Re-Licensure Process for Internationally Trained Providers

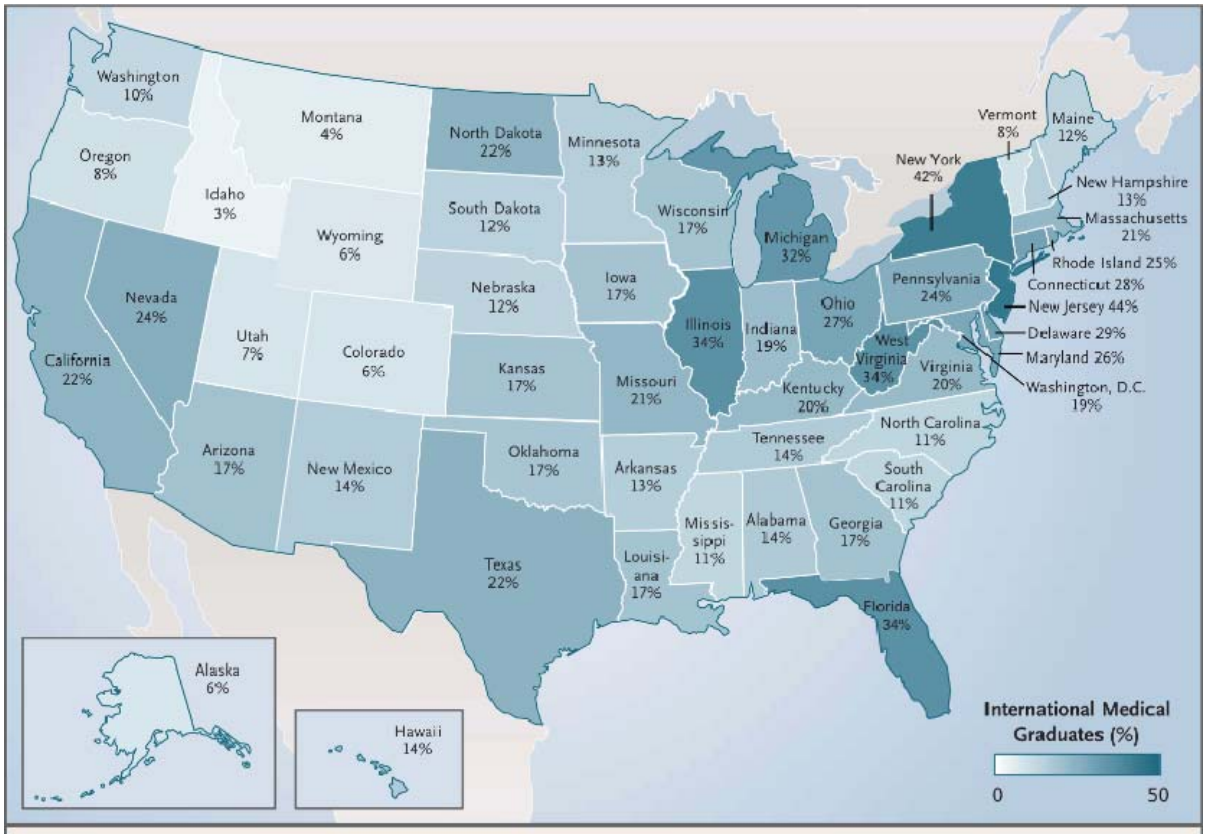

Figure. **Prevalence of International Medical Graduates throughout the United States.**
Data are from the American Medical Association, Physician Masterfile, 2004.

Oregon has one of the lowest percentages of internationally trained doctors at 8 percent.

Domestic Programs

Welcome Back Centers: California

MISSION:

To build a bridge between the pool of internationally trained health workers living in California and the need for linguistically and culturally competent health services in underserved communities.

BACKGROUND:

Welcome Back is a statewide initiative offering counseling and educational programs to internationally trained health professionals. This includes assistance in obtaining appropriate licenses, credentials, orientation and job placement to work in the US health

care system, and development of US-specific leadership, management and advocacy skills among immigrant health professionals.

As California becomes the most diverse state in the Nation, the Welcome Back Centers are very excited with the opportunity to work with its immigrant communities and build on their many assets.

One of the challenges currently facing the health sector is the lack of culturally and linguistically diverse health professionals. This is especially true for the "safety net", community based and public health clinics and health services agencies who are often times the sole providers of health services for immigrant communities. It is well known that important aspects of care, such as treatment adherence and patient satisfaction improve significantly when we narrow the cultural and linguistic gap between the health services providers and their patients and clients. This is true for all health professionals: social workers, nurses, dentists, doctors, nutritionists, pharmacists, psychologists, etc.

This is the fundamental premise behind the Welcome Back Initiative: becoming a part of the solution. By assisting internationally trained health professionals in the process of re-entering the health workforce, we will be infusing the health system with a cadre of culturally and linguistically diverse workers that will allow the health sector to provide better services.

What exactly is Welcome Back?

