maintain the rigour necessary to ensure that licensing standards are not compromised. HRSDC is involved in regulated and non-regulated occupations through bilateral agreements with the provinces and territories.

## **MINC#NIMC, Dr. Dauphinee, Executive Director, Medical Council of Canada**

Dr. Dauphine provided an overview of the Medical Information Number for Canada. The MINC grew out of a need to have some type of unique identifier that would allow a simpler way for the recognition of people. Its relevance became more obvious with issues related to efficiency.

### **Background**

- The MINC office is located from the College of Physicians and Surgeons of Alberta. There is an information technology company that undertakes the technical aspects.
- MINC is a non-profit organization whose members are FMRAC and MCC.
- Officers of the board of MINC are volunteers.
- MINC is strictly a linking mechanism which relates to information that is readily available.

### **Reasons for MINC**

- People change their names.
- People want to request duplicates of items.
- Variations that relate to names.
- When credentials change.
- When jurisdictions change.
- Currently there are no ways to link individuals although there are no linkages between identifiers.

### **How to obtain a MINC#**

- Anyone who writes the MCCEE would receive a MINC#.
- Core information such as name, date of birth, place of birth, gender, medical school, and year graduated, are collected and submitted to a hub computer to create a MINC number.
- The medical regulatory authority informs the physician of the MINC#.

### **Example of a MINC#**

- CAMD-1234-6789
- CA = country code
- MD = profession code
- 1234678 = serial ID number
- 9 = check number

### **Users of MINC**

Although the prime users of MINC are the medical regulatory authorities and the MCC, through memorandums of understanding, organizations can become licensed to use

MINC for a fee. If you are a licensed user you can access the MINC to verify identity when there are two individuals with the same name.

### **Current Activities**

- There is a marketing program underway relating to licensed users.
- Currently, there are 5 regulatory authorities of 13 that are on MINC.
- There is a MINC web site.
- MINC is working with the Australians for a common evaluating exam process. This is another example of a use of the MINC number.

**Discussion:** Questions relating to MINC included the following:

Could a licensed user access the MINC numbers through a web site to verify whether a physician is who he/she says he/she is if there is a physicians only web site?

When a regulatory authority signs on to the MINC does that mean that all physicians registered with that regulatory authority receive a MINC number?

The regulatory authority makes the physicians aware of MINC and obtains permissions. Then a verification process is conducted. After that, as a physician registers the individual receives a MINC number. If the individual received a MINC number through the MCC then that individual already has a MINC number.

What is the success rate of obtaining a MINC number?

Of the 5 regulatory authorities that have signed on, 100% of physicians have a MINC number.

Is there any link between the CPSO number and the MINC number?

No.

Is there any way of verifying a MINC number?

Two ways: The MCC and the regulatory authorities have a photograph.

Can a medical student get a MINC number?

Yes, the field for medical school or year graduated would be blank until graduation.

## **Privacy legislation – Elspeth Gullen, Privacy Secretariat and Brent Barber, Health Human Resources, Canadian Institute for Health Information**

Elspeth Gullen provided a summary of the privacy principles which guide CIHI's data activities and Brent Barber provided a summary of how these principles apply to the Health Human Resources Data Development Project (HHR DDP).

Objectives:

- ❖ To provide an overview of how CIHI has adopted the privacy principles which were adapted from the CSA code.
- ❖ How the privacy principles are useful from a practical point of view.

The document Privacy and Confidentiality of Health Information at CIHI is in its third edition. This document outlines the following items:

- The legal parameters under which CIHI is working.
- 10 privacy principles from the CSA code and PIPEDA.
- Procedures that are followed at CIHI.
- How are data requests handled.
- Identification of the institution information policy.

There are privacy laws in place at the federal, provincial, and territorial level. CIHI is considered a “prescribed entity” under the Ontario Personal Health Information Protection Act. CIHI has to maintain a threshold with respect to privacy and confidentiality.

### **HHR DDP (Data Development Project)**

With funding from Health Canada, CIHI has undertaken to develop 5 new national databases. The health professions that are included are occupational therapists, pharmacists, physiotherapists, medical laboratory technologists, and medical radiation technologists.

