

**Integrating International Medical
Graduates:
Nova Scotia
Resources & Gaps**



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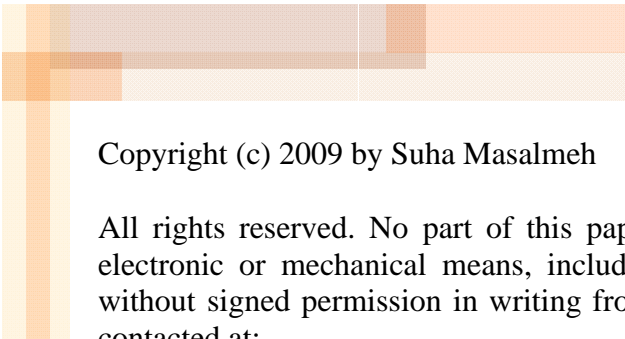
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Executive Summary

International Medical Graduates [IMGs] play an important role in the Canadian health system as they comprise approximately 25% of the physician workforce in Canada (Couser, 2007; Dauphinee, 2005; Lockyer et al., 2007; Nair et al., 2008; Wong & Lohfeld, 2008). Despite the sustained demand for physicians, IMGs face numerous challenges in attempting to become licensed and participate in the medical workforce in Canada. This paper aims to analyze and synthesize information on the resources and gaps in the IMG licensing process in Nova Scotia and provide recommendations to the province to ensure a fair and effective process for their integration in the health care system and support this group in their journey to be licensed. This paper is based on a critical analysis of information collected from literature, internet sources and key informant interviews.

IMGs are not looking for exemptions from standards or shortcuts into the system. They require opportunities to be assessed, oriented, provided with additional training if necessary to fill specific gaps, and to be moved effectively into practice through a system that meets a set of rational criteria. The complexity of the multitude of parameters associated with the IMG licensing process makes the process harder than expected and challenging for both IMGs and stakeholders. Although some progress has been made in Nova Scotia, there remains much work to be done before a fair, equitable and transparent process is in place to support the integration of IMGs into the health care system of the province.

IMG issues are not the responsibility of one party, IMGs and stakeholders including labour, immigration, education and health organizations and the government at

the federal and provincial levels are held responsible for improving the licensure process. The following recommendations are the outcome of an extensive literature review, key informants interviews and an examination of pan Canadian and international approaches:

1. Create a Nova Scotia IMG program
2. Improve IMGs' exposure to the health system through structured observer-ships, mentorships and study groups that include both IMGs and Canadian medical students.
3. Provide Financial Assistance through loans, scholarships, line of credits and fee subsidies.
4. Create basic clinical skills and specialty competency assessments
5. Create short term training opportunities.
6. Review and modify Med III Clerkship Program requirements
7. Conduct a survey for IMGs in the Province to more fully understand their issues and improve the licensure pathways accordingly.

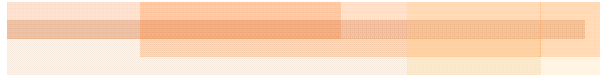


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Introduction

International Medical Graduates [IMGs] play an important role in the Canadian health system as they comprise approximately 25% of the physician workforce in Canada (Couser, 2007; Dauphinee, 2005; Lockyer et al., 2007; Nair et al., 2008; Wong & Lohfeld, 2008). Every year more than 300 IMGs arrive in Canada and only 15% have employment arrangement (Crutcher and Daphinee, 2002). Many provinces and territories rely heavily on IMGs to address their physician supply and to fill vacancies in underserved fields of practice and underserved communities.

Despite the sustained demand for physicians, IMGs face numerous challenges in attempting to become licensed and participate in the medical workforce in Canada. They have been unable to confirm or demonstrate their competency due to tight workforce policies, and limited access to information, competency assessment, training opportunities and bridging programs.

This paper aims to analyze and synthesize information on the resources and gaps in the IMG licensing process in Nova Scotia and provide recommendations to the province to ensure a fair and effective process for their integration in the health care system and support this group in their journey to be licensed. This paper is based on a critical analysis of information collected from an extensive literature review, an examination of pan-Canadian initiatives and key informant interviews.

Background & Rationale

An International Medical Graduate is a physician who graduated from a medical school outside of Canada. IMGs may be immigrants to Canada with medical degrees from other

countries as well as Canadian IMGs who went abroad for their medical education (CIC-IMGs, 2009a; Lockyer et al., 2007; Szafran et al., 2005). For the purpose of this paper, the term “IMGs” refers to immigrant physicians because of their unique challenges and their lower success rates in obtaining licenses to practice in Nova Scotia compared to Canadian IMGs who choose to study abroad. However, the line between the two groups is vague and some of the Canadian IMGs face similar challenges. In most cases immigrant IMGs tend to be older, married, have dependent children, obtained their medical education in Asia, Eastern Europe, the Middle East, or Africa, and have more years of post graduate experience (Szafran et al., 2005).

The IMG population is a diverse group with variable needs for orientation, communication and clinical skills training (Couser, 2007; McGrath, 2004). Some IMGs can move quickly into practice, while others face more challenges to obtain the license to practice (McGrath, 2004). In some cases, alternative career pathways may be recommended (McGrath, 2004). Despite the challenges that this group is facing, they play an important role in the Canadian health care system. There is currently an interest to speed up the process of licensing and create channels to improve the integration of this group in the health care system because of the immense need for physicians in Canada.

The increasing demand for medical care of an aging population is further strained by the aging physician working force (CMA, 2009) together with the imminent physician retirements. Poor integration of IMGs in the Canadian health care system and the 10% cutback in medical school admissions in the 1990s have contributed further to the shortage of physicians

Physicians over the age of 45 years (CMA, 2009):
66% of all physicians in Canada
65.5% of family physicians in Canada
65% of total physicians in NS

that Canada is experiencing now and which is predicted to increase in the near future (Dauphinee, 2005). Even at the current time, it is estimated that Canada needs at least 5000 more physicians in active practice to provide adequate health care services to the population (Busing, 2007).

The future sustainability of the health care system depends on the ability of our system to be self-sufficient in producing enough physicians, integrating IMGs to the system and introducing other health care providers (Audas, Ross & Vardy 2005; Busing, 2007; Dauphinee, 2005).

Many attempts at health system reform have been conducted provincially and nationally, yet successful change has been limited. A recent example is the NS Provincial Health Services Operational Review [PHSOR], which identified the vital role that IMGs are playing in some District Health Authorities in NS (Corpus Sanchez, 2007). Yet the report fails to provide practical recommendations to support the pool of IMGs living in the province.

Many programs and resources have been created to help IMGs in their journey (Couser, 2007), but multiple barriers remain and more work is still required in identifying gaps and moving forward in the process. IMG licensure in Canada is a complicated process. Refer to Appendix A for comprehensive list of barriers experienced by IMGs.

Licensing in Canada

Although this paper is concerned with identifying resources and gaps in the IMG licensing process in NS, it is critical to provide a pan-Canadian perspective on licensing IMGs. In Canada, licensing of physicians and the delivery of health care services lies under provincial jurisdiction (Audas, Ross & Vardy 2005; Wong & Lohfeld, 2008). The

forms of licensing vary among provinces. There are two main licensing categories: full and provincial/defined licensure (Audas, Ross & Vardy 2005). Access to a licensure pathway in Canada depends on a number of factors including the country from which the IMG obtained his/her medical degrees, their English language proficiency, their postgraduate medical education, the extent and currency of their clinical experience, and the provincial regulations (Lockyer et al., 2007).

IMGs seeking to have a full license to practice in Canada are required in most cases to obtain postgraduate medical training in Canada. This is a significant obstacle as few IMGs are able to fulfill this requirement (Audas, Ross & Vardy 2005). The majority of IMGs practice medicine in Canada under a provincial license, which can lead to a full license by fulfilling certain requirements (Audas, Ross & Vardy 2005) such as the passing the Certification examination of the Royal College of Physicians and Surgeons of Canada [RCPSC] or the College of Family Physicians of Canada [CFPC].

Nova Scotia's Licensure Process

There are different routes available for IMGs to practice medicine in Nova Scotia (CIC-IMG, 2009a). Refer to Appendix B for more information on the NS licensure pathway. Also there are various groups involved in the journey toward licensure through education, training, practice and support. Some of these groups are national, while others are local support groups. Refer to Appendix C and M for a list of these organizations and groups, the level of their involvement and an explanation of the role each group plays. The “Preliminary Steps” that are required before an IMG is eligible to move forward in the licensure process include (MISA, 2009b):

- **Credential Verification:** IMGs need to submit their medical credential documents for verification to the Physician Credentials Registry of Canada [PCRC].
- **Language Assessment:** IMGs need to undergo a language assessment to determine their proficiency in English. The language assessment accepted in NS is either the Test of English as a Foreign Language [TOEFL] or the Canadian Language Benchmarks [CLB]. To be able to move forward in the licensing process, the IMG should be able to speak, listen, read and write in English and understand the culture of healthcare in the field of medicine in which he/she will be practicing.

- Minimum of CLB 5 to be able to prepare for the examinations.
- Minimum of CLB 7 or a TOEFL score of at least 250 on the computer based test or 600 on the written test to be able to practice as a physician.

(Manitoba, 2007)

- **Medical Examinations:** There are three sets of examinations offered by the Medical Council of Canada [MCC], which include: Medical Council of Canada Evaluating Examination [MCCEE], Medical Council of Canada Qualifying Examination Part I [MCCQE I] and Medical Council of Canada Qualifying Part II [MCCQE II]. The first two examinations are almost the pre-requirement for any further step taken in the licensure process in NS, while the MCCQE II can support the application as a clinical assessment tool.

After completing the preliminary steps, IMGs have the following routes to licensure available in NS (MISA, 2009b):

- **Repeat Part of Medical Education** - IMGs could apply for entry into the Third Year Medical School Clerkship Program [Med III Clerkship Program].










- **Residency** - IMGs could apply for postgraduate medical education through the Canadian Resident Matching Service [CaRMS] in both the first and second iteration for positions in NS and other provinces.

- **Assessment Entry to Family Practice** - This route is designed for IMGs who are deemed eligible to practice as Family Physicians in NS. This group can apply to the Clinicians Assessment for Practice Program [CAPP]. Applying to the CAPP can be done directly through an application to the College of Physicians and Surgeons of Nova Scotia [CPSNS] or be referred to it by another regulatory body for candidates from outside the province.

The current process contains numerous barriers, such as redundant, costly, and time consuming exams in addition to the very limited access to required postgraduate residency training and lack of short term training opportunities. Refer to Appendix A for a comprehensive list of barriers experienced by IMGs. Examining the available resources and identifying the gaps is important to improve the process and provide recommendations for a better integration of IMGs in the health care system.

Nova Scotia's Reality: Resources

In the last few years, NS has introduced some channels to improve IMG integration into the health care system. Yet many barriers still exist and the current set of programs and policies and the available resources fall far short of providing the appropriate support for IMGs. The following section provides information on the current resources and programs available to help IMGs in their journey to licensure in NS.

Current resources and programs available to help IMGs in their journey to licensure in NS	
 IMG Working Group	 NS Licensure Pathways
 English for Healthcare Professionals Course	 Med III Clerkship Program
 Introduction to the Canadian Healthcare System Course	 CAPP
 OSCE Preparation Course	 10 IMG Positions in the 1 st CaRMS Iteration
	 Clinical Associate Positions

IMG Working Group

The IMG Working Group is a multi-stakeholder group that meets quarterly and acts in an advisory capacity to help develop realistic and sustainable solutions to better integrate IMGs into the NS health care system (Appendix M). Solutions to IMG issues are not going to be made by one group as no one player “owns” the problem (Kutcher, 2008). The group dialogues provide important evaluation of barriers IMGs face and help identify the gaps in the system.