It is a statewide initiative funded by The California Endowment to assist internationally trained health professionals living in California. San Francisco and San Diego received funding to establish a center in their respective counties.

What Services will Welcome Back Centers provide?

Our centers will provide orientation, counseling and support to internationally trained health care workers. The centers will assist each individual in developing a career path plan that builds on their skills, experience and education. In addition to orientation and support in obtaining the appropriate professional credentials and licenses for their profession, participants will be presented with other options or alternatives to consider. These options may include, choosing a different health occupation offered through a Community College or State University or focusing their skills and experience in the areas of health care management, research, advocacy or policy.

What else will Welcome Back Centers provide?

An important aspect of the Welcome Back Initiative is the evaluation component. The actual number of internationally trained health care professionals living in California is not known. The Welcome Back Initiative seeks to learn the number of these health professionals in California, what their professions are and what have been the barriers that professionals have experienced in trying to practice their profession or enter the health care delivery sector. The Welcome Back Initiative seeks to engage internationally trained health professionals in identifying solutions and making policy recommendations that address the barriers they have experienced. An example of a solution could be the development of "fast track" programs within colleges and universities that realistically credit professionals

education and experience, is of short term duration and affordable, and leads to a license to practice the profession. The active involvement of participants in developing possible solutions and policy recommendations is key for the success of the initiative.

Initial Contact:
This is the first contact with a potential participant. It may be on the phone or face-to-face with front desk staff or the Educational Case Manager(s). It is the screening component of the program. Information collected in the "Initial Contact Form" is entered into the Welcome Back database. At this phase, the program collects basic personal information, background, profession and educational information including history of professional license tests taken.

Assessment:
A face-to-face initial assessment is conducted by the Educational Case Manager(s). Areas of the assessment include: a detailed post-high-school education history, detailed professional work history, history of any studies, certificates obtained in the U.S., work history in the U.S., determination of English proficiency and highest ESL level accomplished (when applicable), brief psychosocial history, reason for emigration, and an assessment of motivation (strengths and weaknesses). A career pathway plan is then developed with the participant.

Case Management, Counseling, and Referral Services:
The Case Management and Counseling Services provided at the Welcome Back Center follows a "client-centered" approach. This approach incorporates the following stages: (1) engagement (the process of building a working relationship); (2) assessment (identifying participants career goals, motivation, useful resources, and barriers); (3) planning (converting clients goals into a realistic plan of action); (4) accessing resources (assisting the participant with resources to meet interim steps); (5) coordination (ensuring that support remains available); and (6) disengagement (the accomplishment of participant's goals).

Case Management services may include assistance with obtaining transcripts, obtaining licensing information, help filling out forms, referrals to validation of credential agencies, assistance with enrollment/matriculation process and assistance with financial aid applications. Counseling may include presenting options around alternative careers, working with client's expectations, dealing with perceived loss of status and feelings around that loss, problem solving, providing support and motivational skills.

Based on the plan established and the participant's needs, the Educational Case Manager will determine how often to meet with the participant (weekly, monthly, quarterly). At minimum, participants will see the Educational Case Manager every six months until they exit the program. Based on the plan established and the participant's interests, he/she may participate in educational and/or group interventions offered through the Welcome Back Center and established training programs at various educational/training institutions.

Counseling:

Counseling provided by the Educational Case Manager focuses on issues related to the participant's career goals. Many participants will have experienced the loss of their professional status and may be struggling with the process of adapting to a new culture and a new set of circumstances. Brief supportive counseling, motivational counseling and problem solving would be appropriate.

Case Management Follow-Up:
Based on the assessment and the plan established, the participant and Educational Case Manager decide how frequently they should meet. The services that the Educational Case Manager can provide include:
• Assistance procuring and filling out forms required for licensing agencies
• Information and assistance in applying for validation of credentials
• Researching schools that provide the health career occupation chosen by the participant
• Assistance with enrollment/matriculation process at colleges and universities
• Assistance in applying for financial aid
• Assistance in identifying volunteer and other work opportunities in the U.S. health care sector that match the participant's career goals

Educational Interventions:
Educational interventions are defined as curricula specifically designed for Welcome Back participants and offered through various educational institutions.

Group Interventions:
Group interventions are defined as group activities offered through the Welcome Back Center such as licensing preparation courses, groups by profession, support groups and workshops. It is possible that a group intervention may become an educational intervention offered through an educational institution.

Participants' Records:
All assessments, progress notes, and any other participant information are kept in their records. Records are identified by the participants' names, date of birth, and Welcome Back professional ID number.

Confidentiality:
Educational Case Managers take responsibility for securing the safety and confidentiality of all participant information. Under no circumstances are participants' records taken out of the office. No information about a participant is released without a participant's prior written consent. Educational Case Managers utilize the "Release of Information" form indicating the agency/organization to whom information will be released and the purpose of the release. The participant and assigned Educational Case Manager sign the form. Only Welcome Back Center staff, including the Welcome Back Evaluation Team, has access to these confidential records.

