Programs for International Medical Graduates

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SUMMARY

Medical graduates from other countries provide health care in many regions of Canada; yet differences in training standards can cause problems. A recent survey looked at the requirements of provincial licensing bodies and the preresidency programs of Canadian faculties of medicine. Quebec, Ontario, and Manitoba provide such programs, which differ in length, content, and evaluation process. McGill has recently launched a more focused program.

RÉSUMÉ

Des diplômés de pays étrangers dispensent des soins de santé dans de nombreuses régions du Canada. Les différences en termes de formation peuvent être source de problèmes. Une enquête récente a analysé les exigences des organismes chargés d'accorder les permis d'exercice et des programmes préparatoires à la résidence dans les facultés de médecine canadiennes. Le Québec, l'Ontario et le Manitoba offrent de tels programmes qui diffèrent selon leur durée, leur contenu et leur processus d'évaluation. McGill a récemment mis sur pied un programme mieux adapté.

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INTERNATIONAL MEDICAL GRADuates (IMGS) have played an important role in health care delivery to many areas of North America, especially remote regions. However, concerns about quality of care have arisen because graduates from different countries have received greatly varying training. In Canada, moreover, provincial and federal governments have recently focused attention on medical manpower and resource policies. The comprehensive report, *Toward Integrated Medical Resource Policies for Canada* (the Barer-Stoddart report),[1] specifically addresses the issue of foreign trained physicians and makes recommendations.

Definition

The term IMG is used to refer to different groups: Canadians who have attended medical school abroad; "visa trainees" recruited to meet the needs of Canadian postgraduate training programs; and immigrant or refugee physicians who meet Canadian immigration requirements.[2]

This article focuses on the last group. We review the licensing requirements for IMGs in Canada, as well as existing preresidency programs or preinternship programs that prepare them for residency programs and ultimately for practising medicine.

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Information gathered

Information was gathered from two Canadian surveys. The first asked provincial licensing bodies about their requirements for IMGs. The second asked all 16 Canadian medical schools about their preresidency or preinternship programs. A review of the literature yielded few reports of preresidency training for IMGs in other countries.

Review of the literature

In Canada during 1984-1985, 28.4% of all active physicians, 25% of new licensees, and 22% of postgraduate trainees were IMGs.[3] In the United States, during 1990, 18% of all postgraduate residency positions were filled by IMGs.[4] As in Canada, American policy makers are trying to decrease dependence on these physicians for health care in underserviced areas, while at the same time striving to ensure minimum levels of competence among those within the system.[5,6]

This problem is not unique to North America. In the United Kingdom, manpower policies are attempting to reconcile the needs of the National Health Service with maintenance of standards of

Table 1. **Results of 1992 licensing survey:** *Requirements for international medical graduates vary in different provinces.*

PROVINCE	MEDICAL COUNCIL OF CANADA EVALUATING EXAMINATION	MEDICAL COUNCIL OF CANADA QUALIFYING EXAMINATION	LANGUAGE TEST	SPECIAL STATUS TO COMMONWEALTH COUNTRIES	POSTGRADUATE TRAINING	PRERESIDENCY OR PREINTERNSHIP PROGRAM
Newfoundland	x	x		x	Rotating internship	
Prince Edward Island	x	x			2 y	
Nova Scotia	x	x			2 y	
New Brunswick	x	x			2 y	
Quebec	x				2 y	x
Ontario	x	x	x		Rotating internship	x
Manitoba	x	x		x	Rotating internship	x
Saskatchewan	x	x		x	2 y	
Alberta	x	x			2 y	
British Columbia	x	x		x	2 y	

competence and communication skills for foreign trained physicians.[7]

Although many IMGs have taken their training in English or French, there are significant differences between foreign and North American medical school programs.[8] As a result, IMGs frequently have gaps in medical knowledge, in clinical reasoning skills, and in doctor-patient communication skills.