Although the group brings to the table important issues, this group acts only as an advisory group and has no power and accountability to moving the process forward. It is a challenge for members of the group when a barrier is identified and a solution is agreed upon as the group has no resources or power to implement the solution unless the group is able to influence decision makers’ agendas. As an example, influenced by the multi-stakeholder group, the Dean of Medicine contributed to the creation of the Med III pathway as a resource to support IMGs to be funded by the government of Nova Scotia.

Currently there is no single source of information that IMGs can use to assist them in their journey for licensing (McGrath, 2004). This creates confusion among both IMGs and stakeholders and further complicates the process of licensing. The multi-

stakeholder group is an excellent initiative, but needs to be aligned with an IMG program that adopts the solutions, has an accountability framework and has the ability to assess, assist and support better the integration of IMGs into the NS health care system. This initiative has been adopted by many provinces such as Manitoba, Alberta, BC and Ontario by the creation of IMG programs. There is a need for a more collaborative approach and a one stop shop where IMGs and stakeholders go to find all the information related to licensing, resources and programs that support the process.

English for Healthcare Professionals Course

This course is offered by the Halifax Immigrant Learning Centre [HILC] for newcomers who have international professional health care qualifications and experience and who intend to work in their profession in Canada (MISA, 2009c). It is an intensive communication course that helps participants to bring their communication skills to the level needed to practice effectively in a Canadian health care work environment. A CLB level of at least 7 is a pre-requirement for entry into this course (MISA, 2009c). The course provides a wide variety of exposure to English communication skills based on the Canadian health care culture and contexts (MISA, 2009c).

Throughout the course IMGs have the opportunity to learn medical terminology, how to write relevant forms and reports, communication skills, interview techniques and health care culture (MISA, 2009c). Although the course is comprehensive in the areas that it covers, there is a need to align this course with real life practice. If the skills learned through the course are not utilized, they will eventually be lost over time. It is necessary to follow this opportunity with refresher sessions and more access to hands on experience. This can be created by collaborating with Dalhousie Faculty of Medicine and

other physicians in the province to create sufficient exposure to the health system through attending rounds and observer-ship opportunities.

Introduction to Canadian Health System Course

The Registered Nurses Professional Development Centre [RN-PDC] offers a course titled “Orientation to the Canadian Healthcare System and Professional Practice in NS for Internationally Educated Healthcare Professionals” (RN-PDC, 2009). The course teaches key concepts and principles of professional practice needed to enable IMGs and other International Health Professionals to work in NS (RN-PDC, 2009). The course provides IMGs with information on the structural aspects of the health care system.

The information provided in the course acts as an introduction for the IMG group before entry into the system. For this course to achieve its potential benefits, it is critical to combine it with site visits to various departments for a live demonstration of the system. This can also be achieved by aligning the course with observer-ship opportunities in the field of practice of the IMG. This will give IMGs an extensive exposure to the health care system. The Alberta Medical Communication Assessment Program [M-CAP] is an example from which NS can learn. M-CAP is delivered through a 16 week period to help IMGs improve their language proficiency, communication skills and cultural understanding for entry into practice (M-CAP, 2009). The first 8 weeks of the program includes in class language and communication training components followed by 8 weeks of a practicum placement with a licensed physician (M-CAP, 2009). Refer to Appendix F for further details on M-CAP.

OSCE Preparation Course

The Metropolitan Immigrant Settlement Association [MISA], with the support of a group of Canadian physicians, offers an Objective Structured Clinical Examination [OSCE] preparation course. This program involves medical case discussions, simulations and practice OSCE exams. The program is offered twice a year and is held one evening a week for eight weeks (MISA, 2009a). This program supports a large group of IMGs in improving their performance on the clinical examinations. The program is free of charge and is offered by volunteer physicians who dedicate their time to help IMGs.

The course offered by MISA provides excellent preparation for the Medical Council Examinations and the CAPP. MISA is a Non Governmental Organization [NGO] that provides services to help immigrants settle in NS. Although providing an OSCE preparation course for IMGs is not one of MISA's responsibilities and it is not also equipped with the clinical and educational experience to create such a course, MISA offers this service as it senses the immense need for it and observed its impact on IMG performance in national and provincial examinations. Such a course should be adopted by other organizations that deliver medical education. More collaboration is advised to provide a similar course based on the educational needs of the IMG population. The collaboration is recommended to include Dalhousie University, Learning Resource Centre, and physician groups interested in supporting the IMG population. The learning Resource Centre at Dalhousie University could provide IMGs access to practice basic clinical skills.

Pathways to Licensure

The pathway to licensure for IMGs is complicated and difficult to follow not only for the IMG population, but also for stakeholders. To assist with understanding this pathway, Metropolitan Immigrant Settlement Association [MISA] created a document which outlines a number of potential routes to licensure and helps IMGs in their journey to practice medicine in NS (Appendix D). The pathway is a live document that is under continuous evaluation and change. A modified pathway (Appendix B) integrates the information collected from key informants. The pathway helps both IMGs and stakeholders to have an overview of the process.

Med III Clerkship

Entrance into third year medical school clerkship is a pilot project that was initially created to support IMGs who settled in Nova Scotia and who have been assessed as appropriate for clerkship level education but are ineligible for residency education due to lack of appropriate clinical experience in Canada or a large clinical gap. IMGs completing the third and fourth year of clerkship will be considered Dalhousie graduates and would enter the CaRMS match along with other Dalhousie medical graduates. Participants are required to serve in a Nova Scotia community for a return for service. The program is funded by the Nova Scotia Department of Health. A dedicated faculty member is assigned to support candidates and address any issues that arise throughout their training.

Although the project was created to support those IMGs who were not eligible to take any other route of licensure because of their lack of experience or the clinical gap, program requires candidate to undergo a clinical assessment as a criteria for applying for

the program. The suggested clinical assessment includes one of the following Clinician Assessment for Practice Program [CAPP] (offered in NS), Medical Council of Canada Qualifying Part II [MCCQE II] (offered by the Medical Council of Canada), Clinicians Assessment and Professional Enhancement [CAPE] (offered in Manitoba), or Clinical Skills Assessment and Training [CSAT] (offered in Newfoundland and Labrador) (Faculty of Medicine, 2009a). According to key informants, the actual level of clinical skills needed for entry into the Med III Clerkship Program is basic level of competency in conducting a patient interview and physical examination and understanding basic knowledge of the human body physiology.

Currently there is no basic assessment to evaluate candidates' clinical skills at the level required of third year medical students. The current requirement of a higher standard clinical skill assessment, such as the CAPP, creates unnecessary barriers for IMGs who were initially targeted for this project and thus should be eliminated. Until the province creates a basic clinical skills assessment, candidates for the Med III Clerkship Program should instead be treated as are the international medical students who come in their third year to Dalhousie Medical School in the assessment and orientation they undergo (Link Program: a comprehensive bridging program) (Faculty of Medicine, 2009b). Refer to Appendix E for more information on the Link Program.

10 IMG CaRMS Positions in 1st Iteration

One key route to practicing medicine in Canada for IMGs is through obtaining residency training (Audas, Ross & Vardy 2005). The postgraduate residency positions are organized by the Canadian Residency Matching Association [CaRMS]. CaRMS is a

national organization that manages applications to available postgraduate residency positions in the 13 English speaking Canadian medical schools (Szafran et al., 2005).

Application to residency positions runs twice a year; first and second iteration. In NS, IMGs can apply through both iterations through a parallel application in the first iteration and jointly with other Canadian Medical Graduates in the second iteration. In this first iteration, IMGs can only apply to the 10 specific positions dedicated to this group offered by Dalhousie Postgraduate Medical Education and funded by the government (CaRMS, 2009). Of these positions, five are in Family Medicine and the rest are specialty residencies that change every year. IMGs accepted in these positions are required to sign a return of service contract with the Ministry of Health for either the Province of Nova Scotia, New Brunswick or Prince Edward Island, in the specialty (including Family Medicine) to which they match (CaRMS, 2009).

IMGs from all over Canada compete for these ten positions. The percentage of IMGs matched to overall postgraduate positions in Canada is relatively low and ranges from 4.6% to 16.7% between 1999 and 2007 (CaRMS, 2009). For Nova Scotia and Canada to overcome the shortage of physician resources, there is a need to increase the capacity of medical schools and create more residency positions. The number of postgraduate residency positions should exceed the need of Canadian medical graduates to accommodate more IMGs in the system. This has been adopted with great success in the United States [US]. The US postgraduate medical education is coordinated on a federal level and provides flexibility in the system to open positions for both the US graduates and the IMG population (Dauphinee, 2005). As a result, the residency positions in the US exceed the demand for their US medical graduates (Dauphinee, 2005).

In Nova Scotia, it is recommended to increase the number of postgraduate residency positions to exceed the need of Canadian medical graduates in Dalhousie University and to enable the province to overcome the shortage of physicians. District Health Authorities and governments can collaborate to fund these positions partially. Another possible option is to create structured sponsorship residencies where IMGs are matched into specialty to fill vacancies in Nova Scotia. This has been successfully adopted in British Columbia [BC] through its structured IMG program (IMG-BC, 2009) Refer to Appendix F for further information of IMG-BC.

The Clinician Assessment for Practice Program [CAPP]

CAPP is a program run by the College of Physicians and Surgeons of Nova Scotia [CPSNS], and is designed for IMGs believed to be practice ready for entry into family practice without any additional formal residency training in Canada (CAPP, 2009). The program was initially created to provide medical services to underserved areas in NS and the successful candidates are required to sign a return of service contract in Nova Scotia (CAPP, 2009). The CAPP consists of three stages (CAPP, 2009):

- **Part A** is the initial assessment for “readiness to practice” by Therapeutic Examination and OSCE.
- **Part B** is a 13-month period of continuing professional development and continuous assessment by a physician mentor.
- **Part C** may extend up to three years for the candidate to pass examinations to obtain the Licentiate of the Medical Council of Canada [LMCC] and the certification of the College of Family Physicians of Canada [CFPC].

Refer to Appendix G for further information on the CAPP.

CAPP is a venue for a group of IMGs who have recent clinical experience outside of North America. According to key informants, only 20% of candidates move beyond part A of the assessment. Every year an average of 6 to 8 IMG candidates are deemed eligible for a defined license after completing the CAPP. There is no pass and fail mark for this assessment. The Credential Committee of the CPSNS is responsible for making the decision, which is based on the CAPP results and other documents provided by candidates. The decision making process lacks transparency and there is no appeal process. Although the program has helped some IMGs to practice as family physicians in NS, paying \$5,500 fee for this assessment is a burden on IMGs who frequently have limited financial resources primarily due to extended unemployment, underemployment, or lack of access to financial aids or loans. This burden is further amplified by the low chance of obtaining a defined license, the accumulated fees for other examinations and processes to be eligible for the CAPP, and the lack of any vehicle of “gap training” for unsuccessful borderline candidates.

After completing the CAPP assessment, all participants receive a detailed report of their performance in the assessment. While the report can be used to support application when applying to residency programs (CAPP, 2009), the report fails to provide any suitable clear future directions for candidates except those deemed eligible for a defined license. A comprehensive report with clear direction for future options is ultimately required to help IMGs understand the reality of their situation and the direction they need to take through the licensing pathway. Future options can include: eligibility for a defined license determined by the CPSNS, short term training required, full

residency recommended, medical school clerkship required, and an alternative career should be sought.

Another shortfall of the CAPP is lack of bridging programs. One third of IMGs participating require short term training to address areas of deficiency or weakness. Currently there is no structured program where IMGs have access to first hand clinical experience. For the CAPP candidate to move forward after their assessment, short term training in collaboration with the District Health Authorities [DHAs] and the Dalhousie Faculty of Medicine is necessary. As suggested by a key informant, a supervised 3-6 month rotations in a structured primary care practice could be well sufficient for an IMG to meet the CAPP standard. Continuous evaluation of participant IMGs will ensure that they achieve their objectives of overcoming the current experienced weaknesses. Setting aside residency positions for IMGs who undertake the CAPP and require more than one year of training is crucial.