Consultations:
(Fee for service: Available to all Health Professionals.)
Due to funding limitations, the Welcome Back Center provides case management services to internationally trained nurses and internationally trained doctors interested in becoming nurses. If you are interested in receiving information on the licensing/certification process, information on revalidation/translation, educational assistance on your occupation of interest or if you want to know more about alternative careers we can provide a consultation that consists of one hour of services for a fee of $50.00. To request a consultation please print out the form below and email to: contact@welcomebackcenter.org or fax to: 619-409-6421.

Q and A

Am I eligible for these services?
All foreign-trained health workers currently living in California are eligible for the program. If a potential participant lives closer to another Welcome Back Center, he/she is encouraged to contact that center directly (see Question 14 for list of Welcome Back Centers). The program does not have the capacity to serve persons living outside of California. Persons living outside the United States are not eligible for the program.

How can I participate in the Welcome Back Center?
Call your nearest California center (San Francisco or San Diego).

Does the Welcome Back Center assist all health professionals?
Yes. The Center provides services to all eligible health professionals. This includes nurses, pharmacists, doctors, speech therapists, occupational therapists, laboratory and other technicians, psychologists, dentists, social workers, health educators, and others.

Do I need a work permit to be a participant of the Welcome Back Center?
Everyone is welcome to participate in each of the Welcome Back Centers. Each Center shares any knowledge and information they have about work permits or employer-based "sponsorships"; however, they do not have any influence or means to procure these for participants. The Center has a list of agencies which offer advice/services on immigration status matters.

Does the Center offer educational scholarships?
No. The Centers do not receive funding to provide educational scholarships; however, an Educational Case Manager helps to link participants to college and universities and their financial aid offices. Click Here to go to a good resource for Minority Scholarships, Fellowships and Postdoctoral Awards in Medicine, Public Health and Related Fields.

Does the Welcome Back Center offer professional licenses?
No. Each participant will have to follow existing licensing procedures for their associated profession. Each Center provides orientation about the existing licensing procedures. (In

some instances, each Center will purchase license exam preparation materials to share with participants.)

Does the Welcome Back Center offer job placement?
The Welcome Back Center does not directly find jobs for participants; however we do provide assistance in finding employment and a job announcement binder will be available to share information with participants about job opportunities upon notification by potential employers and other agencies.

If **my English-speaking skills are a challenge for me, is an interpreter be available to assist me at the Welcome Back Center?**
Welcome Back Center staff members communicate in several languages. We will do our best to provide interpreter assistance and/or resources on an individual case-by-case basis.

As an eligible participant, what is the first step in the process?
There is an initial telephone interview by a Welcome Back Center representative. After the initial telephone interview, an appointment is set up for you to meet with the Educational Case Manager. The Educational Case Manager will meet with you to discuss your educational and professional experience. The case manager will offer information and provide guidance about licensing requirements, credential validation agencies, schools, and associated courses (including English language skills courses). With the assistance of the case manager, you will develop a career path plan with the goal of practicing your profession or finding an alternative career in the health field.

When I meet with the Educational Case Manager, what will I need to bring with me?
You will want to bring copies of your diploma(s) and transcripts, as well as copies of other certifications and/or licenses. If you have a professional résumé showing your work experience in your health profession, please bring it to your scheduled appointment.

Will the Welcome Back Center put me in touch with other health professionals going through the same process?
Yes. Each Welcome Back Center has developed group workshops and activities, and general information meetings to serve as peer support groups by profession.

California Recruits Mexico City Doctors to Treat Latino Population

Imagine going to a doctor who doesn't understand your language. You have to speak through an interpreter to describe your problems, give your medical history, and figure out what you're being told by the doctor. That's what 3 to 6 million working poor Latinos in California have to contend with — if they are lucky. Most don't have access to medical services; in impoverished rural areas, there is a dwindling supply of physicians, while in urban areas, few doctors accept MediCal, the state's Medicaid program, because of low payments.

According to the California Medical Association, the number of practicing physicians in California is shrinking. Citing Economedix figures based on 2000 census data, the CMA says California has only 38,900 full-time physicians engaged in patient care. That gives the state 110 physicians per 100,000 residents — 47th of the 50 states in physician supply.

Bram Briggance, associate director of the California Workforce Initiative at the University of California-San Francisco, disagrees with the CMA's numbers. A CWI report pegs the number of practicing physicians in California at 89,000, but Briggance agrees that there are areas with physician shortages. The real issue, he says, isn't aggregate numbers, but whether the right kinds of doctors are practicing where they're needed.

Culturally competent

Language isn't the only barrier to care for California's Spanish-speaking population. If a physician doesn't understand one's culture, even the best care is likely to miss the mark. For example, health problems are the province of the grandmother in the extended Latino family. A culturally competent physician includes the grandmother or the senior family member in the care plan.

Because they can't find linguistically and culturally competent physicians, some Latinos turn to illegal clinics where providers speak Spanish. Some patients have died after being treated by unlicensed and untrained providers.