Few articles describe preresidency or preinternship programs. In the United States, 12-month transitional year programs (not mandatory to qualify for residency) train 1475 people, of whom 15% are IMGs.[4] Existing programs in New York City[8] and in Sydney, Australia,[9] aim to ensure not only clinical competence but also an understanding of the population to be served. Language courses and counseling are available to IMGs. Program graduates have consistently performed well on examinations,[9] and trainees are enthusiastic about the program.[8] Manitoba's refugee preresidency program[10] and Ontario's preinternship program have had similarly encouraging results.[11,12] Through rigorous but fair selection methods, a comprehensive clinical curriculum, and standardized exit examinations, these programs ensure that all practising physicians in these provinces will provide good quality care.

Survey of licensing bodies

We sent a letter to all 10 provincial licensing bodies requesting their requirements for IMGs. We asked specifically whether preresidency programs were mandatory. All responded.

All 10 licensing bodies require the Medical Council of Canada Evaluating Examination or its American equivalent, the certification examination of the Educational Council for Foreign Medical Graduates.[8] In nine provinces, the Medical Council of Canada Qualifying Examination is a prerequisite (*Table 1*).

The number of years of postgraduate training, as well as its content, vary across the country. By 1994, however, all provinces will require 2 years of postgraduate or specialty training for licensure.

Four provinces give special status to graduates from the United Kingdom, Ireland, South Africa, Australia, and New Zealand. Although not stated in the survey, some provinces offer restricted temporary licences to IMGs to provide care in

underserviced areas. Whether this practice will change in 1994 is not known.

Only Quebec, Ontario, and Manitoba require that a preresidency or preinternship program be completed before further postgraduate training.

Survey of faculties of medicine

We sent questionnaires to the deans of the 16 Canadian faculties of medicine to ask how many of them offer a preresidency or preinternship program, and to raise specific questions about the component parts of these programs (*Table 2*). All were returned.

Nine of the 16 respondents indicated that they provide such training. The medical schools in Quebec and Ontario have preresidency programs. In addition, Ontario offers a preinternship program coordinated through a central body. The University of Manitoba runs two programs, one for refugees and one for non-refugees (*Table 3*).

Administration. Five of these preresidency programs are coordinated by the postgraduate dean's office, one by the undergraduate dean, and three by a person delegated by the faculty office.

Prerequisites. The number of IMGs who pass through these programs ranges from four to 40 each year. Because there are usually many applicants for these programs, prerequisites are set. All universities use the Medical Council of Canada Evaluating Examination as an initial screening examination. Ontario and Quebec schools also require evidence of fluency in English or French as determined by the Test of English as a Foreign Language (TOEFL) or a government French proficiency test. Five of the programs conduct further testing with either multiple choice examinations or Objective Structured Clinical Examinations (OSCEs). Ontario preresidency programs are available only to people who have been accepted into specialty programs.

Content and evaluation. The length of the training period varies from 1 to 24 months. As *Table 3* shows, the type of training differs notably, varying from a modified clinical clerkship to a full rotating internship.

Four of the preresidency programs, as well as the Ontario preinternship program, administer exit examinations. These consist of formal orals, OSCEs, or multiple choice questions (eg, Licentiate of the Medical Council of Canada, part 1 of the National Boards).

Regulations for promotion vary widely. Trainees might be required to do remedial work before repeating a failed rotation or might be dismissed after a specific number of failures; some programs have no set rules.

Generally, no formal program evaluation takes place, although many centres

Table 2. **Questionnaire sent to faculties of medicine**

1. Do you have a preresidency program for IMGs?
2. Who is responsible for coordinating the program?
3. How many IMGs pass through this program each year?
4. What prerequisites must be fulfilled by the IMGs before entering this program?
5. How long is the program? Of what does the program consist?
6. Is there an examination at the end of the program? Of what does it consist?
7. What regulations exist in case of failure of one or more rotations?
8. How do you evaluate whether you are meeting the objectives of your program?

Table 3. **Content of preresidency and preinternship programs**

PROVINCE	CONTENT
Quebec preresidency	8 weeks internal medicine 4 weeks each: family medicine, pediatrics, obstetrics and gynecology, and psychiatry or emergency medicine
Manitoba preresidency	
• Refugee	Clinical clerkship and rotating internship
• Non-refugee	Rotating internship
Ontario	
• Preresidency	4-12 weeks in specialty of future residency 8 weeks internal medicine and surgery
• Preinternship	4 weeks each: obstetrics and gynecology, pediatrics, psychiatry, and family and community medicine

follow the IMGs' performance in their subsequent residencies and on the certification examinations. Only one program plans to analyze these data formally.