Clinical Associate Positions CDHA

Physician Clinical Associate positions were originally created to fill clinical needs in the health system. These positions have been utilized by IMGs either as an alternative career or to gain some Canadian experience. Physician Clinical Associates work under the supervision of the attending specialists on service and aid in the care of inpatients and outpatients in the unit in which they work. The positions are offered currently in only a few fields and the majority of positions are in the Cardiology Department at Capital District Health Authority. Currently there are no Clinical Associate positions in the field of Family Medicine.

The clinical experience gained through working as a clinical associate is not considered academic experience because it does not follow medical teaching standards. Yet, these positions have been proven beneficial to IMGs as an opportunity to gain entry into the system. As a basic human resource technique, the position should be attached with a professional development component that will help IMGs to further develop their skills and advance in the field of medicine. The clinical associate physicians have proven to overcome the shortage of physicians.





This approach has been adopted by other provinces such as Ontario, which launched in 2008 a pilot project for IMGs, who passed all their Medical Council of Canada examinations and were unable to obtain residencies, to become Physician Assistants in hospitals and other health care settings (Magnus, 2008). IMGs who were involved in this pilot program were required to undergo a 9-step conversion that included four months of training (Magnus, 2008).

Clinical Associate positions are one of the valuable opportunities for the IMG population to work in a relevant field of practice, yet access to this opportunity and other employment opportunities is hampered by many systematic obstacles. The process of integrating IMGs is challenging and more work is still needed. The following section explores gaps in the system and provides dialogues on how to move the process forward in a fair and just manner.

Nova Scotia's Reality: Gaps

In addition to the gaps identified in the previous sections, there are major gaps in the NS licensure process which have not yet been addressed. Continuous evaluation and

commitment from all stakeholders will enable the system to create a just and fair process to benefit both the IMG population and the health care system.

Gaps in the IMGs journey to licensure in NS	
 Specialists' Route to Licensure	 Clinical Canadian Experience
 Basic Competency Assessment	 Financial Assistance

Specialists' Route to Licensure

Almost 50% of IMGs arriving in Nova Scotia are specialists who have over three years of experience. Lack of assessment for specialists is common all over Canada except in few provinces such as Manitoba, Ontario and Quebec. Refer to Appendix F for more information on the specialist routes in these provinces. Some specialists are more flexible than others in changing their fields of specialty. This will depend on the field specialty and the number of years of experience. In Nova Scotia, those interested in Family Medicine can undergo the CAPP to assess their eligibility for a defined license. However, not all IMG specialists are eligible. In addition, a few specialists IMGs are exempted from the long and unpredictable path of licensing including those who obtained their medical education from countries such as the US, UK, South Africa, New Zealand and Australia. For the unfortunate majority, there is no clear pathway in NS. Obtaining a license for a specialist IMG in NS is almost impossible.

One of the barriers faced by specialists IMGs, especially for the ones with more than 10 years of experience, is the requirement to undergo a basic medical knowledge examination such as the MCCQE I. Requesting an IMG specialist to undergo a basic examination is similar to asking a university graduate in spite of their field of study to undergo a basic knowledge assessment of high school subjects. For an IMG specialist it

might take a year or two to pass this exam. Time is crucial in the licensing process, because any IMGs with more than three years away from practice are not eligible for licensing and will fail to even match to postgraduate residency positions.

According to key informants, it is critical to create a clinical assessment for specialists shortly after their arrival in Canada with the collaboration of Dalhousie Faculty of Medicine, District Health Authorities and the government. The assessment period could range from 3 to 6 months. The assessment needs to be combined with a written or oral test in the field of specialty, similar to the Manitoba assessment of specialists (Non-Registered Specialist Assessment Program [NRSAP] (Manitoba, 2007). The assessment should be affiliated with the university and coordinated with the DHAs. The level of assessment should be based on the most advanced year of specialty residency program in Canada.

After the assessment, a key informant suggests that specialists deemed “practice ready” could be granted a defined license to work under the supervision of another specialist. Other candidates may need full residency or additional short term training. Specialists in this category could apply to either the first year of residency [PGY 1] or the second year of residency [PGY 2]. Both groups could be evaluated continuously and when performance proves to be higher than the standard of the year group, the IMG specialists should have the opportunity to advance more quickly through residency training.

Basic Clinical Assessment

Time is an important factor in the licensing journey, but systematic and administration barriers create clinical gaps for the IMG population and as result to lose some of their

clinical experience. To overcome that, there is a need for the creation of a timely assessment of IMGs clinical skills (Hall et al., 2004). Years can pass by before IMGs are able to complete all the required exams and as a result a significant gap in their clinical experience is created while preparing for the exams in Canada. The assessment process should start as soon as the IMG arrives in Canada after completing only the MCCCE. The assessment will provide IMGs the opportunity to demonstrate their competencies in a structured and professional format. Basic skills assessment should include direct observation of IMGs interactions with patients and comprise multiple assessments done by difficult examiners on a variety of patients' problems (Nair et al., 2008).

In Nova Scotia, there is a need for an affordable, comprehensive and accessible clinical assessment that has a broader scope than the CAPP. The assessment should provide IMGs with information on their strengths and weaknesses and provide a realistic evaluation of their chances for obtaining a license to practice in NS. Prior to the assessment it is critical to provide orientation and practice to enable IMGs to understand the assessment format and to clarify what is expected from candidates.

Clinical Canadian Experience

The lack of IMGs' exposure to the Canadian health care system and its structure creates an obstacle for this group to pass the medical qualifying exams. The MCC examinations are not designed to assess pure medical knowledge but rather the ability to use medical knowledge in clinical scenarios. Obtaining Canadian clinical experience is the key to improved success rates among IMGs to obtain a license to practice in their fields (Szafran et al., 2005; Wong & Lohfeld, 2008). IMGs need further orientation and training in social, structural, communication, and Evidence Based Medicine [EVM] to bring them to

the same level as their counterparts in Canadian medical schools (Wong & Lohfeld, 2008). Obtaining Canadian experience can be done on different levels: observer-ship, mentorship, and study groups.

- Observer-ship should be structured and open in all hospital departments, family physician practices and long term care facilities. Physicians can obtain recognition and/or remuneration for the roles they will play in introducing IMGs to the system and allow them to have first hand experience.
- Mentors as experienced physicians practicing in the system could aid IMGs in their journey and help them develop a study plan based on the IMG skills level. Formalized mentoring programs should be explored for facilitating the transition of IMGs into the medical practice (Lackyer et al., 2007; Wong & Lohfeld, 2008).
- Study groups organized jointly between IMGs and Canadian medical graduates would greatly assist both groups in learning. An example for this study group is the UK model (Anderson, Sykes & Fisher, 2007) (Appendix H). Developing the material for these groups such as case studies could be done and administered by postgraduate students who act as mentors for the study group. This will benefit this group to fulfill their mandate for teaching.

Financial Assistance

In NS there is barely any financial support for IMGs who are striving to obtain a license to practice medicine and at the same time must provide for their families. Their financial situation is further deteriorated by the lack of relevant employment opportunities available for the IMG population and the lack of uptake of IMGs by employers. The province along with the federal government and other national organization need to

create low interest loans, line of credits, and scholarships available for the IMG population. Also subsidizing fees can alleviate some of the financial barriers this group faces.

Other provinces such as Manitoba created programs to provide financial aid to their IMG population. In Manitoba, the Credential Recognition Program [CRP] is a provincial program that is designed to help immigrant professional with cost of licensing, upgrading courses, books and other fees associated with the licensing in Manitoba (Manitoba, 2007). CRP pays 50% of all eligible costs and up to a maximum of \$2,250 (Manitoba, 2007). Also the program offers wage subsidies to employers who hire immigrant professional for jobs to match their professional background. Registering for the program is free of charge (Manitoba, 2007) (Appendix F).

Planning and implementing processes that help integrate the relatively small group of IMGs in NS is perceived as a burden on a system that is already overwhelmed with financial, structural and human capacity issues to meet the needs of its population. This perception is challenged by the success of other provinces such as Manitoba that share the same characteristics of financial, structure and human capacity of NS. It is important to take immediate actions rather than wait for the number of IMGs to accumulate in this province.

Despite the complexity of issues involved in licensing IMGs, some initiatives have significantly improved their integration into the health care system and have provided us with materials for comparison and learning. Other provinces and countries have succeeded in some areas. Success is possible and should be sought along the way


while learning from experiences and shortfalls. Refer to Appendix F and H for further information on other provinces and international approaches.

Basic Principles

Whether examining the system or presenting recommendations for improving the IMG licensure process, basic principles should be fulfilled to ensure a fair outcome. Figure 1 in Appendix I presents all principles recommended by literature and key informants interviews for any IMG specific program. The following paragraphs provide further explanation of these principles.

- **Timely:** Programs should be offered as soon as possible to IMGs either before landing or shortly after arriving in Canada to eliminate any waste in time. IMGs licensure processes should undergo continuous evaluation to eliminate any unnecessary or redundant steps.
- **Affordable:** IMG specific programs should have realistic fees, which should be affordable by the main stream IMGs.
- **Accessible:** For programs to achieve its full potential it should be accessible by targeted audience of IMGs.
- **Practical:** IMG programs should have clear objectives and goals that are fully communicated to all stakeholders. This can be done by the standardization of processes on different levels and by eliminating redundancy. Programs should provide IMGs with resources to support their transition into practice rather than only plan to fill the clinical gap (Lacker et al., 2007).
- **Coordinated:** There is a need for a pan-Canadian multi-stakeholder physician resource planning mechanism to ensure the sustainability of any initiative and its

effectiveness (Busing, 2007; McGrath, 2004). Coordination would allow smoother integration and transition of IMGs within the health care system.

 **Flexible:** Programs should have the flexibility to fit the diverse needs of IMGs as “no one size shirt fits all”. Each IMG will need different sets of options and processes to fulfill in their licensure journey.

Nova Scotians IMGs have no different needs than other IMGs in other countries or provinces. The pathways need to be evaluated and there is a need for collaboration on all levels for an improved future for the healthcare system and better integration of the IMG population.

Recommendations

The failure of policy and the health care system to integrate the IMG population to the health care system has resulted in human and ethical tragedy. There is a significant waste of resources as a result of the underutilization of the skills and experiences of internationally trained physicians (Dauphinee, 2005). IMGs are not looking for exemptions from standards or shortcuts into the system. They require opportunities to be assessed, oriented, provided with additional training if necessary to fill specific gaps, and to be moved effectively into practice through a system that meets a set of rational criteria. The issues associated with integrating IMGs in Nova Scotia are associated with labour, immigration, education and health sectors at both the federal and provincial levels. The following recommendations are the outcome of the literature, key informant interviews and an explanation of pan Canadian and international approaches.

1. Create a Nova Scotia IMG program

IMG issues are not the responsibility of one party, all stakeholders and IMGs are part of the problem and the solutions. An IMG program would act as a “one-stop-shop” where IMGs and stakeholders could obtain information and resources related to IMGs licensure process. The program could coordinate the involvement of all stakeholders and would be funded provincially to improve the integration of IMGs in the health care system and the province’s recruitment and retention strategies, which would eventually serve to alleviate some of the pressure on the shortage of physician resources in NS. An IMG program would move the process forward to create effective strategies that close the gaps in the system.

As a preliminary step of the NS IMG Program, an IMG coordinator position needs to be created. That person should be accountable for facilitating the current resources and stakeholders’ engagement in improving the licensing process. As a first step, there is a need to create a resource guide document similar to the one available for IMGs in Manitoba (Manitoba, 2007). The document would outline the current pathways and the available resources that will aid IMGs who live or choose to move to NS and wish to work in the province.