During the 1999–2000 legislative session, Assembly Democrat Marco Antonio Firebaugh, who represents predominantly Latino central Los Angeles, introduced a bill that passed both houses and was signed by Gov. Gray Davis. The law created the Task Force on Culturally and Linguistically Competent Physicians and Dentists, whose members include the CMA, the California Dental Association (CDA), the California Medical Board, and the California Hispanic Health Care Association. The group will develop CME standards for cultural and linguistic competency.

A task force subcommittee studied the feasibility of a three-year project to bring 50 Mexican physicians and 20 dentists to underserved areas of California, to practice in not-for-profit community clinics. The proposal was introduced last February as AB 1045 by Firebaugh.

AB 1045 passed the Assembly in May and was referred to the Senate Business and Professions Committee, whose chairperson scheduled interim hearings in Mexico City this month and in Los Angeles next month. The CMA, the CDA, foreign dentists and physicians, and international medical graduates will testify.

The California Hispanic Health Care Association is AB 1045's sponsor. Executive Director Arnold Torres wants to help the medical establishment to determine how California physicians can do a better job of serving the 31 percent of California's population whose mother tongue is Spanish. "You're talking about a major redirection of medical schools, which should have been done long ago. That takes a phenomenal amount of resources that haven't been there for a long time."

Meanwhile, the frustrated Torres sees the unmet health needs of working poor Latinos. In Monterey County, the association's six clinics can't recruit enough primary care doctors, so they've had to hire locum tenens physicians, who cost much more but aren't so

productive as staffers. Farm workers don't go to the clinics because the temporary physicians don't speak Spanish.

Practice requirements

To participate in AB 1045's program, Mexican physicians would have to be board-certified in Mexico in family practice, pediatrics, Ob/Gyn, or internal medicine; pass Parts 2 and 3 of the United States Medical Licensing Examination (USMLE); participate in a CME program after arriving; take English-language classes; and practice under a three-year temporary license.

Proponents see a viable short-term solution here, but opponents — including the CMA, the CDA, and the state medical board, say it could undermine quality of care. "We would be very concerned about establishing a limited license for a select few on a short-term basis for only the poorest of the poor," says Bob McElderry, the CMA's associate director of government relations. "That establishes a bad precedent and a two-tiered health care system that says, 'Because you're poor, you don't get a fully credentialed, licensed doctor.'"

Instead, the CMA recommended that the state medical board streamline the licensure process for Mexican physicians in the program; that they take the same exams as other medical graduates, though Part 1 of the USMLE could be taken in Spanish if the applicant passes an English proficiency exam; that physicians in the project fulfill the same residency requirements as other international graduates; and that California medical schools be encouraged to establish a supervised residency training program in the clinics.

The CMA's long-term recommendations include residency programs in underserved areas and a loan forgiveness program for service in underserved areas. McElderry agrees that California medical schools need to produce more physicians who reflect the state's diversity.

"The contours of this measure are still in flux," says Firebaugh. "We may set up a sister association with particular medical schools. Or we may do something in our own medical schools, which would not be a bad outcome."

- Managed Care Magazine
By Bob Carlson
November 2001

CALIFORNIA: Making Strides to Recruit Doctors Fluent in Spanish

A great new pilot program taps into the surplus of medical-school graduates in Latin America to address the chronic shortage of U.S. doctors who speak Spanish.

Gilberto Cota studied medicine in Mexicali, Mexico, but never practiced medicine because he couldn't get into one of his home country's few residency programs. After moving to Southern California several years ago, Mr. Cota resigned himself to working as a diabetes counselor. His Mexican medical license wasn't valid in the U.S.

Today, Mr. Cota is on the verge of practicing medicine, thanks to a pilot program that taps into the surplus of medical-school graduates in Latin America to address the chronic shortage of U.S. doctors who speak Spanish. Amid a record influx of Latin American

immigrants, clinics and hospitals across the country are struggling with Spanish-speaking patients.

Mr. Cota, 33 years old, is on his way to becoming a licensed U.S. physician. He receives a $21,000 stipend from University of California at Los Angeles to take courses that are preparing him for U.S. medical board exams. Mr. Cota recently interviewed at Riverside County Regional Medical Center in Moreno Valley, Calif. Some two-thirds of its patients are Hispanic, and many don't speak English. Yet only eight of the 27 resident family physicians there speak Spanish.

The result is poor communication that can cost millions of dollars annually in unnecessary tests, emergency-room visits and inaccurate or delayed diagnoses. Lack of understanding leads to confusion about medication dosage and side effects, noncompliance with doctors' instructions and a lower likelihood of follow-up care.

"To provide safe and quality care, a physician has to understand the patient," says Patrick Dowling, a professor of family medicine at the David Geffen School of Medicine at UCLA.

Hispanics constitute 14% of the nation's 300 million people. But only 5% of all physicians practicing in the United States are Hispanic.

The Pew Hispanic Center, a nonpartisan research group, reported recently that fewer than one in four Latino immigrants reports being able to speak English very well.