There are several phases:

- Information Needs Phase: Contact the regulatory bodies for these health professions
- Identify the minimum data set: List of information that we are going to collect
- Apply CIHI's privacy principles and the completion of a privacy impact assessment
- Data elements:
  - provincial unique identifier
  - gender
  - educational attainment
  - employment practice information – full-time, part-time, casual
  - area of practice
  - type of employer
  - hours worked

- geographical information: postal code

## **Privacy Principles**

### **Accountability**

Definition: At CIHI, it is important to build a culture of privacy. Although the CEO is ultimately responsible, there is a Privacy, Confidentiality and Security Team. CIHI employees sign a confidentiality agreement.

### **Identifying Purposes**

Definition: You have to clearly identify the purpose for which you are collecting the information. This encourages issues of transparency, builds trust, and accountability. The Privacy Impact Assessment is an extensive process that looks at the purpose and use.

#### *HHR DDP (Data Development Project)*

There is a broad purpose for the data collection and a detailed purpose for each data element so there is a strong rationale for the collection. The purpose is for longitudinal retrospective and concurrent analysis. This is the reason for maintaining the data.

### **Consent**

Definition: This is for the knowledge and consent for collection, use or disclosure of personal information and there are exceptions where it is inappropriate. For CIHI, the consent requirements are set by the provincial and territorial jurisdictions. CIHI is a secondary data collector so it receives its data from data providers. CIHI does not have a relationship with the data subject and relies on the jurisdiction to comply with the legislative requirements. CIHI has an ongoing consultation with ministries of health and data providers about the implementation of this process.

#### *HHR DDP (Data Development Project)*

The data provider signs a letter of agreement with CIHI about providing the data. CIHI ensures that the data provider has the legal authority to provide the data; however, the onus is on the data providers for compliance with their privacy legislation and/or internal by-laws.

### **Limit Collection**

Definition: It is necessary to look at why it is important to collect the information in order to define what data needs to be provided. Data requirements are decided in conjunction with data providers. CIHI has Letters of Agreements which contain the obligations of CIHI for the security and confidentiality of that information.

#### *HHR DDP (Data Development Project)*

For the HHR DDP, the data providers are the provincial and territorial regulatory bodies.

### **Limit Use, Disclosure & Retention**

Definition: The data is collected only for the purposes for which it was collected and retained only for as long as necessary. At CIHI, it is a multi-stage process with a data

request form reviewed by the Privacy Secretariat and approved by the CEO. Factors that are considered include source of request, aggregate or record-level, institutional, and sensitivity.

*HHR DDP (Data Development Project)*

Requesting data from CIHI is a very involved process. If information is not already available in a publication the request would come to HHR DDP for a greater level of detail or at an aggregate level like counts by province for occupational therapists with gender and age. Depending upon whether the request is for record-level data or aggregate data, the request would be presented to the Privacy Secretariat. CIHI does not release personal identifiable information and cell sizes less than 5 are suppressed. Sometimes a request can take between 2 to 6 months.

**Accuracy**

Definition: CIHI has a data quality strategy which is important to a data quality framework.

*HHR DDP (Data Development Project)*

A report on the quality of the information provided accompanies each data release so accuracy is part of CIHI's privacy criteria.

**Safeguards**

Definition: There are physical, technical, and administrative safeguards in place to ensure the security of the information.

**Openness**

Definition: Openness refers to transparency, communication, education, and trust. A lot of information is available on a web site or in a catalogue of products and services.

**Access and Amendment**

Definition: An individual must have access to the information about oneself. Since CIHI is the secondary data collector the individual is referred to the data provider.

*HHR DDP (Data Development Project)*

Since there isn't enough information at CIHI to ensure the identity of the individual the individual is referred to the source.

**Challenging Compliance**

Definition: The individual must be able to address a challenge concerning the compliance to Principles 1 to 9. CIHI has procedures in place for individuals to make inquiries about privacy policies and practices. This builds upon trust and transparency.

*HHR DDP (Data Development Project)*

There are copies of the Privacy Impact Assessments available for the nursing databases and the pharmaceutical area.