2. Create channels that improves IMG’s exposure to the Canadian health care system:

Passing examinations, undergoing clinical assessment and working in Nova Scotia require understanding of how the system works. Any IMG interested in obtaining a license to practice medicine in NS needs to undergo an extensive orientation to the system. The recommended venues include observer-ship opportunities, mentorships and study groups. These should be created in addition to the available resources such as the

“Orientation to the Canadian Healthcare System and Professional Practice in NS for Internationally Educated Healthcare Professionals Course” and the “English for Health Care Professionals Course”.

Communication skills and language barriers have been one of the barriers that IMGs face. Communication skills can be improved by providing opportunities for assessment and practice to understand the system and the communication component of patient care and inter-professional relationships. Examples of the communication skills that IMGs need include negotiating treatment plans, end of life issues with patients and families, and conflict resolution (Hall et al., 2004).

- a. **Observer-ships** will allow IMGs to experience first hand the system structure, process and how it works. The observer-ships should be provided in a wide variety of fields of medicine to fulfill the diverse needs of IMGs. The development of a directory of physicians who show interest in aiding the IMG population and offer them an opportunity to observe their practice would be an excellent first step. As an incentive these physicians can take recognition for continued medical education credits or if capacity allows remuneration for their role.
- b. **Mentorship.** Mentors help IMGs in exam preparation, creating study plans and exposure to the Canadian health care system. Every IMG should be assigned to a physician mentor who will help develop a learning plan and determine future goals. The physician mentor can be the window through which the IMG can explore the Canadian health system.
- c. **Study groups** that include both IMGs and Canadian medical students. The structure and format of the study group would depend on the needs of both IMGs and the

Canadian medical students. It could start as a pilot project conducted twice a year with voluntary participation. Sessions could be planned one evening a week for 10 consecutive weeks. Participants could range from 10 to 20 and for each session are divided into small groups. The small groups can take roles in case study discussions as patients, examiners, and evaluators. These roles rotate among the groups. The cases are created by residents to fulfill their teaching requirement within the standards for accreditation of residency training programs (CFPC, 2006). Residents can be the tutors of the groups. They can supervise the small group discussions and provide final remarks on the cases discussed. The format of the study groups is an excellent opportunity for Canadian medical students to be exposed to diversity and global health issues. IMGs will benefit from the study groups in understanding the health system operation and help them in their preparation for examinations.

3. Provide Financial Assistance:

The financial burdens that face the IMG population can build further barrier for their ability to undergo examinations and assessment. Supporting this group financially in their journey for licensure is critical. This financial support can take place until the IMG finds meaningful and relevant employment. The financial aid can be through providing loans, scholarships, line of credits and subsidize their fees. Also financial incentives could be provided for employers who provide job opportunities for IMGs by subsidizing some of the fees paid by employers to integrate the IMG in to their workforce.

4. Create Competency Assessment:

When creating an assessment program, it is essential that administration and faculty in medical education programs understand cross-national medical training and practices (in

terms of differences and similarities) (Wong & Lohfeld, 2008). This will improve the efficacy of medical educational programs by bringing more depth to the assessment of the IMG's medical knowledge and bring more understanding of his/her clinical abilities and training needs (Wong & Lohfeld, 2008). Tutorial and clinical skills programs are essential in hospitals to help IMGs adapt to the new environment and prepare better for their examinations (Couser, 2007). Couser (2007) recommends 12 tips to guide educators to develop programs targeted for IMGs (Appendix J).

In Nova Scotia there is a need for a competency assessment that is targeted to identify the level of clinical skills of IMGs as soon as they arrive in Nova Scotia to enable them to demonstrate their clinical skills and understand their position in the licensing pathways. The competency assessments should be flexible and practical to address the diverse needs of IMGs including new graduate IMGs, experienced physicians with more than three years of experience in either Family Medicine or other specialty. Each of these groups has different needs and should be provided with a special designed assessment format.

- a. **Basic Clinical Skills Assessment:** The assessment should start as soon as the IMG arrives in Canada and should only require the IMG to pass the MCCEE and be able to communicate effectively in English with a suggested CLB of 7. To speed up the process, it is important to advise all IMGs to undergo MCCEE before arriving in Canada and improve their English skills as well. The assessment should provide IMGs with realistic outcomes and expectations of their journey to licensure in NS.
- b. **Specialty Assessment:** This assessment is targeted for IMGs who have more than three years of experience in a field of medicine. Under this category, assessment

should be designed for each individual field of medicine. Currently in Nova Scotia there is a competency assessment for Family Physicians [CAPP]. A specialists' route is a major gap and needs to be created as soon as possible. Learning from other provinces' experiences such as Manitoba and Ontario will aid and speed up the process of licensing IMG specialists. The suggested assessment period varies from 3 to 6 months and up to 12 months in some specialties. After the assessment if the IMG is deemed "practice ready" a defined license is granted. If the candidate requires short term training of one year or less, the short term training should be provided with collaboration between DHAs, and the Dalhousie Postgraduate Medical Education and Continuing Medical Education. The candidates who need more than one year of experience would be given residency positions starting in the first year or in an advanced year of postgraduate training. Periodic evaluation of the IMG throughout their residency will determine their levels of competency and may allow the IMG to move faster and complete their training faster than their Canadian counterparts.

5. Create short term training opportunities

These positions are important to IMGs who only require a maximum of one year training to be able to practice in Canada. The short term training is identified through assessment of their clinical skills in their field. The short term training positions should be provided in collaboration with government, DHAs, and Dalhousie Medical School including Postgraduate Education, Continuing Medical Education and Undergraduate Education. The short term training can be conducted in a site identified for IMG training similar to St. Paul's Hospital in BC (Appendix F). The site does not have to be a university

affiliated site but the training structure should be able to overcome the weaknesses identified in the IMG performance at their assessment.

6. Modify Med III Clerkship Program requirements

The current requirements for this program are adding unnecessary barriers for IMGs interested in this program. If basic clinical skills assessment is created it can be the requirement for admission to Med III Clerkship Program. If this is not yet created, IMG candidates can be treated similar to the International students admitted to the third year medical school and the three months programs they undergo (Appendix E) should be recommended for the IMG group too.

7. Conduct a Survey for IMGs in the Province to understand their issues

Conducting a survey to better understand the barriers faced by IMGs will help build a system that eliminates barriers and decrease difficulties. The survey could be conducted through in-person interviews, mail-outs, electronically, or phone interviews. Questions should target both the group of IMGs who were successful in obtaining a license to practice in their field and the unsuccessful group of IMGs who despite their attempts failed to obtain the license. Both groups will provide important information to policy makers and stakeholders to improve the process and address shortfalls (Refer to Appendix K for a survey sample).

Conclusion

The complexity of the multitude of parameters associated with the IMG licensing process makes the process and challenging for both IMGs and stakeholders. The burdens on IMGs are visible in their ongoing struggles to obtain licensure and in the small percentage of IMGs who make it through successfully. Despite the complex challenges

associated with IMG licensure, introducing more IMGs into the health care system is clearly essential to ensure its sustainability (Busing, 2007). Although some progress has been made in Nova Scotia, there remains much work to be done before a fair, equitable and transparent process is in place to support the integration of IMGs into the health care system of the province.



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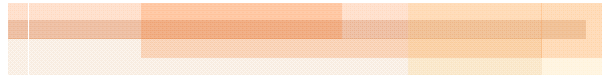
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Appendix

Key Informants

List of Key Informants Interviewed for this project:

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Nova Scotia Department of Health

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Associate Professor
Department of Family Medicine
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Dr. William Lowe

Deputy Registrar, Registration
College of Physicians and Surgeons of Nova Scotia

Jan Sheppard Kutcher MA, MSW




















Employment Services Manager
Metropolitan Immigrant Settlement Association

Dr. Douglas Sinclair MD, CCFP (EM), FRCPC

Associate Dean of Continuing Medical Education
Chair, IMG Work Group
Faculty of Medicine
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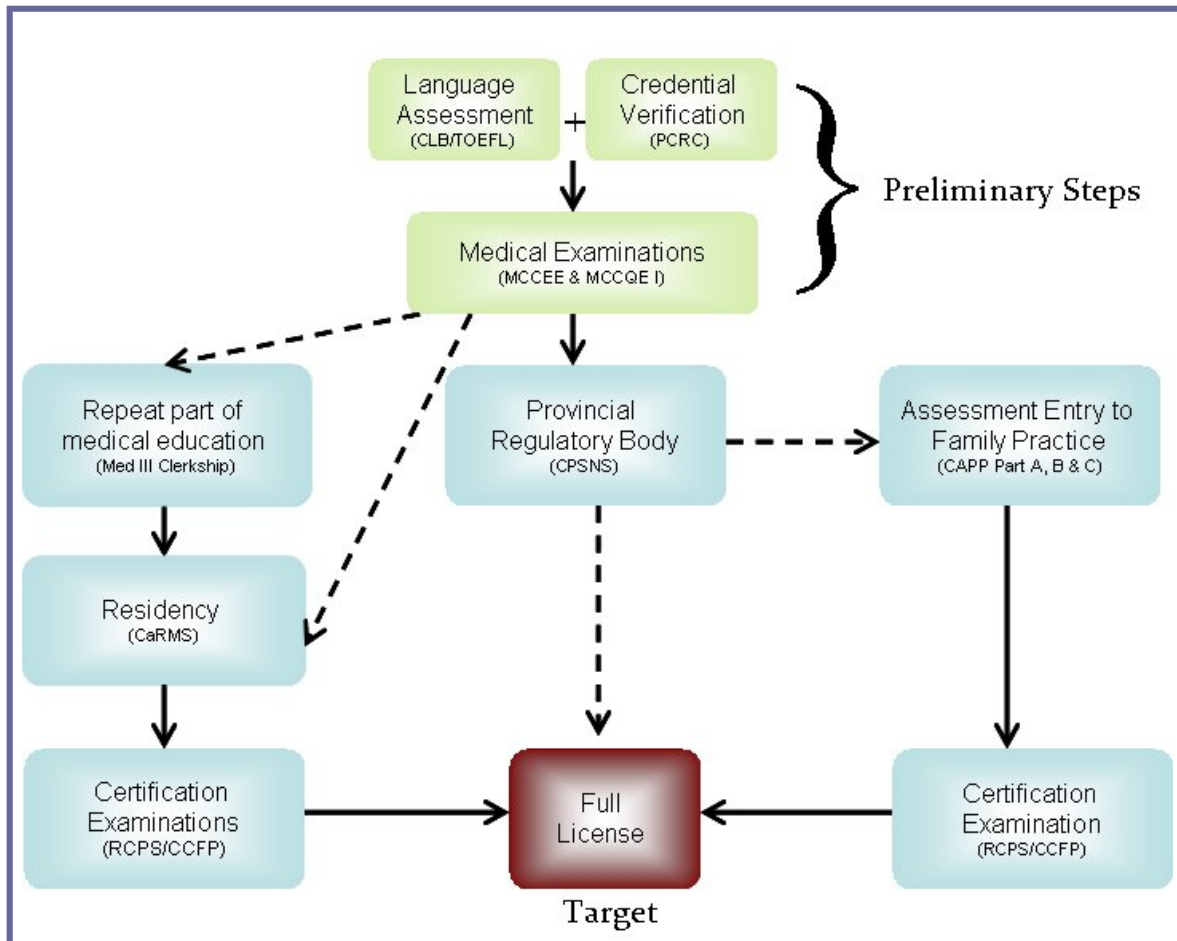