In California, where 33% of the population is Hispanic, only 4% of physicians are Latino. Confronted with this reality, Dr. Dowling and fellow physician Michelle Bholat designed a 14-month program that qualifies graduates from Latin American countries to enter family-medicine residencies at teaching hospitals in California.

Before starting the program, many of the participants had been working in the U.S. as X-ray technicians, nursing assistants or as health-care volunteers. A program that prepares them to work as physicians in the U.S. is "an obvious solution," Dr. Bholat says.

The graduates receive prep courses for U.S. medical licensing exams, observership training at a UCLA hospital and support in their application for a residency program. On completing their residency, participants commit to spending at least three years in a "medically underserved area," in a large city or rural community.

Currently, 14 Latin American medical graduates are enrolled in different stages of the UCLA program, at the cost of about $48,000 apiece. The program, funded entirely by private foundations, is completing its first full year in February. Drs. Dowling and Bholat are currently seeking funds to expand enrollment.

Down the road, the two doctors plan to replicate the program at other University of California campuses, as well as introduce it to other states grappling to serve Spanish-speaking patients. Many states have burgeoning Hispanic populations. In North Carolina, the Hispanic population has jumped to more than 500,000 from 76,000 in 1990, according to the Census Bureau. Midwestern states like Iowa and Wisconsin also have seen steep increases.

Texas, where 35% of the population is Hispanic, is already eyeing the UCLA pilot. "This is a socially-responsible program that we need to replicate in Texas," says Carlos Jaen, chairman of the Department of Family & Community Medicine at the University of Texas Health Sciences Center at San Antonio.

Dr. Jaen says that he has witnessed "multiple occasions" when miscommunication has resulted in "dangerous situations." For example, the word "once" is spelled the same as the Spanish word for eleven. When a prescription states that a medication be taken "once a day," some Spanish-speaking patients have interpreted it as 11 pills daily. For heart medication, this dose could be toxic and cause death.

There is little research about the link between language barriers and medical errors. In a survey conducted in 2003 by the California Academy of Family Physicians, nearly half of all doctors said they were familiar with incidents in which quality of care had been compromised by language barriers. One doctor reported that a patient with shortness of breath was believed to be having an anxiety attack. In fact, he was suffering from a diabetes complication called diabetic ketoacidosis that can cause a coma.

In another reported case, a patient told a physician he had a "mass" in his chest, suggesting a tumor. In fact, the patient had a leak from a previously diagnosed abdominal aortic aneurysm, a vascular condition. The patient's poor English and misunderstanding of the previous doctor delayed care for a condition that can be fatal.

In 2000, 11.9 million U.S. residents were members of a "linguistically isolated" household, in which no person age 14 or over speaks English at least very well, compared with 7.7 million in 1990, according to the Census Bureau. In that decade, there was a 53% surge in the number of U.S. residents whose English proficiency is limited. "Unfortunately, cases in which language barriers cause compromised quality of care and preventable medical errors may become increasingly common," says Glenn Flores, professor and director of general pediatrics at the University of Texas Southwestern Medical Center in Dallas.

Meanwhile, Latin American countries produce more medical school graduates than their hospitals can accommodate for residency training. In Mexico, about 12,000 students complete medical school each year but hospitals only offer 4,300 residency slots. The UCLA program is designed to tap into that oversupply.

Blanca Campos, who couldn't secure a spot in a residency program in Costa Rica, recently passed her medical boards and is applying for a position as a family-practice resident at Los Angeles hospitals that cater to many immigrants. "If they see doctors who understand their language and culture, these patients are more open about their health issues," she says.

Asma Jafri, the physician who supervises the family medicine residency program in Riverside, says that the majority of patient complaints at the county hospital concern miscommunication. Aside from language fluency, Latin American doctors are able to grasp cultural nuances and native medical practices, such as use of herbal remedies, that may be relevant to a patient's case.

"The schedules of physicians fluent in Spanish are always full as opposed to the doctors who only speak English," Dr. Jafri says.

- Miriam Jordan
www.experience.com

Texas:

That's right — they're not from Texas. Newly licensed doctors enlisting to treat the state's Medicaid and Medicare patients are more likely to have been trained at international medical schools, according to a review of state medical licensing data.

Of the roughly 1,500 doctors who have received fast-tracked licenses in the last three years in exchange for agreeing to treat the state's neediest patients, nearly 40 percent were trained at international medical schools — everywhere from India and Mexico to Uzbekistan and Rwanda — while a quarter were trained at Texas medical schools. The Texas Medical Board fast-tracked more licenses for doctors trained in Pakistan than it did for those educated in Louisiana or Oklahoma. (Scroll over our interactive world map to see where these internationally trained doctors got their medical education.)

Internationally educated doctors are nothing new in Texas. Doctors trained outside the U.S. or Canada already make up more than a fifth of the state's licensed physicians and more than a quarter of the new doctors licensed every year. They're essential to the state's medical workforce; in the midst of a national primary care shortage, they sustain everything from Texas' public health clinics to its rural doctors' offices.