**Discussion:** Questions relating to CIHI included the following:

If you are developing a data set for pharmacists, would you be able to identify how many individuals are internationally educated?

Yes, it is possible to identify their education inside Canada, outside Canada, field of study, etc.

Would you consider the privacy legislation to be a hindrance as opposed to being helpful? How does one keep a balance between the two?

Once people understand why one is setting restrictions and these principles are in place there is less paralysis in place. At CIHI, the structure is defined and the privacy policies augment its work.

## **Description of the IMG Database and the Role of the Assessment Centres Data – Rita Forte, Project Director, IMG Database**

Rita Forte provided a summary of the components of the IMG Database and the data collection for the assessment centres.

### **Objectives**

- ❖ An overview of the IMG Database
- ❖ Two parts to the data collection for assessment centres
- ❖ Master list of variables and how it is tailored to each centre

### **Objectives of the Database**

- To determine the number of unique IMG's in Canada who have engaged with the Canadian evaluation/licensure agencies for the purpose of attaining a licence to practise medicine.
- This includes identifying anyone who has passed the MCC examinations, and individuals that have been assessed by regional assessment centres.

### **Database**

- The database itself consists of 6 data providers.
- 3 of the 6 are individual organizations (MCC, CFPC, RCPSC).
- 3 of the 6 are data providers that are looked at as a group although the list of variables may be specific to a province/territory (regulatory authorities, assessment centres, faculties of medicine).
- There are common variables to each data provider. There are 14 common variables that are used to make sure we have the right person. These variables include report year, report month, name, date of birth, gender, name and country of university awarding MD degree.

#### **Faculties of Medicine**

- The focus is on variables which relate to post-MD training.

#### **College of Family Physicians of Canada**

- The focus is on variables which relate to evaluation and certification.

#### **Royal College of Physicians and Surgeons of Canada**

- The focus is on variables which relate to evaluation and certification.
- One aspect of the variables for this data submission is that it includes IMG's and Canadian Medical Graduates who completed at least 1 year of post-MD training outside of Canada.

Regulatory authorities

- The focus is on variables which relate to certification, licensure, and practice.

### **Data Collection**

- The first part relates to grouped numerical facts which is an immediate snapshot.
- The immediate snapshot data refers to total numbers of new IMG's assessed in the current year.
- They will make available an initial concrete summary of tracking specific events.
  
- The second part relates to individual records and the variables are specific to one data provider.
- These variables will depend on the steps in the assessment process and on the possible outcomes.

### **Summary**

- Since data providers are also data users requests/suggestions for statistical analysis are welcomed.
- Essentially, the filtering criteria for the data would be all physicians who received their MD degree outside Canada AND who have been through the assessment with an outcome.
- Things to consider in data sharing include the background and purpose related to CAPER's mandate, the data provider, and the purpose of the IMG database; obligations of CAPER to produce tables and charts with no identifiable information released from CAPER; and, the data provider's role.

**Discussion:** Suggestions for the IMG Database included:

- Return to service agreements
- Privileges which are attached to the licence
- Observership - formalized and unformalized
- Who is funding the assessment

**Introduction and Facilitator – Nick Busing, President & Chief Executive Officer, AFMC**

Presentations from each assessment centre included items related to:

- Describing the IMG process in your province
- How physicians are selected for assessment
- Highlights from the past year including the number of assessments you are doing or have done at your centre
- Unique aspects of your assessment process
- Complexities(challenges) at your centre
- What is the relationship with the regulatory authority
- How does the assessment centre fit into the medical school

AFMC's point of view and the medical school point of view relates to being committed to the continuum of education of how students come into our medical schools, how they progress through into post-graduate training, and to continuing professional development. In that continuum, there is a focus from AFMC and governments' points of view with regard to the equitable access for IMG's to post-graduate training. The eventual assessment processes may range from provincially driven to standard assessment processes across the country. Since every province/territory is going to have different needs the task is to determine the common elements.

## **British Columbia – B.C. International Medical Graduates Program**

Rod Andrew has been the director of the IMG program in BC since 1997 although he has been involved in teaching and assessing IMG's since 1990.