Appendix A: Barriers Experienced By IMGs

Barriers Experienced By IMGs	
<ul style="list-style-type: none">  Significant lack of co-ordination between national Canadian immigration policies and provincial doctor licensing policies  No single source of information that IMGs can use to assist them in their journey for licensing  Lack of understanding of the Canadian health system  Insufficient orientation to the health system  Failure to provide fair and sufficient opportunities for assessment  Social and professional challenges  licensing barriers to practice  Communication skills (diagnostic emphasis, medication names and availability, medical literature and reference materials (local medical culture))  Lack of support faculty members, peer support and other physicians 	<ul style="list-style-type: none">  Communication, language and cultural difficulties  Financial barriers  lack of feedback  Small numbers of IMG residency positions  Ambiguous selection criteria  Disorientation associated with personal and professional loss  Personal losses include loss of personal identification, belonging, financial autonomy, and ability to fulfill familial roles  Difficulties in understanding expected roles and responsibilities within the medical hierarchy  Failure to address issues related to acculturation and to develop tacit aspects of clinical practice in new locales to help physicians better adapt  One day assessments fails to provide a full picture of the IMG competencies

Sources: (Couser, 2007; Hall et al., 2004; Heal & Jacobs, 2005; Hoekje, 2007; Lockyer et al., 2007; McGrath, 2004; Narasimhan, Ranchord & Weatherall, 2006; Szafran et al., 2005; Wong & Lohfeld, 2008)

Appendix B: Pathways to Licensure in Nova Scotia

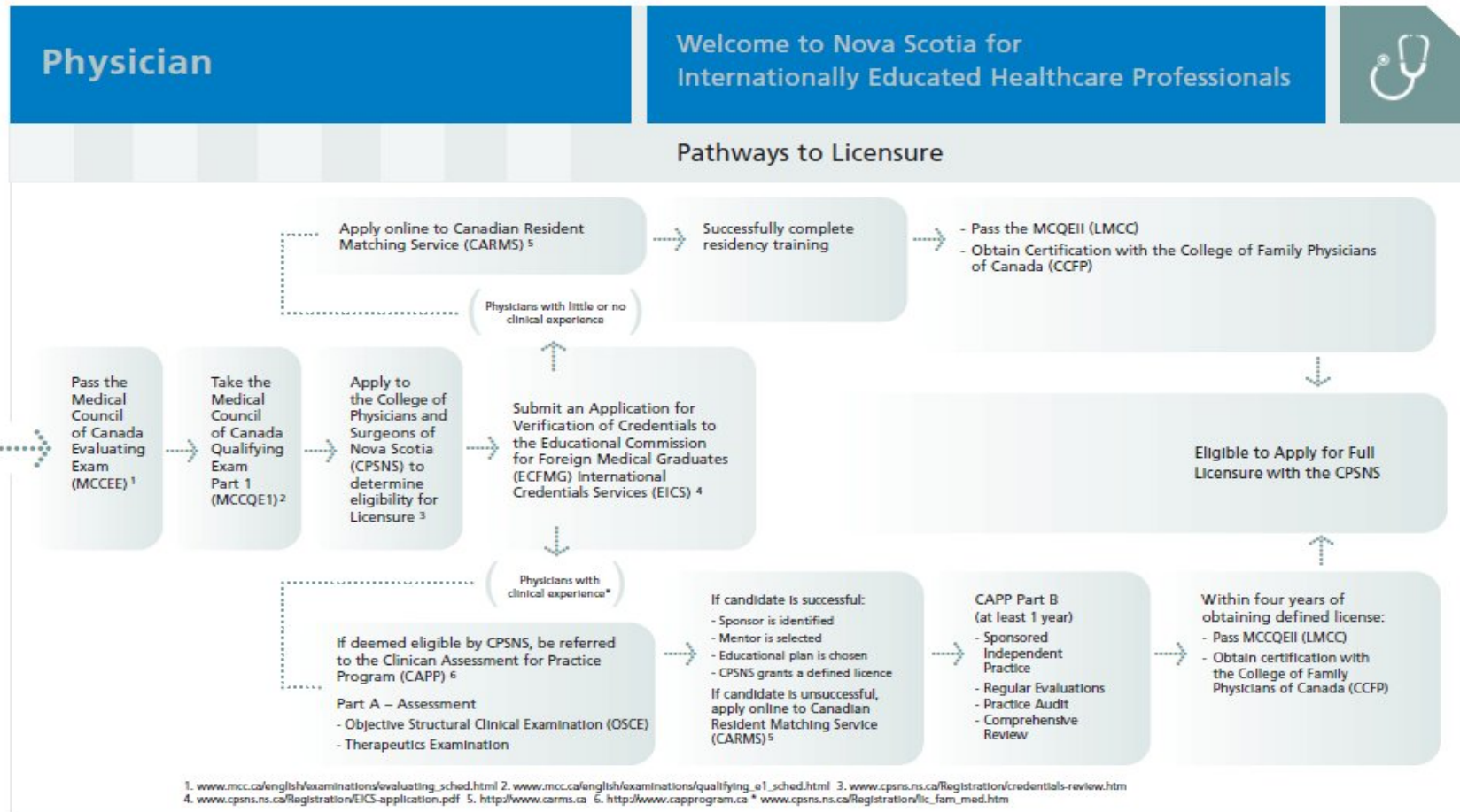


Source: modified version of MISA's pathways (MISA, 2009) to licensure in Nova Scotia

Appendix C: Key Organizations and Stakeholders in the NS Licensing Process

Education & Training	Accreditation	Royal College of Physicians and Surgeons of Canada [RCPSC] College of Family Physicians of Canada [CFPC]
	Delivery	Dalhousie University, Faculty of Medicine
	Training Coordination	Canadian Resident Matching Service [CaRMS]
Licensure	Examining Body	Medical Council of Canada [MCC]
	Certification	College of Physicians and Surgeons of Nova Scotia [CPSNS]
	Approved Training Listings	WHO World Directory of Medical Schools FAIMER International Medical Education Directory (IMED)
	Source Verification	Physician Credentials Registry of Canada [PCRC]
Practice	Government Departments	Nova Scotia Department of Health Health Canada Citizenship and Immigration Canada NS Office of Immigration Human Resources and Social Development Canada [HRSDC]
	Recruitment services	Nova Scotia District Health Authorities
Support	Organization to support immigrants	Metropolitan Immigrant Settlement Association [MISA] Halifax Immigrant Learning Centre [HILC]
	Think Tank	IMG Working Group
	Interest Group	Association of International Physicians and Surgeons of Nova Scotia [AIPS NS]

Appendix D: Pathways to Licensure in Nova Scotia



Source: (MISA, 2009b)

Appendix E: IMU Program - Dalhousie University Link Program for IMU Students

Dalhousie University is a Partner Medical School (PMS) with the International Medical University in Malaysia. Each year Dalhousie accepts 4-8 students from the IMU to Dalhousie University, Faculty of Medicine to complete their third and fourth years of the MD program. Upon successful completion IMU students receive the MD degree from Dalhousie University.

Prior to beginning the clerkship years, the students are required to participate and complete the LINK PROGRAM, a comprehensive bridging program that provides them with the core clinical skills and practice sessions as taught throughout the first and second year program at Dalhousie. This program is designed to help the students to practice history and physical examinations, become familiar with the hospital and health care systems in which they will be working. The ultimate goal of the Link Program is to ensure these international students are entering the clerkship at an equivalent level compared to Dalhousie students.

The components of the Link Program include:

Month 1:

- Communication Skills Training
- Skills and Procedures
- Psychiatry clinical sessions
- Pediatric clinical skills
- Patient Doctor systems review session
- Objective Structured Clinical examination

Month 2:

4 weeks ward experience within the Internal Medicine department with a senior faculty member

Month 3:

- return to the Learning Resource Centre for additional practice sessions for histories and physicals
- Case Practice sessions based on self evaluation of skills
- Gynecology and Male Genital workshops
- Final OSCE for evaluation of strengths and weaknesses

Source: (Faculty of Medicine, 2009b)

British Columbia

The International Medical Graduate of British Columbia Program [IMG-BC].

IMGs living in BC can apply to residency programs through either CaRMS match or through IMG-BC

The program is funded by the provincial government

It is designed to help IMGs obtain postgraduate training that will eventually lead to licensing to practice medicine in Canada.

The program is based at St. Paul's Hospital in Vancouver, which is an acute care, academic and research hospital.

Candidates are required to pass both the MCCEE and MCCQE I.

The candidate undergoes an evaluation that includes 11 OSCE stations, followed by a 1 week orientation and a 12 week clinical assessment.

Candidates are selected based on their overall performance in the assessment.

Fee for applying for this program is \$150

Salary of \$500/month for the 12 weeks clinical assessment offered to the candidate

There are 18 residency positions funded by the BC government (12 positions in Family Medicine and 6 are specialists which may include Internal Medicine, General Surgery, Psychiatry, Obstetrics/Gynecology, Laboratory Medicine/ Pathology, Anesthesia and Pediatrics.

(IMG, 2009a; IMG-BC, 2009)

Ontario

Health Force Ontario (Access Centre)

Funded by the government of Ontario.

One stop shop for all international educated health professionals and majority of them are IMGs

Provides one-in-one appointments, information sessions, and study groups.

Centre for the Evaluation of Health Professionals Educated Abroad (CEHPEA)

A non-profit organization that used to be called IMG-Ontario

Part of the Ministry of Health and Long Term Care of Ontario's

Designed to expand and enhance services provided in Ontario to internationally educated health professionals

Provincial body responsible for assessing IMGs for acceptance into postgraduate training programs.

200 training and assessment positions annually for IMGs

Despite the recent increase in IMG training positions in Ontario from 50 to 200, IMGs still are unable to obtain opportunities for residency. This suggests that substantial barriers still exist.

Practice Ready Route

Offered by CEPHEA created

Fast-track 6 months assessment

Assesses the clinical abilities of IMGs in teaching hospitals

Successful candidates are granted a provincial licensed in under-serviced areas

Pre-entry Assessment Program (PEAP)

Designed for externally funded IMGs at the University of Ottawa

To assist IMGs in improving communication skills such as to negotiate treatment plans with patients, breaking bad news, discussing DNR and end of life issues with patients and families, ethical and legal issues.

Physician Assistants

Launched as a pilot project in 2008

IMGs who passed all their MCC examinations and were unable to obtain residencies can take this chance to work in hospitals and other health care settings as a viable career path

Among the 59 people hired as physician assistants, there are 39 IMGs in four areas.

IMGs who involved in this pilot programs were required to undergo a 9-step conversion that includes four months of training.

Source: (CEPHEA, 2009; Hall et al., 2004; Health Force Ontario, 2009; Magnus, 2008; Wong & Lohfeld, 2008)

Manitoba

The Credential Recognition Program [CRP]

Operated by the Government of Manitoba, Labour & Immigration Manitoba.
Designed to help immigrant professional with cost of licensing, upgrading courses, books and other fees associated with the licensing in Manitoba
Pays 50% of all eligible costs and up to a maximum of \$2,250
The program offers wage subsidies to employers who hire immigrant professional for jobs to match their professional background.
Registering for the program is free of charge.

Physician Resource Coordination Office [PRCO]

Established in 2005
Non-profit site funded by Manitoba government to coordinate the recruitment of physicians on behalf of Manitoba's employers.
Requires passing the MCCEE
Candidates undergo a pre-screening interview if they are deemed eligible for a defined license in the province.
The interview is designed to determine the suitability of the IMG to practice in rural or northern practice as primary care providers.
PRCO arranges the process and provides the eligible IMG with a job offer.

Medical Licensure Program for International Medical Graduates (MLPIMG)

Assists internationally trained physicians to obtain licensure to practice in Manitoba.
Offered by the Faculty of Medicine, University of Manitoba and is supported by the University of Manitoba, the College of Physicians and Surgeons of Manitoba [CPSM], and Manitoba Health.
Manitoba Government is currently funding up to 15 positions annually.
Manitoba Health covers the cost of the CAPE evaluation and enhanced training.
The employer covers the candidate's salary during the training period.
Candidates should have a minimum of one year of postgraduate medical training practiced mostly in general practice.
Candidates are required to pass the MCCEE, but preference is given to MCCQE Part I & MCCQE Part II.
Assessment Process consist of:

- Preparation and pre-assessment (lasts 3 days).
- Clinician's Assessment and Professional Enhancement [CAPE] (lasts 3 days) and includes MCQs, short-answer therapeutics assessment, a structured oral interview, and simulated patient encounters.