"The impact is not only in Texas, but nationwide," says Dr. Ashok Kumar, the president of theTexas Academy of Family Physicians and an international graduate himself. "These are the doctors who are going to serve Texas' rural patients, urban patients, underserved patients."

As more longtime doctors stop seeing money-losing Medicaid and Medicare patients — the result of far-from-adequate federal and state reimbursement rates — the burden will increasingly fall to these international medical school graduates. Many of them have visas that are contingent upon their work with poor and underinsured populations in cities and small towns. With health care reform expected to push an estimated 1 million new Texans onto state Medicaid rolls, the pressure on the doctors who do accept these patients will only mount.

International doctors come to Texas because it's a big state with a lot of opportunities but also because they're recruited here. Medical schools, Veterans Affairs hospitals or group practices in search of a particular kind of physician often help international graduates get visas, sometimes with strings attached.

To get licensed in Texas, these graduates must go through a rigorous and lengthy process, including getting three years of post-graduate training in the U.S. and proving that their medical education was "substantially equivalent" to the education provided in a school here or in Canada. Many international schools are already pre-approved. Others require mounds of paperwork, and months upon months of review — which Kumar says leads some young doctors to flee to states with less-stringent licensing procedures.

So when the Texas Medical Board offers to help doctors cut through the red tape in exchange for their agreement to take government-subsidized patients, it's no surprise that many international graduates jump at the chance. "They self-select to do that, because they know their applications as a rule take longer to process," says Jaime Garanflo, the medical board's director of licensure.

Agreeing to treat Medicaid and Medicare patients, or to practice in an underserved community, is also a fast way to build a practice and build credibility, says Jose Camacho,

executive director of the Texas Association of Community Health Centers, which represents providers and federally funded clinics that treat the uninsured and underserved. But Camacho says these doctors vary in their success — and that sometimes the cultural barriers they face are insurmountable. In one case, a Middle Eastern doctor came to practice at a federally financed clinic, only to realize the facility's executive director was female. He left, saying that, in his country, men didn't take orders from women. On the other end of the spectrum, Camacho says, is an Indian doctor placed in Brownsville who learned to speak Spanish so he could communicate with his patients and found ways to get Indian spices mailed to him from Texas' big cities so he never felt too far from home.

"We often talk about being culturally sensitive to our patients," Camacho says. "The reverse is also true. We have to be culturally sensitive to the providers' needs."

Kumar knows this firsthand. Kumar went to medical school in India, completed his surgical residency in England, then came to the University of Texas Health Science Center at Tyler for his family medicine residency. After a short stint practicing in Oklahoma, he came back to practice in Texas. Today, he's the director of medical student education at the University of Texas Health Science Center at San Antonio. He said he and his family practice colleagues, particularly those working with underserved patients in remote areas, have been completely embraced by their communities.

"When I came here, it was — both weather-wise and culture-wise — a little bit of a shock," he says. "But anyone has to acclimatize

- The Texas Tribune
By Emily Ramshaw and Matt Stiles
May 11, 2010

Canadian Initiatives

TORONTO, ONTARIO, SEPTEMBER 1, 2010—The Government of Canada is funding a project that will make the process of obtaining a medical license faster for internationally trained physicians. The Honorable Jason Kenney, Minister of Citizenship, Immigration and Multiculturalism, made the announcement today on behalf of the Honorable Diane Finley, Minister of Human Resources and Skills Development.

The Medical Council of Canada will receive over $2.8 million in Foreign Credential Recognition Program funding for its project entitled National Registration Process for Internationally Educated Physicians.

"Canadians with loved ones who are sick or injured want foreign-trained medical doctors in the emergency room or the doctor's office doing what they do best," said Minister Kenney. "This investment is part of the federal government's overall action plan to work with the provinces and territories to ensure that licensing bodies put in place better programs to recognize foreign credentials."

Since 2006, the Government of Canada has made foreign credential recognition a top priority. The Government created the Foreign Credentials Referral Office in 2007 with an initial investment of $37.2 million over five years, which was increased by $7.5 million in Budget 2009 and subsequently by $6 million in 2010–2011.

Through Canada's Economic Action Plan, the Government also invested $50 million to improve foreign credential recognition. Our government put foreign credentials on the agenda at the First Ministers Meeting in 2009, which led to the creation of a pan-Canadian framework for the recognition of foreign qualifications, developed in partnership with the provinces and territories and other stakeholders.

The Medical Council of Canada's project will create a registration process that will allow foreign-trained physicians to apply for a medical license electronically, in any province or territory. This includes an online portal where international medical graduates can access licensing information and apply for eligibility assessments for entry into practice or postgraduate programs in Canada.

The Council will also collaborate with governments, regulatory agencies, faculties of medicine and other assessment organizations to create a national credentials database for physician documents, in order to further streamline the application process.