### **Background**

- Prior to the development of the IMG program in BC, the climate surrounding IMG's included a hunger strike.
- The program started with 2 IMG's going into residency in family medicine although more than two IMG's were assessed.
- Specialty fields being assessed: Family Medicine, Internal Medicine, General Surgery, Psychiatry, Obstetrics/Gynaecology, Paediatrics, Anaesthesia, Laboratory Medicine/Pathology.

### **Initial Requirements**

- MCCEE, MCCQE Part I, TOEFL, residency in BC for one year, two letters of reference from a physician.

### **Evaluation Tools**

- Multiple Choice Questionnaire, OSCE
- Of those taking the OSCE the top 20-25 are selected to move onto the next phase of clinical evaluation.
- 1 week orientation
- 12 week clinical assessment in family practice, psychiatry, internal medicine, geriatric medicine, and emergency medicine
- Following the assessment candidates are ranked from 1-22.

### **Outcomes**

There are 12 positions in family medicine and IMG's can access residencies in specialties. Also, IMG's may have a generalist evaluation before training in a specialty. Previous training may shorten the number of years of post-MD training.

### **Summary**

- A residency site for training IMG's in family medicine is being created at St. Paul's Hospital.
- CPSBC has been involved since the assessment program's inception.
- Faculty of Medicine has been involved in this process since its inception.

**Discussion:** The discussion raised issues relating to:

- CaRMS match as an outcome from the assessment
- Return of service agreements

## **Alberta – Alberta International Medical Graduate Program**

Howard Wright is the Provincial Coordinator for the AIMG.

### **Background**

- The program is funded by Alberta Health and Wellness.
- The mandate is to increase the number of IMG's eligible to work as physicians in Alberta.
- This program began in 2001 with 5 cycles of application. The focus is pre-residency after medical school.
- Objectives include assessing IMG's, providing an orientation/evaluation period, and serving as a resource.
- Governance includes representatives from governments, post-graduate training, Rural Physician Action Plan, Regional Health Authorities, CPSA, and program staff
- The number of physicians registered in the province is approximately 6200 and approximately 1700 are IMG's so 28% of physicians are IMG's.
- The total number of residents at U of A are 589 and the number of IMG Visa are 49.
- The total number of residents at U of C are 480 and the number of IMG Visa are 35.
- There are 19 AIMG at U of A and 22 AIMG at U of C.

### **Requirements**

- Permanent resident, lived in the province one year prior to, MCCEE, MCCQE1, TOEFL, CV, transcripts, references, personal statement.

### **Assessment Stages**

- Application form
- File review where teams of individuals including faculty, residents and public members go through the application file
- OSCE – practice and scored
- Interviews – Family medicine interviews are done collectively by interviewing the top 45. For the specialties, the individual programs interview for specialty training positions that are available.
- Summative review
- 4 month orientation/evaluation period

### **Outcomes**

- There are three possible outcomes: residency, extended orientation, or exiting the program. If ranked, the IMG chooses family medicine or a specialty. There are no return of service agreements.
- 405 applicants of which 376 are complete

- 54% female, age range 24-62
- Number of people taking the OSCE is 331
- Number of medical schools represented among the IMG candidates equal 56
- To date 94 residency positions have been funded

**Discussion:** The discussion raised issues relating to:

- Results of the 4 month evaluation
- Is there a correlation between the OSCE and performance during clinical evaluation
- Residency positions in approximately 10 specialties

## **Saskatchewan**

Dr. Penny Davis is the Director of the Division of Continuing Professional Learning at the College of Medicine, University of Saskatchewan. Part of her responsibilities include the assessment of IMG's.

### **Background**

- There are 1600 physicians in Saskatchewan and 54% are IMG's.
- There are between 100 and 110 IMG's coming into the province per year.
- The total numbers remains at 1600 so there is a fair number that come in and come out of the province.
- Historically access to residency is through the second iteration of the CaRMS match.
- Over the last two years the provincial government has agreed to fund some residency programs specifically for IMG's.
- The aim of the program was not to prepare people for residency, it was to see if they are practice ready in the province.
- There is a remediation and secondary assessment centre so that all IMG's coming into Saskatchewan can get a provisional licence under which they can work as a physician provided their documentation looks good and they sit the CAPE in Manitoba at the first possible opportunity.
- Assessment for family physicians at this time with no specialists yet.

