

International Medical Graduates International Medical Graduates of Canadian Origin & Canadian Medical Graduates: Canadian Healthcare Training and Self-Sufficiency

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Background

The Canadian Federation of Medical Students (CFMS) recognizes that changes to the distribution of residency spaces allocated by the provincial government affect the number of residency spots available to Canadian Medical Graduates (CMGs) and impacts the training of future physicians. . Currently, only Manitoba and Quebec maintain an open match for the first round iteration of the Canadian Resident Matching Service (CaRMS). In all other provinces, there are a number of residency spots dedicated to IMGs in the CaRMS first iteration. Alberta and British Columbia have separate and distinct provincial programs that operate outside CaRMS In the second iteration of CaRMS, all unfilled residency training positions in Canada are open to IMGs and Canadian Medical Graduates (CMGs).

A subgroup of International Medical Graduates (IMGs), International Medical Graduates of Canadian Origin (IMGCs) IMGC have asked for further consideration with regard to this issue. The CFMS believes that due to steadily increasing external stresses on our system with respect to trainee capacity, investment in domestic training is the optimal approach to meeting the healthcare needs of Canadians. Furthermore, the CFMS believes that given the disproportionate distribution of the global burden of disease and the pressing need for locally trained physicians in developing countries, Canada should ultimately aim for self- sufficiency in terms of health human resources.

The Issue

Canada faces significant health human resource (HHR) challenges and needs an increased supply of family physicians and physicians in rural areas. Statistics Canada (2009) reported that nearly 1.9 million Canadians are unsuccessful in their attempts to find a family doctor. In order to meet these challenges it must be determined what role IMGs and IMGCs will play in the Canadian approach to health care that promotes self-sufficiency in physician training and supply.

Significant ill-advised government cuts to medical school enrollment in the 1990s have been implicated in Canada's shortfall of HHR. These cuts explain in part why healthcare demand significantly outstrips current supply. Inadequate government investment in medical schools and in residency training programs combined with HHR shortages and the attractiveness of medicine as a profession have led to an excess in those interested in medical training in Canada compared to the number who can be reasonably accommodated within the current system.

In order to address the physician shortfall, governments, in concert with medical schools, have significantly increased medical school enrolment over the last decade. The likelihood of choosing family medicine and practicing in underserved areas are both important considerations. Recently, the incorporation of IMGs into the physician supply in order to meet the healthcare needs of Canadians has also become a tenet of various government strategies. IMGCs have also received particular attention, despite being less likely than their CMG counterparts to practice in underserved areas and specialties (CaRMS, 2010). At a time when medical schools across Canada are expanding initiatives to recruit students from underrepresented disadvantaged socio-economic status and rural backgrounds, it is important to consider the implications of expanding training for IMGCs, whose backgrounds are more likely to be urban (CaRMS, 2010).

IMGCs and Legal Issues

In any consideration of IMGs and IMGCs there are legal and human rights implications. Chew et. al (2010) noted that the IMGCs are increasing in number in countries such as Australia, Ireland, and the United Kingdom. For example, The University of Queensland in Brisbane, Australia had successive increases in the number of students of Canadian origin each year from 23 to 61 to upwards of 100 in the classes completing their program in 2010, 2011, and 2012 respectively (Miernik, 2010). In the future, there will likely be no less than 100 Canadians out of the 130 spots per class open to international students each year in that one program.

Although IMGCs have mobilized as a political group, because both IMGs and IMGCs

have participated in medical training at universities that are not accredited in accordance with Canadian standards, any attempt to treat these two groups differently invites human rights challenges. Policies that differentiate between IMGs and IMGCs invite calls of discrimination based on country of origin. Ultimately this means that we cannot ethically distinguish between IMGs and IMGCs.

Medical Capacity

The recent increase in medical school enrollment has led to a Canadian medical education system that may be stressed beyond its capacity. Concern has been expressed that this stress may lead to decreased quality of medical education, significantly decreased opportunities for procedural skills training, and inadequate maintenance and availability of medical facilities (Topps & Strasser, 2010). Symptoms of these phenomena include countrywide overcrowded clinical rotations, an inability to obtain clinical electives in all disciplines, and a surplus of graduating trainees compared to existing job market infrastructure.

The aforementioned capacity issues, and costs associated with the recent increases in enrollment have led to calls to limit or decrease medical school enrollment in Quebec and Alberta. For example, Alberta maintained its increased enrollment for 2013, despite provincial government consideration to decrease their numbers to where they were for the class of 2010. Any decrease in number is counterproductive to the sustainability of Canadian healthcare training.

Given that the system is strained in terms of capacity, the CFMS is opposed to any increases in the number of medical trainees without appropriate investment in their education, training, and job prospects. Without a significant investment in expanding the training capacity in the Canadian medical education system, we cannot support the introduction of more IMGs into an already overcrowded system.

As alluded to above, the CFMS supports a self-sufficient approach to medical training. At the recent World Health Assembly in Geneva, Canada was informally characterized as a "poacher" of medical professionals. This is an important issue that needs to be addressed, as we need to consider the consequences of Canadian actions on the ability of patients to access a physician within the global medical community.

Declaration

The CFMS, as the national voice of Canada's future physicians, is highly concerned about the human health resource distribution within our nation. The CFMS advocates for the establishment of self-sufficiency in physician supply over the long term.

Any increases in training positions must be met with appropriate investments in resources to ensure that Canada maintains its reputation for high quality physician education. This includes new facilities, attracting new clinical teachers, faculty development, and investment in education technology. Simply overcrowding learners into the existing system is not an appropriate solution.

The CFMS is not against IMG participation in the Canadian Medical Education system. The participation of this group, however, should not be detrimental to Canadian medical students and it should not be seen as an ultimate solution to Canada's physician shortage. The provision of high quality medical education and residency training for graduates of Canadian medical schools should be the first priority, as should a self-sufficiency strategy for physician supply that does not inappropriately recruit physicians from other countries with a high burden of disease.

Pertaining specifically to the IMGs, it has long been the position of the CFMS that there should be expansion in the medical education system so that interested and qualified students can obtain an undergraduate medical education at home rather than travelling overseas and potentially setting up a costly, complicated repatriation system. There is an ethical imperative for Canada to be self-sufficient in terms of its HHR, and not rely on the recruitment of professionals from other countries without compensation. Many of these countries have physician shortages of their own. Governments and national medical organizations must come together to commit to the long-term vision of self-sufficiency in Canada's physician supply.

Recommendations

An increase in capacity in the Canadian medical education system must take a sustainable approach rather than simply adding volume to an already stressed system. The best way to increase capacity at the present time is through continued expansion of distributed medical education (DME) training sites [ref].

The CFMS urges governments to continue providing medical schools with funding for the development of well-resourced DME training sites, including satellite campuses, an approach that the Association of Faculties of Medicine of Canada supports. DME sites provide clinical and cultural competencies that allow for excellence in residency and medical practice in underserved areas (Senf, Campos-Outcalt, & Kutob, 2003). Currently, IMGs and IMGCs are being streamed into these areas, yet they may not be trained for the medical needs of these specific populations and are statistically less likely to stay (CaRMS, 2010). Conversely, Canadian students from underserved regions who are trained at distributed sites are more likely to remain in these areas in the long term for the same reasons that IMGs and IMGCs choose to leave.

If further DME training sites are developed, training capacity will increase significantly, fewer Canadians will need to go overseas to train in medicine, and Canada will move closer to HHR self-sufficiency. The CFMS is in full support of this model and urges governments across the country to invest in this approach to expanding medical education, improving clinical outcomes, and meeting the healthcare needs of Canadians.

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