If necessary, candidates are given up to one year of Enhanced Training. At the end of this time candidate who successfully finishes the program are given a license to practice in Manitoba.

Manitoba cont...

Assessment for Entry into Family Practice (rural Manitoba)

Created at end of 2006

Assessment of IMGs readiness to practice as family physicians in Manitoba. MCCEE and the pre-screening interview through PRCO are pre-requirements. Manitoba government funds up to 10 assessments, 4 times a year.

Capacity of up to 40 assessments/year

Hiring institution and Manitoba Health cover the costs of assessment.

Assessment process includes:

- 2.5 day of orientation session
- Family Practice Assessment (FPA) for 3 days (MCQs, short-answer therapeutics assessment, a structured oral interview, and simulated patient encounters).
- Clinical Field Assessment (CFA) over 3 months.

The candidate is either granted a defined license, provided with short term training to overcome the gap, is advised to have a full residency through CaRMS application or is advised to seek an alternative career.

Non-Registered Specialist Assessment Program (NRSAP)

Organizes and facilitates clinical assessments of specialist IMGs.

Standardize assessments for each specialty carried out in a fair and unbiased manner.

3 to 12 months assessment period, but may vary in length between specialties and is determined by individual departments.

Most departments require a 3 to 6-month period.

Assessment includes evaluation of clinical knowledge, skills, and attitudes.

The assessment costs are covered usually by the institution that will hire the person. Salary will be given to the candidate during the assessment period, which cannot be less than that of a postgraduate resident in the fifth year.

Registered Clinical Assistant (Non-Certified) (RCA)

An option for IMGs who are interested in working as clinical assistants.

Clinical assistants are health care providers who practice medicine under direct supervision of a physician to support physicians in their roles.

IMG interested in this position should have a degree in medicine from a faculty of medicine acceptable to the Council and must undergo examination to ensure their competencies in working as clinical assistants.

Source: (CaRMS, 2009; Manitoba, 2007)

Alberta

Alberta International Medical Graduate Program [AIMG]

Provides access to a defined number of residency positions.

Program is funded by the Alberta government

Application fee for this program is \$100 per discipline.

Applicants are required to pass the MCCQE I before applying.

The program assesses IMGs knowledge, skills and behaviors and provides them with orientation to prepare IMGs for the residency program.

The interviews are conducted by the program similar to the process conducted in CaRMS match.

Medical Communication Assessment Program [M-CAP]

Designed to help IMGs to improve their language proficiency, communication skills and cultural understanding for entry into practice.

The program is delivered by Alberta Employment and Immigration [AEI] in conjunction with Citizenship and Immigration Canada [CIC].

The program is held over a 16-week period.

Prepares IMGs for OSCE, Medical Council of Canada Examinations and for residency programs.

Program uses language instructors, standardized clinical case scenarios, physician feedback, and standardized patients (professional actors) to create authentic and dynamic communication situations relevant to the practice of medicine.

Weekly template of in-class preparation activities, coached role-plays, individual video-taped performances on rehearsed medical cases, daily feedback and self reflection, and a final video-taped performance for each participant on unrehearsed medical cases, organized in a hierarchy of increasing communicative complexity.

Total of 16 weeks.

- Weeks 1 to 8 include an in-class language and communication training component.
- Weeks 9 to 16 include a practicum placement with a licensed physician.

Each participant receives an honorarium for full participation in the program to assist with associated participation costs. The honorarium is \$500/month for a total of \$2000 for the 16-week program.

Source: (AIMG, 2009; M-CAP, 2009).

Quebec

Information Sessions

Delivered to IMGs by the Collège des médecins du Québec [CMQ] and the ministère de l'Immigration et des Communautés culturelles (MICC).

Recrutement Santé Québec [RSQ]

An independent entity that is a portal of entry for all IMGs (outside Canada and US) and it helps to find an establishment in a region that has needs in family medicine or specialty and would like to sponsor the candidate.

Restrictive license in Quebec:

The process has 10 steps.

Requires the IMG to be registered with RSQ

Verify the medical credentials.

Required to pass the French language examination of the Office de la langue française [OQLF] and pass on any of the following MCCEE, Standard Certificate of the ECFMG, or USMLE Step 2.

Successfully complete an evaluation period (usually 3 months, preceded usually with 1 week observation) affiliated with a university and accredited by the CMQ. Performance during the assessment is compared with a resident in the last year of residency training

During the assessment the candidate is required to have professional liability insurance.

Candidate is required to attend one of the ALDO-Québec educational activities which cover the legal, ethical and organizational aspects of medical practice in Québec.

Assessment is preceded usually with a one week observation.

Source: (CMQ, 2009; RSQ, 2009)

Newfoundland & Labrador

Clinical Skills Assessment and Training Program [CSAT]

Created in 1997 by the Faculty of Medicine of Memorial University.

Designed to assess IMGs core knowledge, skills and competencies in Family Medicine settings.

The policy guidelines of the program are provided by the Faculty of Medicine, College of Physicians and Surgeons of Newfoundland and Labrador, Newfoundland and Labrador Medical Association, and Newfoundland and Labrador Health Boards Association.

There is also an academic advisory committee that provides guidance in the academic matters within the program.

The program is designed on an individual basis and the date of the assessment is based on an agreement between the candidate and the CSAT Program.

The program has the capacity to provide an average of 4 individual assessments per month.

The assessment includes MCQs, therapeutic assessment, structured interview, and standardized patient encounters.

Provides individualized training and then evaluates the effectiveness of the training.

The training is attached with a return of service agreement.

There are four assessment examinations, two each day for two consecutive days.

The assessment fees are \$3,500 and the training fees are \$600 per week for prescribed training to a maximum of 25 weeks. Re-assessment fees are \$1,500 for the candidates who are required to undergo the assessment.

Access to this program is through the College of Physicians and Surgeons of Newfoundland and Labrador.

A comprehensive report is sent to candidates and it outlines their strengths and weaknesses.

Training is only provided if there is a gap in knowledge, skills and competencies that can be addresses through a one-on-one prescribed training program of six months duration or less.

The province also provides special postgraduate residency positions funded by the government for candidates who undergo the assessment.

Source: (CIC-IMG, 2009b)

Appendix G: The Clinician Assessment for Practice Program [CAPP]

The Clinician Assessment for Practice Program [CAPP] consists of three components:

- Part A assesses the candidate's competency for readiness to practice through evaluation of the candidate clinical skills, diagnosis and problem definition, clinical reasoning and decision making, investigation and management, professional behavior, and communication skills. This part consists of Therapeutics Examination and Objective Structured Clinical Examination [OSCE].
- Part B is intended for candidates who are deemed ready to practice and are granted a defined license in NS. The candidates will receive a 13-month program of continuing professional development, ongoing support, guidance and evaluation by a physician-mentor, and in-depth assessment of the candidate practice at six and ten months. The Credential Committee of the CPSNS reviews all relevant information and makes a decision on whether the defined license should continue, and whether a formal mentorship is still required.
- Part C starts after the end of the initial year of defined licensure and may extend up to three years. During that time, the candidate is expected to pass a set of examinations to obtain the Licentiate of the Medical Council of Canada [LMCC] and certification by the College of Family Physicians of Canada [CFPC].

Source: (CAPP, 2009)

International Experience

United States

Responsibility of health and education falls to the state governments rather than the federal government.

Process of integrating IMGs is coordinated at the federal level.

License to practice requires residency training.

IMGs are required to undergo an assessment of their knowledge and clinical skills through the credential verification process and examinations through the Educational Commission for Foreign Medical Graduates [ECFMG]

Examinations are a combination of clinical and MCQs.

First sets of examinations precede migration.

To enable the United States to provide enough opportunities to IMGs, the postgraduate training positions exceed the demand to train US medical school graduates.

Encourage and support IMGs to take on the role of physician-scientists.

Sources : (Boulet et al., 2006; Dauphinee, 2005; Vidyasagar, 2007)

New Zealand

34% of physicians practicing are IMGs

IMGs are required to sit both written and oral examination and pass the English examination.

Created a specific program to prepare IMGs for the New Zealand registration examination (NZREX)

Sources: (Narasimhan, Ranchord & Weatherall, 2006)

Australia

There is no national approach to support the integration of IMGs in the Australian health care system.

Since 1978, the Australian Medical Council (AMC) has conducted clinical examination to assess IMGs.

Successful candidates undergo a 12 months of supervised practice before obtaining full registration.

2 day pre-examination courses

- Offered by the Royal Australian College of General Practitioners [RACGP]
- To prepare IMGs to take the RACGP examination.

Peer support group

- Funded by Mackay Division of General Practice (MDGP)
- 3 month pilot program in 2004.
- The group meets six time every two weeks
- Identify issues that IMGs in Mackay consider important in their social and academic wellbeing, to address some of these issues, and to provide peer support.
- IMGs involved in this program gave positive feedback on its effectiveness and recommended the creation of such groups in the future.

Pre-employment assessment

- A pilot assessment
- Funded by the state government in Victorian hospitals
- Designed for IMGs to meet safe practice standards, standardized and comprehensive pre-employment assessment
- Followed by a year of supervision, oversight of practice and/or mentorship.
- The assessment compromised a standardized interview, online written test and clinical skills assessment.

Tutorial program and clinical workshops

- Created by the Tasmania Hospital
- IMGs in this hospital are required to undertake the program.
- The program is imbedded in the hospital's orientation and continuing education program.
- No competency assessment component attached to the program.
- Can assist IMGs in preparation for the Australian Medical Council clinical exams.

6-week pre-employment training program

- Similar to that of trainee interns.
- May address professional knowledge, patient management, and communication issues.

Mini clinical exercise [Mini-CEX]

- Developed by the American Board of Internal Medicine and implemented in Australia
- to overcome issues associated with the difficulties in assessing competency and clinical skills
- Involves direct observation of trainee performance in a focused clinical encounter and is followed by immediate feedback.
- Skills assessed include medical interviewing, physical examination, professional/humanistic qualities, counseling, clinical judgment, organization / efficiency and overall clinical competence.
- Ratings are based on a nine-point scale, (where 1-3 signified unsatisfactory performance, 4-6 satisfactory performance, and 7-9 superior performance at a level equivalent to mid-postgraduate year 1)
- Examiners are asked to summaries their judgment whether the candidate has met expectations, borderline or did not meet expectations.
- Assessment includes four stations in emergency medicine (two examinations, one history taking and one counseling), three in medicine (one history taking, one management and one counseling), and three in surgery (two examination and one management).

Examination Preparation Course

- Created by the Postgraduate Medical Council of South Australia (PMCSA).
- Funded by both the government and self funded too.
- Designed to support IMGs in cultural and medical communication skill, MCQs tutorial program, ready for work program, hospital tutorials, OSCE practice exam, clinical bridging program, and study groups.
- Participants in this program showed higher pass rate of AMC examinations.