### **Assessment Process**

- The individual receives a report from CAPE(Clinicians Assessment & Professional Enhancement) which points out strengths and areas of deficiency.
- The CPSS can decide to not provide a licence, provide a full licence or a provisional licence. If a provisional licence is awarded the IMG agrees to do some remediation and then be reassessed for licensure.
- The CAPE is used as a guide as to what people need and what needs to be reassessed; however, some physicians may have problems with MCCQE1 and then receive assistance for that.
- For CAPE, 20% unsuccessful, 20% successful, 60% in the middle, need remedial program.

### **Secondary assessment (done if full licence not awarded)**

Assessors review the physician's knowledge, their skills, their attitudes and behaviour. They develop a remediation program that would contain home study areas, mentorship. Focused educational objectives are provided at the beginning of the program and then part of the assessment at the end is to see if the IMG's have met those educational objectives.

### **Assessment Tools**

- Multiple choice questions
- Home study programs in areas such as pharmacology
- CME diary
- Preceptor to provide a clinical report which is based on FITER / ITER system
- OSCE
- Case discussion with 2-3 peers in practice
- Medical record review if the physician has been in practice for a reasonable length of time based on a formal process of what is appropriate for that record
- Preceptors are faculty-based and community-based. They are committed but not obliged to take part by the College of Medicine. There is an attempt to make the preceptor as relevant to the physician's experience as possible( e.g. rural, culture) and to obtain a mix of preceptors giving their opinions.

### **Outcomes**

At the end of the program, if the referral was from the CPSS concerning practice ready then report goes to the CPSS. If the IMG's are applying for any of the IMG positions in Saskatchewan then the report is given to the residency directors to help in selection.

### **Summary**

- For the past year, 24 people went through the program.
- Their requirements have ranged from an 8 week partial placement in psychiatry to requiring 6 months training.
- 10 year follow-up: less than ¼ of the people are in Saskatchewan and practicing.

## **Manitoba – Medical Licensure Program for International Medical Graduates**

Dr. Gisèle Bourgeois-Law is the Director of Clinician Assessment Programs at the University of Manitoba.

### **Background**

- An assessment program originally started in 1989 and it was for physicians in practice who were experiencing difficulty.
- Manitoba started assessing IMG's in 1997 at the request of Saskatchewan and the following year was asked to assess IMG's for Nova Scotia.
- About a year and a half ago, IMG's for Manitoba started being assessed.
- For IMG's in Manitoba, there are two routes to practice. The assessment is for IMG's entering into practice for the direct route and a small amount who enter the Manitoba IMG program.

### **MLPIMG(Medical Licensure Program for International Medical Graduates) Route** (Dr. Ruth Simkin is the director for this route.)

- Requirements include being a Manitoba citizen.
- 15 people are chosen to sit CAPE. It is hoped that at least 10 people will emerge that require one year of training before going into practice.
- Selection is strictly based on scores on MCCEE, MCCQE1, MCCQEII. If an individual has the MCCQEII, then they are selected initially. For the past couple of years people with only the MCCEE have not been able to be assessed through CAPE.
- For the last two years the spaces have not been filled: 5 out of the 15 and 6 out of the 15 were deemed to require at least 1 year of training or less to become practice ready.
- The success rate is good for the ones that complete the 1 year of training. About 2 people have not successfully completed it. Reasons for success seem to include that there is an understanding of the cultural issues.

### **Direct Route**

- As a result of a human rights complaint, the direct route started about one and a half years ago. Before that, there was a preferred country which included South Africa. Now everybody who comes through has to have an assessment and the number of individuals from South African medical schools has decreased.
- 65% of rural physicians are IMG's.
- For the direct route, the individual has to have passed the MCCEE, have been in practice in 3 of the last 5 years, have a conditional job offer, and have completed CAPE. Individuals are referred so pre-screening is completed and the people that are referred do well.

