

# 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),<sup>1</sup> 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.<sup>2</sup>

This article focuses on the last group. We review the licensing requirements for IMGs in Canada, as well as existing

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preresidency programs or preinternship programs that prepare them for residency programs and ultimately for practising medicine.

## 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.<sup>3</sup> In the United States, during 1990, 18% of all postgraduate residency positions were filled by IMGs.<sup>4</sup> As in Canada, American policy makers are trying to decrease dependence on these physicians for health care in underserved areas, while at the same time striving to ensure minimum levels of competence among those within the system.<sup>5,6</sup>

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.<sup>7</sup>

Although many IMGs have taken their training in English or French, there are significant differences between foreign and North American medical school programs.<sup>8</sup> 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.<sup>4</sup> Existing programs in New York City<sup>8</sup> and in Sydney, Australia,<sup>9</sup> 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,<sup>9</sup> and trainees are enthusiastic about the program.<sup>8</sup> Manitoba's refugee preresidency program<sup>10</sup> and Ontario's preinternship program have had similarly encouraging results.<sup>11,12</sup> 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.<sup>8</sup> 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

underserved 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 prer residency 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 prer residency 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 prer residency program.

The revised program began in the fall of 1992, with the family medicine pro-

gram 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 prer residency 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 underserved areas of the country, a substantial number will continue to enter the medical system, many as family physicians. Faculties of medicine should consider providing prer residency 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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Animal studies using the parenteral route have shown that "Tantum" Oral Rinse possesses properties of an analgesic—anti-inflammatory agent. This effect is not mediated through the pituitary-adrenal axis. Studies using the topical route have demonstrated the local anesthetic properties of benzydamine hydrochloride. In controlled studies in humans with oropharyngeal mucositis due to radiation therapy, "Tantum" Oral Rinse provides relief through reduction of pain and edema. Similar studies in patients with acute sore throat demonstrated relief from pain.

#### Indications

"Tantum" Oral Rinse is indicated for relief of pain in acute sore throat and for the symptomatic relief of oro-pharyngeal mucositis caused by radiation therapy.

#### Contraindications

"Tantum" Oral Rinse is contraindicated in subjects with a history of hypersensitivity to any of its components.

#### Precautions

The use of undiluted "Tantum" Oral Rinse may produce local irritation manifested by burning sensation in patients with mucosal defects. If necessary, it may be diluted (1:1) with lukewarm water. Since "Tantum" Oral Rinse is absorbed from the oral mucosa and excreted mostly unchanged in the urine, a possibility of its systemic action has to be considered in patients with renal impairment.

#### Use In Pregnancy

The safety of benzydamine HCl has not been established in pregnant patients. Risk to benefit ratio should be established if "Tantum" is to be used in these patients.

#### Use in Children

Safety and dose directions have not been established for children five years of age and younger.

#### Adverse Reactions

The most frequent adverse reactions reported are: local numbness (9.7%), local burning or stinging sensation (8.2%), nausea and/or vomiting (2.1%). The least frequent were reports of throat irritation, cough, dryness of the mouth associated with thirst, drowsiness and headache.

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There are no known cases of overdosage with benzydamine HCl gargle. Since no specific antidote for benzydamine is available, cases of excessive ingestion of the liquid should receive supportive symptomatic treatment aimed at rapid elimination of the drug.

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Product monograph is available on request.

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**WARNINGS:** Before initiating therapy, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, clavams, cephalosporins or other allergens, as serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. If an allergic reaction occurs, discontinue Clavulin and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, i.v. steroids and airway management, including intubation, should also be used as indicated. **PRECAUTIONS:** Periodic assessment of renal, hepatic and hematopoietic function should be made during prolonged therapy. Clavulin is excreted mostly by the kidney. Reduce the dose or extend the dose interval for patients with renal dysfunction in proportion to the degree of loss of renal function. The possibility of superinfection (usually involving *Aerobacter*, *Pseudomonas* or *Candida*) should be kept in mind. If it occurs discontinue Clavulin and institute appropriate therapy. The occurrence of a morbilliform rash following the use of ampicillin in patients with infectious mononucleosis is well documented. This reaction has also been reported following the use of amoxicillin. A similar reaction would be expected with Clavulin. Use in pregnancy is not recommended unless the anticipated benefit justifies the potential risk to the fetus. Penicillins have been shown to be excreted in human breast milk. It is not known whether clavulanic acid is excreted in breast milk. Caution should be exercised if administered to a nursing mother. **ADVERSE REACTIONS:** Gastrointestinal: Nausea, vomiting, diarrhea, abdominal cramps, flatulence, constipation, anorexia, colic pain, acid stomach and pseudomembranous colitis. The incidence of gastrointestinal side effects tends to be proportional to dose and tends to be greater in children than in adults. Hypersensitivity Reactions: Erythematous maculopapular rash, urticaria, anaphylaxis and pruritus. A morbilliform rash in patients with mononucleosis. Rarely erythema multiforme and Stevens-Johnson syndrome have been reported. Liver: Transient hepatitis and cholestatic jaundice have been reported rarely. Moderate rises in SGOT, alkaline phosphatase and lactic dehydrogenase. The significance of these findings is unknown. Hematologic and Lymphatic Systems: Anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, lymphocytopenia, basophilia, slight increase in platelets, neutropenia and agranulocytosis have been reported during therapy with the penicillins. These reactions are usually reversible on discontinuation of therapy and are believed to be hypersensitivity phenomena. Other: Vaginitis, headache, bad taste, dizziness, malaise, glossitis, black hairy tongue and stomatitis. **DOSE AND ADMINISTRATION:** The absorption of Clavulin is unaffected by food. Adults: For urinary tract, upper respiratory tract, skin and soft tissue infections which are mild to moderate, one Clavulin-250 tablet every 8 hours. For severe infections and lower respiratory tract infections, one Clavulin-500F tablet every 8 hours. Children: For urinary tract, upper respiratory tract, skin and soft tissue infections which are mild to moderate, 25 mg/kg/day of Clavulin in equally divided doses every 8 hours. Children's dosage should not exceed that recommended for adults. Children weighing more than 38 kg should be dosed according to the adult recommendations. For severe infections, otitis media, sinusitis or lower respiratory tract infections, 50 mg/kg/day of Clavulin in equally divided doses every 8 hours. Children's dosage should not exceed that recommended for adults. Children weighing more than 38 kg should be dosed according to the adult recommendations. Treatment should continue for 48-72 hours beyond the time the patient becomes asymptomatic or bacterial eradication is obtained. At least 10-days' treatment is recommended for infections caused by  $\beta$ -hemolytic streptococci to prevent acute rheumatic fever or glomerulonephritis.

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Product Monograph available on request.

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