"Once the application for medical registration launches in 2012, the process to apply for a medical license will become much easier," said Dr. Trevor Theman, Vice-President of the Medical Council of Canada's Executive Board. "Physicians will only have to submit a pre-populated electronic application and provide access to authenticated credentials

Solutions to the Medical Doctor Shortage in BC: A Plan on How to Integrate More Immigrant IMGs into the BC Healthcare System

In British Columbia there is a critical medical doctor shortage and according to the BC Medical Association this province needs more than 400 new physicians each year to replace those retiring, moving to other jurisdictions, or reducing the time spent practicing1. Since 2002 the provincial Liberal government has implemented a plan to double the number of Canadian medical graduates from 128 to 256 by the year 2010. This ramping up of our graduate capacity was clearly needed as BC had only 3.2 medical school spaces per 100,000 people in 2002, the lowest of any province in the country. The September 2006 intake class size is 2322; if all of them graduate in 2010 that still leaves a shortfall of 168 doctors for that graduating year. Of course this is an improvement over the shortfall this year which is over 270 doctors.

At the same time that this crisis is unfolding BC attracts the highest number of IMGs (International Medical Graduates) in the country after Ontario and Quebec. In any given year BC has between 600-900 IMGs looking for work in their field. Many of these doctors are Canadian citizens, have passed all our national qualifications and standards exams, speak the languages of our main immigrant populations and are willing to work in under-serviced areas of the province. In Ontario it is estimated that there are as many as 5000 IMGs 5 and in Alberta as many as 700.

Cost Benefit of IMG Providers: An IMG (who must repeat residency) and a Canadian Medical Graduate (CMG) from UBC both cost the province around 150k for a two year family practice residency. An IMG however, does not cost the province for the rather expensive graduate medical training and can also be working in two years or less as apposed to six years for a CMG.

This is a major difference in cost and speed to licensure in favor of internationally trained medical doctors. Something else to note is that most IMGs come with experience and can speak the languages of our main immigration populations. Another significant fact is that every one of the IMGs who has graduated from the St. Paul's IMG residency program since its inception has taken up practice and stayed in British Columbia.

Clinical Assistance Programs:

To date the focus of discussion on the West Coast has been the introduction and/or expansion of the 'Nurse Practitioner' as a way of alleviating the shortage of medical doctors, especially in under serviced areas "…still, the cost of producing a licensable physician from the IMG pool is much lower than the additional cost of 4 years of medical school incurred by Canadian graduates." Rodney Andrew and Joanna Bates, 'Licensing International Medical Graduates'. CMAJ 2000The belief is that nurse practitioners could accomplish much of the work of a fully licensed medical doctor and do so at less cost to the province.

We believe this approach is problematic as there is already a critical shortage of nurses. The only way to create a nurse practitioner is to provide additional training to an existing nurse. This is like 'robbing Peter to pay Paul.' The fact is that only a fraction of the qualified IMGs in British Columbia are able to access work in the healthcare system. The introduction of IMG clinical assistants would be a net positive expansion of medical care and is clearly a superior approach for many reasons.

In Calgary and Edmonton, where there are established clinical assistant programs, the IMGs that are successful in obtaining these positions have to date also been very successful in obtaining provincial residency training and certainly the experience of clinical assistants in the more established program in Calgary is that they dramatically improve their chances of obtaining CaRMs (Canadian Residency Matching Service) residencies as well. This is because by the time an IMG is able to successfully compete for a paid clinical assistant position and fulfill the duties of that job, he/she has the depth of knowledge about the 'culture of medicine' that is necessary to better compete for residency training. Clinical assistants can also be added to the workforce in less than six months. A short (3-6 month) evaluation/orientation is all that is needed for qualified IMGs and they could be working again as doctors. Another added bonus of expanding the use of IMG clinical assistants is the fact that these positions could be located in those areas where the services of medical doctors are needed most. As is the case now in Alberta, those interested in a position would need to apply and possibly relocate. Those not interested in a position in Prince George, as an example, need not apply.

So, not only does the expansion of clinical assistant positions get qualified international medical doctors working again as doctors, thus alleviating the shortage; it also ensures that the supply of nurses stays intact; it dramatically improves the ability of those IMG clinical assistants to get residency training and thus full licensure and they can be working in areas of BC where they are most needed and can do so in less than six months time. We recommend that the provincial government adequately fund the

Introduction of Training Program for Domestic Medical Practices

Clearly orientation is important and from a pure common-sense perspective makes a lot of sense. Internationally trained medical doctors fill out paperwork and interact with support staff/patients differently in their home country and may have also worked with different kinds of equipment. What they need is an opportunity to adapt to the way we do things here in Canada; which is not difficult, it just takes some time and they need to have access to this information and direction.

Currently there is no bridge training available to the general IMG population in BC and sadly as a result many CaRMs match residencies are left vacant rather than filled with IMGs who are missing this knowledge. The fact is that IMGs who lack orientation training have failed out of CaRMs residencies in sufficient numbers now that faculty, in many cases, are unwilling to take the risk of filling a residency with an IMG. They would rather keep a residency vacant, hoping that a CMG eventually takes it or that they are able to recruit a doctor from South Africa for example, and not have to spend any money on residency training.