### **Summary**

- There have been problems with this assessment so it is going to change in the next 6 months. The CAPE is a 3-day assessment and proved to be not long enough to assess all required skills.
- Since everybody who comes in the direct route has to work in rural Manitoba they have to have emergency skills. The result is that some individuals don't know how to perform tasks such as sutures.
- The federal government, the provincial government, the Office of Rural Northern Health, the Regional Health Authorities of Manitoba, and the University of Manitoba have spent the last year developing a process that satisfies all parties.
- In addition to the 3-day assessment, there will be a three week clinical assessment which will include a two-day orientation.
- The outcomes would range from immediate entry to practice, up to 1 year of training, and counseling for alternate careers. This would include accepting 25 people a year.

**Assessment Process – Specialists, Non-Registered Specialists Assessment Program (NRSAP)**

- This program has been in place for the past 4 years.
- The duration of assessment varies from 3 months to 1 year.
- In order to be assessed, individuals have to have credentials assessed by the CPSM and have a job offer.
- The regions have to pay a fee to cover the cost of supervision, observation plus salary equivalent to that of a PGY5 resident.
- Assessments have been in OB/GYN, general surgery, urology, pathology, cardiology, neurology, and anesthesiology. Internal medicine will be starting up soon.

## **Ontario – IMG-Ontario**

Radu Vestemean is the President and Chief Information Architect of Knowledge4You Corp. and provides information technology for IMG-Ontario. He provided an overview of the application process and how the data is captured for IMG-Ontario given the thousands of applications that are received. To cope with this data flow, an applicant information system was developed. Dr. Vestemean described the data management system rather than the assessment program.

### **Self-service Environment**

- The applicant will go online, apply, and fill the data fields including payment. The information resides with the IMG-Ontario office. The IMG-Ontario staff updates information based upon documents that are received and exams that are taken. The applicant has access to his/her file so he/she can update an email or an address.
- The IMG completes information relating to specialty, personal information, legal status, language, MCCEE, undergrad and postgraduate medical education, certification, licences, clinical practice, and referees.

### **IMG-Ontario Staff**

- A staff member can search applicants, names, date of birth, number of times applied, and application status. Additional information includes registration information that the staff enters to ensure that criteria has been met. Also information relating to acceptance into a program indicates university, specialty.
- Once the applicant writes an exam, the staff makes results available. This process was on paper and emails, and with the process online the applicant logs into the application and reviews results.

### **Data**

- The number of hits to the IMG-Ontario web site include domains from Canada, Saudi Arabia, United Kingdom, the non-profit sector, and US educational.
- Based on the data generated from the applicant and staff, charts can be generated relating to gender, application status per specialty, and the number of times an applicant applies.
- Based on the data submission for the IMG Database, the data export would come from the data maintained by IMG-Ontario.

**Discussion:** The discussion raised issues relating to:

- Accessibility to the online application for non-English speaking applicants
- The self-service application is constructed using non-complex language
- Communication issues have been resolved with one site for updating
- Access to computers at IMG-Ontario office or PGME office with someone helping individuals to complete the application

- The magnitude of the IMG-Ontario program involved 900 OSCE's in the previous round
- There are varying outcome streams which include residency, clerkship, PGY1, PGY2, and accepting IMG's into the second round of CaRMS
- Policy direction was to have IMG's enter practice quickly, but it seems that many of the IMG's require PGY1 level training. There is an intent to reevaluate the program
- Not all IMG's are required to enter into return-to-service agreements
- Individuals entering PRP(a pre-residency program) to access their level as PGY1 or at PGY1 or higher are required to enter into return-to-service agreements with the underserved area program in Ontario

## **WAAIP – Western Alliance for Assessment of International Physicians**

Howard Wright is also a member of the core project team for WAAIP.

### **Background**

- This is a demonstration project with the objective to improve access to medical services by integrating IMG's in the western and northern Canadian physician workforce.
- This program looks at practice ready. There was a lot of debate about what practice ready means. The individuals in this program are close to being licensed.
- One year demonstration project funded by Health Canada through the western provinces. The funding was pooled based on the four western provinces and the three territories and will end 31 March 2006.
- Clinical Evaluation: Family Medicine, General Surgery, and General Internal Medicine for this pilot project.