Discussion

Although some of these programs existed almost 10 years, little has been written about them by either program administrators or the IMGs themselves. Is there a sound rationale for determining the specific content and length of the program? What is the effect on the educational system and on the trainees? Are the same evaluation methods that are used for North American graduates valid and fair for IMGs? And finally, do these programs achieve their desired goals?

Since 1987, the Quebec faculties of medicine have provided a limited number of annual positions for IMGs in preresidency programs. Each university is assigned a fixed number of these trainees by the Corporation Professionnelle des Médecins du Québec, and provides a period of orientation and "retraining" determined by the individual faculty.

The McGill experience

At McGill University, the mandate to coordinate this program was given to the Department of Family Medicine's postgraduate education committee, because Quebec no longer has a rotating internship program and because more than half of the IMGs ultimately choose family medicine residencies.

Our experience with these trainees echoes that reported in the sparse literature. We consistently encountered difficulties such as inadequate medical knowledge, gaps in problem-solving abilities, and cultural barriers between IMGs and North American patients, in addition to the acclimatization problems experienced by the IMGs themselves. The subsequent performance of the IMGs who entered our program showed that the preresidency program was not addressing their needs. This led to a serious review of the objectives, curriculum, and regulations for promotion by a committee made up of the major disciplines involved in the preresidency program.

The revised program began in the fall of 1992, with the family medicine program director coordinating the scheduling and the evaluation process. To determine its effectiveness, rigorous methods of evaluation will be required to assess not only clinical competence during the preresidency and residency programs, but also the program's effect on and acceptability to both the trainees and their teachers.

Conclusion

Although we hope to reduce our reliance on IMGs to provide health care to underserviced areas of the country, a substantial number will continue to enter the medical system, many as family physicians. Faculties of medicine should consider providing preresidency programs for these physicians to ensure that they possess the knowledge, attitudes, and medical skills required to meet standards of competence and that they have appropriate communication skills. ■

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References

1. Barer ML, Stoddart GL. *Toward integrated medical resource policies for Canada.* Prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health, 1991. Winnipeg: Conference of Deputy Ministers of Health, 1991.
2. Barer ML, Stoddart GL. Toward integrated medical resource policies for Canada. 4. Graduates of foreign medical schools. *Can Med Assoc J* 1992;146:1549-54.
3. Department of National Health and Welfare. *Report of the Joint Working Group on Graduates of Foreign Medical Schools to the Federal/Provincial Advisory Committee on Health Human Resources.* Ottawa: Department of National Health and Welfare, 1986.
4. Rowley BD, DeWitt CB, McGuire MB. Selected characteristics of graduate medical education in the United States. *JAMA* 1991;266(7):933-43.
5. Inglehart JK. Reducing residency opportunities

for graduates of foreign medical schools. *N Engl J Med* 1985;313(13):831-6.

6. Stimmel B, Graettinger JS. Medical students trained abroad and medical manpower: recent trends and predictions. *N Engl J Med* 1984;310(4):230-5.
7. Lister J. Special report: the impact of overseas medical graduates on service and training in the United Kingdom. *N Engl J Med* 1986;315(16):1038-40.
8. Bogdonoff MD, Fins JJ. University medical center participation in residency training programs for graduates of foreign medical schools. *Ann Intern Med* 1991;114(5):426-7.
9. Webster IW, Rawlinson RW. Innovative bridging program for overseas trained doctors. *Med J Aust* 1991;155:553-6.
10. Klass D. Program for refugee physicians. *Can Med Assoc J* 1988;139:847-8.
11. Rothman AI, Cohen R, Ross J. Evaluating the clinical skills of foreign medical school graduates participating in an internship preparation program. *Acad Med* 1990;65(6):391-5.
12. Rothman AI, Cohen R, Ross J, Poldre P. Validating an Objective Structures Clinical Examination (OSCE) as a method for selecting foreign medical graduates for a pre-internship program. *Acad Med* 1991;66(9): 567-9.

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