Sources: (Couser, 2007; Hart & Vernon-Roberts, 2005; Heal & Jacobs, 2005; McGrath, 2004; Nair et al., 2008; Narasimhan, Ranchord & Weatherall, 2006)

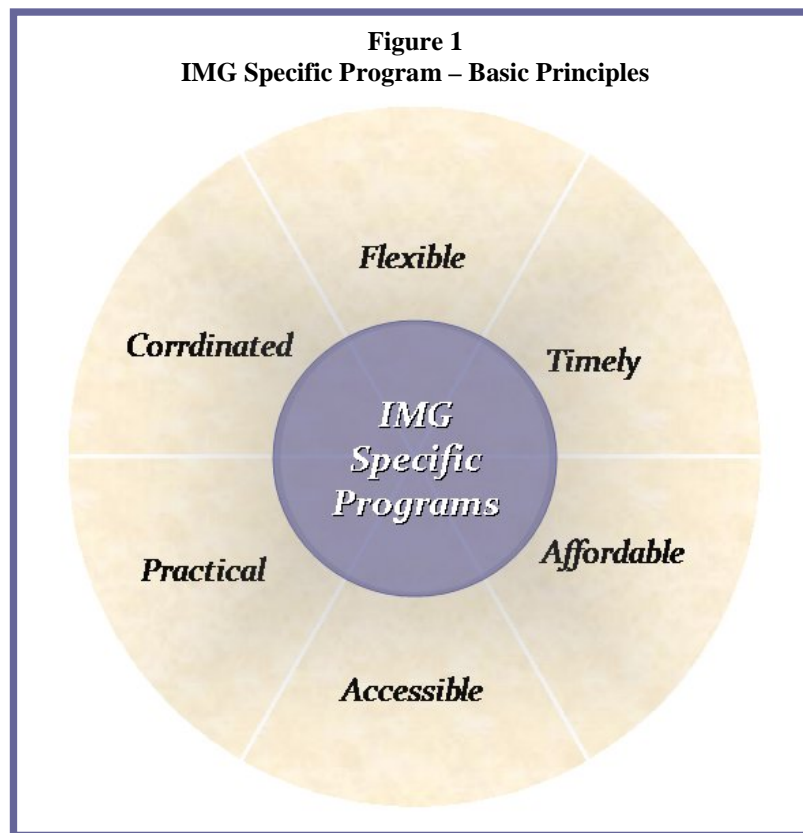
United Kingdom

REACHE

- Education centre for refugee and asylum seeker health care professional.
- Assist IMGs re-qualification and entry into the UK National Health Services.
- Offers English language classes, medical knowledge and skills update, help with cultural adaptation for the workplace and assistance with job finding and interview skills.
- Centre devised a program that brings medical students and refugee doctors together one evening per week to prepare for OSCEs.
- Attendance to this program is voluntary
- 6 to 20 participants divided into small groups
- Groups take turns to role play as the examination candidate, the patient or the examiner.
- Tutors circulate in the room to ensure that groups run smoothly and to identify learning points to be fed back to the class.
- Social and educational benefits obtained by medical students include:
 - Greater understanding of different cultures in how it affects the practice of medicine
 - Greater understanding of issues associated with the difficulties faced by the immigrant and refugee group
 - Greater awareness of the value of opportunities to practice clinical and communication skills and value of exchange of skills and knowledge
 - Two ways learning
- Refugee physicians obtained the following benefits:
 - Improve English language skills especially in terms of understanding idioms and slang terms, and enhanced ability to conduct a professional consultation in English
 - Improve understanding of the physician-patient relationship
 - Increase confidence and social support of the UK system

Source: (Anderson, Sykes & Fisher, 2007)

Appendix I: Figure 1 - IMG Specific Program – Basic Principles



Source: (Principles derived from literature, key informants and pan-Canadian and International experiences)

Appendix J: 12 Tips to Develop Programs Targeted for IMGs

Couser (2007) recommends the following 12 tips to guide educators in developing programs targeted to support IMGs:

1. Understand the program participants (demographics, different training schemes, different disease profiles, different clinical practice models)
2. Have a defined mission statement for the program (provide clinical and practical support and training, build trust)
3. Acknowledge and build upon prior learning and experience (IMGs will enrich the culture of the job and communities they serve)
4. Understand cross-cultural learning styles (i.e. interactive group learning, passive receivers of information).
5. Understand and integrate the registration, educational, immigration and accreditation requirements of participants in your jurisdiction
6. Provide relevant and applicable training (Flexibility in its delivery i.e. in person or online modules, or using a mentor system).
7. Relate activities to safety and quality (e.g. early notification of senior staff, working in interdisciplinary teams, and creating a culture of support)
8. Be able to rapidly respond to local needs and changing requirements
9. Engage with existing staff and programs (make friends, not enemies)
10. Provide incentives for participants
11. Provide consistent and accessible information (developing a working database of participants, a regular newsletter for clinical updates and advertise upcoming tutorials and courses both electronic and paper formats, a web-page)
12. Look after the IMGs families

Source: (Couser, 2007)

Appendix K: IMG Survey

Suggested questions are similar to a survey conducted by Wong and Lohfeld (2008), which include:

- How would you describe what it is like to be an IMG?
- What is your experience of being an IMG from a professional point of view?
- How does/did our Canadian training compare with your previous training?
- What were the challenges and what were the positive aspects of your Canadian training?
- What do you think of the process of re-training IMGs?

Other questions should be added for screening issues related to the unsuccessful group and what would have to be done differently for this group to be successful in obtaining a license to practice medicine in Canada.

Source: (Wong & Lohfeld, 2008)

Appendix L: Abbreviations










AIPS NS	Association of International Physicians and Surgeons of Nova Scotia
CLB	Canadian Language Benchmarks
CAPE	Clinician's Assessment and Professional Enhancement
CAPP	Clinicians Assessment for Practice Program
CaRMS	Canadian Resident Matching Service
CFPC	College of Family Physicians of Canada
CPSNS	College of Physicians and Surgeons of Nova Scotia
CSAT	Clinical Assessment and Training Porgram
HILC	Halifax Immigrant Leaning Centre
IMGs	International Medical Graduates
MCC	Medical Council of Canada
MCCEE	Medical Council of Canada Evaluating Examination
MCCQE I	Medical Council of Canada Qualifying Examination Part I
MCCQE II	Medical Council of Canada Qualifying Examination Part II
MISA	Metropolitan Immigrant Settlement Association
OSCE	Objective Structured Clinical Examination
RCPSC	Royal College of Physicians and Surgeons of Canada
RN-PDC	Registered Nurses Professional Development Centre
TOEFL	Test of English as a Foreign Language

Appendix M: Key Organizations and Stakeholders in NS

Royal College of Physicians and Surgeons of Canada [RCPSOC]

<http://rcpsc.medical.org/>

The Royal College of Physicians and Surgeons of Canada (RCPSOC) is a national, nonprofit organization established in 1929 by a special Act of Parliament to oversee the medical education of specialists in Canada. The work of the College centers around its prime objective — to ensure the highest possible standards of specialist training and specialist care for the people of Canada. The Royal College:




-  prescribes the requirements for specialty education in 61 areas of medical, surgical and laboratory medicine including 2 special programs
-  accredits specialty residency programs
-  assesses the acceptability of residents' education and training
-  conducts certifying examinations (except in Quebec where it shares this responsibility with the Collège des médecins du Québec)
-  assures a high standard of specialist care through its Maintenance of Certification Program
-  promotes high standards of professional and ethical conduct among its members
-  upholds professional development and lifelong learning
-  advocates for and supports the development of sound health policy
-  provides management support to national specialty societies

College of Family Physicians of Canada [CFPC]

<http://www.cfpc.ca/English/cfpc/about%20us/mission/default.asp?s=1>

The College of Family Physicians of Canada is a national voluntary organization of family physicians that makes continuing medical education of its members mandatory. The College strives to improve the health of Canadians by promoting high standards of medical education and care in family practice, by contributing to public understanding of healthful living, by supporting ready access to family physician services, and by encouraging research and disseminating knowledge about family medicine.

As the voice of family medicine in Canada, The CFPC will:

-  champion quality health care for all people in Canada,
-  support its members in providing quality patient care through education, research and the promotion of best practices, and
-  ensure that the role of the family physician is well understood and widely valued.

Canadian Resident Matching Service [CaRMS]

www.carms.ca



CaRMS - The Canadian Resident Matching Service is a not-for-profit organization that works in close cooperation with the medical education community, medical schools and students, to provide an electronic application service and a computer match for entry into postgraduate medical training throughout Canada. CaRMS provides an orderly and

transparent way for applicants to decide where to train and for program directors to decide which applicants they wish to enroll in postgraduate medical training.







Medical Council of Canada [MCC]

www.mcc.ca

With the Key Stakeholders, the Medical Council of Canada:

-  Develops, validates and implements tools and strategies to evaluate physicians' competence; and
-  Maintains a national registry of physicians and their qualifications throughout their professional careers.

Strategic goals:





-  Provide the qualification (Licentiate of the Medical Council of Canada) for entry into practice.
-  Initiate and promote with partners, a national integrated assessment strategy of physicians throughout their careers.
-  Initiate and promote innovation, research and development in assessment and evaluation.
-  Maintain the Canada Medical Register and promote with partners the development of a national registry.
-  Maintain and promote liaison with competent provincial, national and international organizations in assessment and evaluation.
-  Be an open, transparent, responsive and accountable organization.

College of Physicians and Surgeons of Nova Scotia [CPSNS]

<http://www.cpsns.ns.ca/>

The College of Physicians and Surgeons of Nova Scotia is the professional body responsible for regulating the province's medical profession in accordance with the Nova Scotia Medical Act and its regulations.

Among other responsibilities, the College:

-  Undertakes physician registration and licensing
-  Encourages high standards of qualification, practice and ethics among its members
-  Investigates complaints against physicians
-  Manages and supports the Clinician Assessment for Practice Program [CAPP] and the Nova Scotia Physician Achievement Review [NSPAR] Program

WHO World Directory of Medical Schools

<http://www.who.int/hrh/wdms/en/>




It lists all medical schools which have been recognized and granted a charter by their host countries. The database only lists these programs and does not provide any information in relation to the quality of education at these medical schools.

FAIMER International Medical Education Directory (IMED)

<http://www.faimer.org/work.html>

IMG Working group FAIMER is a non-profit foundation committed to improving world health through education. The mission of FAIMER is to support the Educational

Commission for Foreign Medical Graduates (ECFMG) as it promotes international medical education through programmatic and research activities. Vision:

-  To create and enhance educational resources for those who teach physicians committed to improving and maintaining the health of the communities they serve.
-  To investigate and understand the educational experiences and migration patterns of international medical graduates and to determine their impact on population health.
-  To be the best source of information on international medical education.

Physician Credentials Registry of Canada [PCRC]

<http://www.pcrc.org/en/about.shtml>






The Physician Credentials Registry of Canada [PCRC], a division of the Medical Council of Canada (MCC), was established to provide a centralized repository for physicians' core medical credentials. This service is designed to reduce duplication of effort by gathering, verifying and permanently storing credentials in a centralized repository.

The PCRC places a physician's medical credential documents in an electronic repository that allows this individual to establish a confidential, lifetime professional portfolio that can be shared at his or her request with an authorized licensed user, including, but not limited to: provincial and territorial medical regulatory authorities and certifying and qualifying bodies in Canada.

Nova Scotia Department of Health

<http://www.gov.ns.ca/health/>





The Department of Health sets strategic direction for the health system through:

-  Direction and support of health transformation initiatives
-  Funding to District Health Authorities and provincial programs, including ground and air ambulance programs
-  Development and support of provincial programs and initiatives
-  Administration of continuing care services, the Senior's Pharmacare Program and the Family Pharmacare Program
-  Policy, legislation and standards

Health Canada

<http://www.hc-sc.gc.ca/ahc-asc/index-eng.php>

Health Canada is the Federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances. Health Canada's goal is for Canada to be among the countries with the healthiest people in the world. To achieve this goal, Health Canada:

-  Relies on high-quality scientific research as the basis for our work.
-  Conducts ongoing consultations with Canadians to determine how to best meet their long-term health care needs.
-  Communicates information about disease prevention to protect Canadians from avoidable risks.
-  Encourages Canadians to take an active role in their health, such as increasing their level of physical activity and eating well.

Citizenship and Immigration Canada

<http://www.cic.gc.ca/english/department/mission.asp>

This is a federal department with the following mandates:

- Developing and implementing policies, programs and services that:
 - Facilitate the arrival of persons and their integration to Canada in a way that maximizes their contribution to the country while protecting the health, safety and security of Canadians;
 - Maintain Canada's humanitarian tradition by protecting refugees and persons in need of protection; and
 - Enhance the values and promote the rights and responsibilities of Canadian citizenship.
- Advancing global migration policies in a way that supports Canada's immigration and humanitarian objectives.