### **WAAIP Partners**

- There are many partners from varying jurisdictions working together. This is a huge learning and collaboration amongst ministries of health, provincial licensing bodies, faculties of medicine, health regions for assessment sites, provincial IMG programs, and internal staff.
- Western Northern Health Human Health Resource Planning Forum is the umbrella group that has about 18 projects and WAAIP is one of them.
- Project steering committee, a core project team, and 7 different work groups all with individuals from the 7 types of organizations.

### **Application Process**

IMG's had to apply to this program. Individuals required the MCCEE, a conditional employment offer from a health region or be sponsored by a ministry of health. 112 applications were received and each provincial regulatory college decided who would move onto the assessment.

### **Two Assessment Phases**

- Step A: 41/112 went on to Step A with 35 in family medicine, 5 in Internal medicine, 1 in general surgery. Provinces were represented with 5 from AB, 15 from BC, 7 from MB, 12 from SK, and 2 from YK.
- Step B: 25/41 went on to the 3 month field assessment.

### **Summary**

Within a short time frame the process included getting all of the groups together, addressing varying expectations of the partners, deciding how to handle the information collected, and deciding whether to expand the specialties and expand the process. The tools are being evaluated.

## **Newfoundland and Labrador – Clinical Skills Assessment and Training Program**

Dr. Carl Sparrow is the director of the assessment program for Newfoundland and Labrador.

### **Background**

- In 1997, the provincial government discovered a need to recruit rural family physicians. The medical school was not supplying physicians to work in rural Newfoundland in family practice.
- The biggest sponsors were the provincial government, the Office of Professional Development at Memorial and the Newfoundland Medical Board.
- The CSAT program began in 1997 and it started producing physicians in 1998. It is based a lot on the Manitoba program.
- CSAT also assesses physicians that are referred from the medical board who are Canadian physicians that may be in need of an assessment or from other provinces.
- CSAT also assesses referrals from New Brunswick and PEI.

### **Training**

- None of the training programs are done in St. John's. This is unique because we want to get people outside of the major city.
- If a health board authority is sponsoring somebody, then it is required that some of the training be done under that health board so the individual gets to know that area.
- There is a medical advisory committee from the faculty of medicine.
- CSAT reports to the CPSNL who may modify educational prescriptions.

### **Applying to the Program**

- The person applies to the CPSNL online and then the college assesses the credentials.
- Refers the individual to CSAT if the credentials are deemed appropriate.
- All applications are screened by CPSNL.
- CSAT sends out a package and the individual has to get an offer of employment at the end of the program.
- An applicant does not have to be a resident of NL to apply.
- The program is self-sufficient with no government funding. The funding comes from the individual or the health care board. The health care board, depending upon their need, will usually pay the cost of the assessment.

### **Assessment**

- Two day formal exam
- 6 month clinical training program in Emergency, Family Practice, Internal Medicine, Psychiatry, OB/GYN
- Every two weeks, an assessment is done.

- The maximum number of people CSAT can take into the program is 14.

### **Summary**

- Since 1998, there have been 130 assessments and 69 completed it and are working in Canada.
- Some have to do reassessment based on the initial exams.
- The total number of assessments for 2005 was 21 and the number of new assessments is 16.
- Two years ago, CSAT did a retrospective study to look at what people wanted out of the program.
- 35-40% pass the CFPC exams about two years after having completed with CSAT.
- Three years after they complete CSAT program, there is a 70% chance that the individual is still in the province.
- 70% of individuals who practice medicine out of St. John's are IMG's accumulated over time.
- Strengths include that IMG's bring a lot of things: All can identify with the impact of social stress, cultural values, and family, and speak many languages.
- Barriers include the medical model that IMG's were taught with, social taboos with their inquiries, and reluctant to share power with patients.