Profession Specific Language Training

This training could be made available through community colleges with the ability of IMGs to access student loans in order to cover the cost of tuition. What this training does is further increase the number of IMGs who can successfully complete the mandatory national exams and/or compete for a CaRMs or St. Paul's residency positions. With greater numbers of people able to pass exams and/or compete for residency training we have a larger pool of qualified IMGs who are moving forward toward licensure. If we combine this with more residency training positions being made available, we have a recipe for more qualified IMGs working as licensed doctors.

Expansion of Residency Positions

There are two components that affect the ability of the UBC Faculty of Medicine to provide post graduate residency training. One is funds and the second is having enough 'preceptors' or training staff in order to conduct and manage the training. Although both these components are closely linked and certainly more money over time can assist in the expansion of training staff; we think there is way to expand quickly, using existing resources and have both IMG sand CMGs benefit as a result. When the famous Barer/Stoddart *"Toward integrated medical resource policies for Canada"* report was given to the Federal, Provincial, Territorial Conference of Deputy Ministers of Health in 1991, the justification was in place to reduce medical doctor enrollment in universities across the country. This came at a time when other western industrialized countries were planning for upcoming shortages of doctors and nurses due to imminent baby boomer retirements. The result was that provincial governments cut funding to medical universities and less Canadian doctors were trained, year over year for the next decade. This of course is arguably the single biggest reason we have critical medical doctor shortages today, but there was another outcome that turned out to be a boon for medical universities.

Faculties of medicine across Canada had an excess of 'preceptors' or training staff. To their credit, Universities turned this challenge around and started training more 'visa

student' doctors from countries like Saudi Arabia, Bahrain and the United Arab Emirates. Not only were universities able to keep the size of their training staff and some were even able to expand, but the fees that they could charge for training doctors from other countries were higher than what they were receiving

As a result, the University of British Columbia to this day, trains a large number of 'visa student' doctors. These are doctors who receive medical training in Canada, paid for by their home country and then must, upon completion, return to their country of origin.

The outcome of this practice is that we actually have many more' preceptors' than the public or government may realize. These training staff are not factored into the resources for domestic training however, but are kept as a completely separate resource pool and are very rarely talked about.

What we suggest is needed at this time is a re-allocation of these important 'preceptor' resources so that more CMG and IMGs retrained. We are not suggesting that UBC's practice of training other countries doctors, mostly specialists, be stopped completely; only that the number of doctors that the faculty of Medicine plans to train in the years ahead be reduced and that some of those training staff be reallocated to domestic use.

The fact is that there are many medical students graduating from UBC who are not able to get specialist training because of the lack of specialist residencies allocated for domestic purposes. We suggest that when this re-allocation occurs, that the specialist preceptors that are freed-up be used to train more UBC graduates and the family practice preceptors that they would otherwise have used, now be allocated to immigrant IMGs.

This is a win/win situation for everyone. The CMGs get more specialist residencies, IMGs get more family practice residencies and the province gets a net increase in fully licensed medical doctors. All this accomplished with existing training staff already in place at the Faculty of Medicine at UBC.

Expansion of Canada's "Acceptable List"

We believe it is now in the public's interest to have the top medical universities of our main immigration countries for the past several decades, evaluated and understood. If this was done by an independent body or with independent verification of the facts, we believe that the current list could be expanded and/or that specific shortcomings could be identified and addressed with additional short term and inexpensive training courses or other appropriate interventions.

Access to licensure does not imply the lowering of standards or the undermining the safety of the public. It increases the diversity in a profession, and thereby provides the public with better service in this multicultural society.

There are many examples of IMGs who are currently working as successful and fully licensed medical doctors in BC. Could we have integrated them more efficiently rather than forcing them to repeat their entire residency training? Are there medical training systems that are close enough to ours that graduates from those countries or universities need only take a few additional courses or evaluation/training before being licensed? The fact is that

many countries like India, Philippines or Iran base their medical education systems on the British or US model.

Creating a Supportive Environment for IMGs Saves Resources

Internationally trained medical doctors when they arrive in British Columbia benefit in so many ways by receiving clear, precise and timely direction about the challenges that lay ahead, best practices and the various tools and supports that are available.

If this is done in a supportive atmosphere, where they can meet fellow professionals, form lasting friendships, join study groups and feel part of a larger community then the results are quite profound. The most obvious outcome is that they spend less time trying to find there way around the maze of institutions, policies and deadlines that make up the various paths to licensure for IMGs. This means that the path to licensure is quicker and because there are fewer costly errors along the way, limited financial resources are not wasted.

IMGs that are supported in this way are also better candidates for orientation training and end-up taking it at the right time in the licensure process. Other outcomes such as reduced incidences of depression, less stress, greater focus on goals, increased exam scores and a more positive attitude are also important benefits as these new Canadians try to find their way back into 'community' and work as doctors again.

- October 2nd, 2006