NS Office of Immigration

<http://www.novascotiainmigration.com/en-page7.aspx>

The Nova Scotia Office of Immigration works with the Federal Government of Canada to promote immigration to NS. Through the provincial nominee program, immigrants are selected based on the real needs of Nova Scotia. The department also provides incentives to help encourage people from around the world to settle in Nova Scotia.

Human Resources and Social Development Canada [HRSDC]

http://www.hrsdc.gc.ca/eng/corporate/about_us/index.shtml

Human Resources and Skills Development Canada (HRSDC) is a department of the Government of Canada. HRSDC's mission is to build a stronger and more competitive Canada, to support Canadians in making choices that help them live productive and rewarding lives, and to improve Canadians' quality of life. To do this the department:

- develop policies that make Canada a society in which all can use their talents, skills and resources to participate in learning, work and their community;
- create programs and support initiatives that help Canadians move through life's transitions—from families with children to seniors, from school to work, from one job to another, from unemployment to employment, from the workforce to retirement;
- create better outcomes for Canadians through service excellence with Service Canada and other partners; and
- engage our employees, establish a healthy work environment, nurture a culture of teamwork, and build our leadership capacity.

Nova Scotia District Health Authorities

<http://www.gov.ns.ca/health/about/DhA.asp>

Nova Scotia's health services are delivered by nine District Health Authorities and the IWK. These health authorities deliver health care services to residents and are responsible for all hospitals, community health services, mental health services and public health programs in their districts.

Metropolitan Immigrant Settlement Association [MISA]

http://www.misa.ns.ca/about_misa.php

The Metropolitan Immigrant Settlement Association (MISA) is a community-based organization which welcomes newcomers and recognizes their essential role in Canada. Founded in 1980, MISA is an established and respected agency known for its professionalism and competence in the delivery of services to newcomers. Over the past several years, MISA has been able to build on this credibility and has become not only the primary immigrant serving agency in the Atlantic, but, has a reputation for excellence that is comparable to any SPO in the country.

Halifax Immigrant Learning Centre [HILC]

http://www.misa.ns.ca/about_hilc.php

Halifax Immigrant English as a Second Language Society, known as Halifax Immigrant Learning Centre was incorporated as a non profit organization and gained charitable status in 1988 and received its first federal funding for settlement language training in early 1989. Although, set up initially in response to a growing need for language training for women, HILC quickly became a primary language training deliverer in HRM for all newcomers to the community. In the last 18 years it has received funding from CIC, Nova Scotia Dept of Education, Canadian Heritage, Metro United Way, HRSD and the Nova Scotia Office of Immigration to provide services that support the language development leading to the social and economic integration of newcomers to Nova Scotia.

IMG Working Group

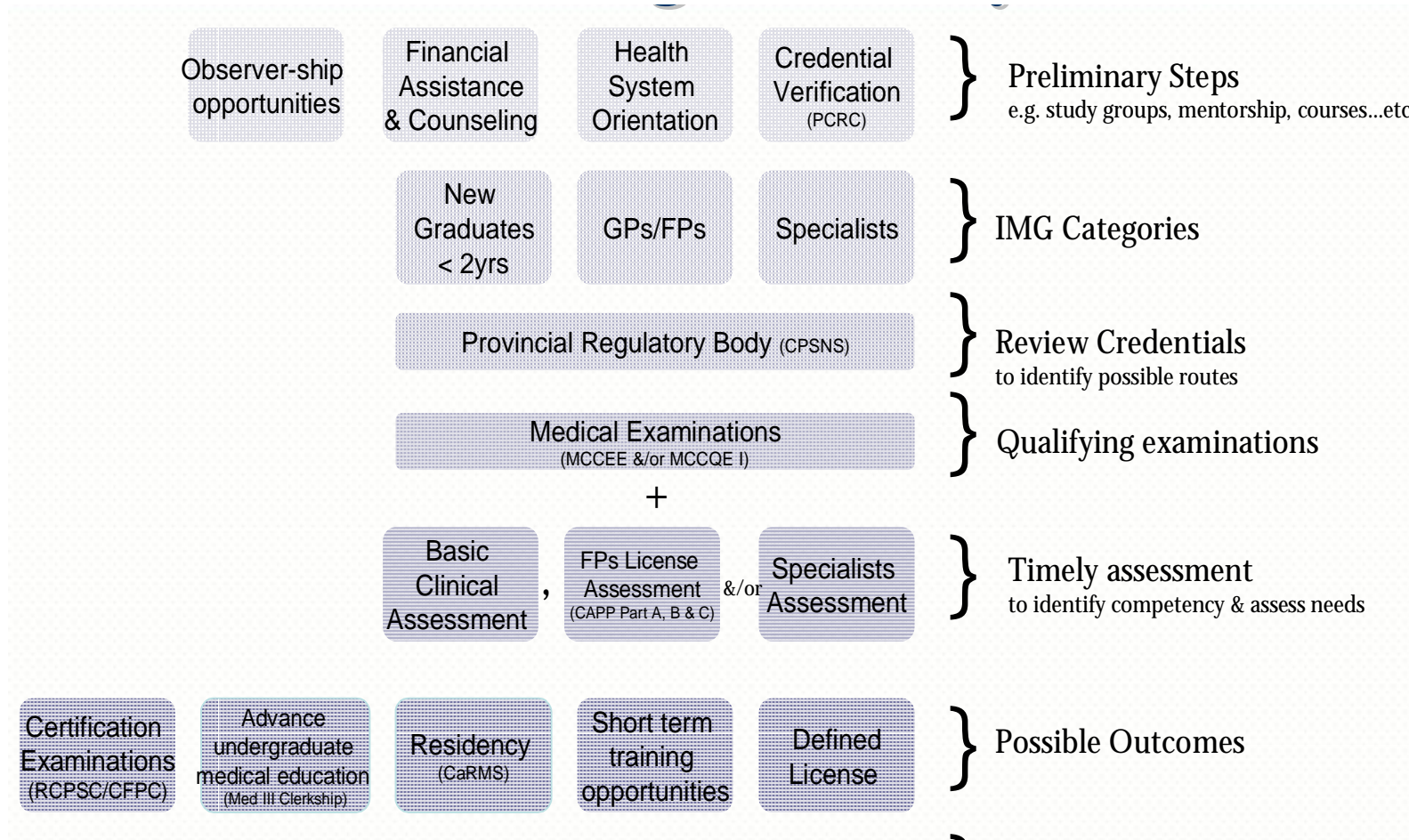
The IMG Working Group was established on 2006 to better coordinate the provincial efforts to face challenges related to the integration of IMGs into the health system in NS. The Group is an inclusive group and meets quarterly to identify the outstanding barriers and facilitate collaborative partnerships by bringing all key stakeholders to the discussion table. It acts as an advisory capacity to help develop realistic and sustainable solutions. Key partners in the IMG Work Group are Dalhousie Faculty of Medicine, College of Physicians and Surgeons of Nova Scotia [CPSNS], Nova Scotia Department of Health, Nova Scotia Office of Immigration, Association of International Physicians and Surgeons of NS [AIPSNS], Registered Nurses Professional Development Centre [RNPDP], Dalhousie Academy of Medicine, Metropolitan Immigrant Settlement Association [MISA], and Halifax Immigrant Learning Centre [HILC].

Association of International Physicians and Surgeons of Nova Scotia [AIPS NS]

http://www.misa.ns.ca/iep_physician.php

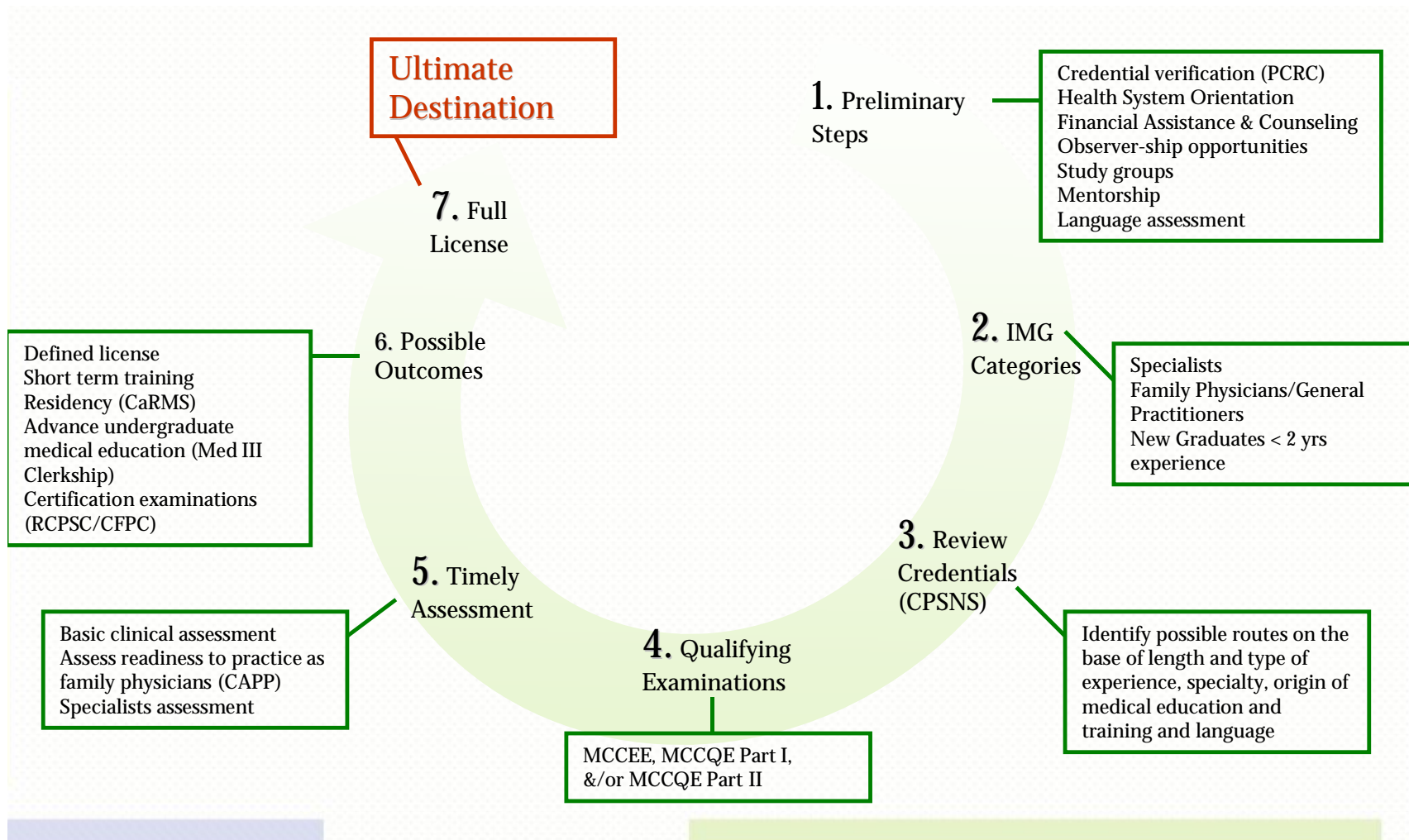
The Association of International Physicians and Surgeons of Nova Scotia [AIPS NS] is a collective voice for International Medical Graduates [IMGs] to effectively communicate IMGs issues to stakeholders and the public. AIPS NS is a non-profit organization based on dedicated volunteerism through executives, members and other supporting organizations. The association represents physicians and surgeons who obtained their medical training outside of Canada and choose Nova Scotia to be

Appendix N: Modified Nova Scotia Licensing Pathway



Source: (Derived from literature, key informants and pan-Canadian and International experiences)

Appendix O: Optimal IMG's Licensing Steps



Source: (Derived from literature, key informants and pan-Canadian and International experiences)