### **Important Aspects**

- Community health is becoming extremely important in these programs.
- Palliative care - a new program which is part of family practice component where the palliative care director goes through medications.
- The writing of narcotic prescriptions
- Diabetic education
- Addiction services
- Preceptors to work with IMG's
- Challenges include the fitness and suitability to practice in Newfoundland and Labrador, and the opportunity to stay in a community long enough to feel part of the community.

**Discussion:** The discussion raised issues relating to:

- Whether the questions in the assessment become known amongst IMG's
- The role of structured oral interviews

## **Nova Scotia – Clinical Assessment for Practice Program**

Robert Maudsley is the Director of the CAPP program in Nova Scotia.

### **Background**

- The program was founded out of necessity. For several years individuals that applied for licensure in Nova Scotia were referred to the CAPE program in Manitoba.
- With no funding coming from the provincial government to start this program, the council of the college decided to move ahead and the council put \$300,000 of their reserve fund to get CAPP started.
- CAPP started 17 months ago.
- There are no training positions available for IMG's in the province.
- Candidates are accepted by referral. The college reviews their credentials.
- The focus is on determining readiness to enter family practice.

### **Requirements**

People must have graduated, trained, and practiced abroad. CAPP accepts individuals that are Canadian citizens/permanent residents with no residence requirement of NS. CAPP takes referrals from any regulatory authority.

### **Assessments**

- Assessed 56 candidates in June 2005. Of those 56, 11 are now in practice in Nova Scotia.
- Second assessment occurred in December 2005 with 44 candidates.
- Original of the report to candidate and a copy goes to referring college.
- 17 candidates requested their results to go to CaRMS.
- Next assessment is in June 2006

### **Assessment Process**

- Part A – Assessment of OSCE and written therapeutics exam with a report of strengths and weaknesses. If an individual is granted a provisional licence by the CPSNS then he/she goes on to Part B
- Part B - 1 year with a mentor. For those on a defined licence they must have a sponsor(district health authority) and a mentor. There are 50 areas not in metro Halifax and the district health authorities put forth names of mentors. Each CAPP physician has an individualized education plan developed in collaboration with Dalhousie CME.
  - 2-4 week period with mentor
  - Formal process with monthly progress reports from the mentor
  - 5 hours/week with mentor
  - At 4-6 months there is a practice assessment by an external assessor and at 10 months a multi-source assessment.

- Credentials committee decides whether licence will continue or formal mentorship. The individual has to be sponsored until a full licence.

**Future:** The platform for CAPP for a pilot with registered nurses of NS for assessment for nurse practitioners.

**Discussion:** The discussion raised issues relating to:

- Certification by CFPC within 4 years and differences between pass/failure rate for Canadian medical graduates and IMG's (failure rate for Canadian graduates 5-7% and for IMG's 30%)
- Individualized education plan through web-based learning and teleconferencing
- Objectivity of mentor and the support given to community-based mentors by mentorship coordinator

## **Outcomes of the Workshop:**

- Increased awareness of the notion of privacy to build a culture of privacy while accomplishing research tasks.
- Privacy policies/legislation can be used as an asset to ensure that research is conducted.
- Diversity is reflected in the unique programs and approaches to assessment of IMG's in provinces/territories.
- Ontario, Quebec, Alberta, BC have assessment programs that include residency. Other provinces are assessing IMG's for "practice ready" capacity.
- Incorporated within the discussion were the following two questions: What does "transparency" mean for assessment centres? What is the IMG perspective regarding "portability" of credentials?
- What is the depth and the pool of IMG's in our communities?
  - Quality of people that are coming into assessment is higher than three years ago, e.g. graduate degrees from Canadian universities
  - Pool of applicants is probably not going to diminish that much
  - Over the last few years there has been an increase in the number getting into practice and residencies.
  - There is an untapped source of physicians for practice in Canada.
  - The number of people passing the MCCEE has increased
  - Since there are a limited number of spaces for assessing IMG's it will take a long time to exhaust the pool
  - Whether IMG's should be on a clinical training team in a hospital or one-on-one preceptor
  - Varying levels from residency to fast-tracking IMG's into practice ready

*A sincere thank you to all those who participated in this workshop.*