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2009

Working Paper No. 23
Série de documents de recherche no. 23

Centre Métropolis Atlantique
Atlantic Metropolis Centre

The Atlantic Metropolis Centre's Working Papers Series
Série de documents de recherche du Centre Métropolis Atlantique

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Integration of International Medical Graduates into Rural Nova Scotia Communities: A Qualitative Pilot Study

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Abstract/Résumé:

Report on a pilot study exploring integration and retention of International Medical Graduates (IMGs) in N.S. rural locations. Discusses the policy issues surrounding the integration of IMGs and outlines directions for future research.

Keywords/Mots-clefs: immigrants, health professions, International medical graduates, internationally educated health professionals

Table of Contents

Acknowledgments

A number of organizations and individuals provided generous support and assistance during the course of this research pilot. Special thanks go first to the internationally educated physicians in Nova Scotia who took the time to share their experiences of the challenges they face coming to and staying in the province. Special thanks as well to the staff of the College of Physicians and Surgeons NS for their help locating internationally educated physicians both in and out of the province.

1. Introduction

> "The professional lives of foreign doctors exist mainly in their imagination, as they face an unpredictable future."
>
> Ranjana Srivastava, F.R.A.C.P. IMG tutor (2008)

Purpose of the Research:

This report presents the results of a research pilot intended to explore the integration and retention of internationally educated physicians (IEHPs) in Nova Scotia, particularly rural Nova Scotia. Understanding why international medical graduates (IMGs) come and why they stay in the province will help in program and policy development to reduce barriers to IEHP integration and long-term retention. While a fair amount of research has addressed the role of internationally educated medical graduates in the context of supply and demand in the physician workforce, that research has been limited to the examination of credentials, competencies, demographic characteristics and distribution across specialties, practice locations, and/or geographic regions. To date, very few studies have been based on the experiences and perspectives of IMGs/IEHPs as they relocate and navigate their way through settlement into communities, the re-accreditation process, and entry to professional practice. This research pilot explored just such issues in hopes of contributing a more textured understanding of the personal and collective experience of IMGs in Nova Scotia.

Objectives:

The objective of the pilot study was to conduct interview-based research to explore the factors influencing the retention of internationally educated physicians in rural Nova Scotia by comparing the experiences of three groups: internationally educated physicians new to rural Nova Scotia, internationally educated physicians who have been practicing in rural Nova Scotia for more than five years, and internationally educated physicians who have left the province to relocate in other Canadian provinces. The pilot is intended to support development of a fully developed study of integration and retention factors of IMGs in Nova Scotia.

Policy Context:

Immigration: Our 'New' Cultural Diversity and the Canadian Workforce Supply:

Canada formally recognizes itself as a nation built through immigration, taking pride in its historical commitment to a "multicultural mosaic" or integrationist approach to the acculturation of newcomers. Celebration and promotion of cultural diversity are matters of public policy and entail providing a range of social and cultural services to ensure that integration involves a two-way process of adaptation resting on the commitment of immigrants to Canadian society and of Canadians to the acceptance and valuing of cultural difference. In theory, then, Canada is considered to be a nation more friendly to newcomers than such assimilationist countries as its neighbour to the south.

While public discourse surrounding Canadian immigration has traditionally focused on the innovations and contributions to cultural diversity that immigrants bring to Canadian society, more recently, public attention has turned to the role of immigration in meeting workforce shortages. Canada's aging population, falling fertility rates and trend toward fewer working hours and earlier retirement make us increasingly reliant on immigration to sustain population growth and meet current and projected workforce needs. Canada is the second largest country in the world in terms of land mass but ranks 33rd in population. Twenty per cent (approximately one in five) of Canadians were born in another country, second only to Australia for percentage of the population that is foreign born. Canada's annual immigration rate relative to population size is now greater than that of any other country, including of Australia. The annual percentage of Canadian-born individuals entering the workforce is still currently greater than the number of immigrants entering the labour market; however, our domestic supply of workers will not meet future demands, and in 10 years, all net labour force growth will come from immigration. (Statistics Canada, 2007b).

In response to these labour market needs, and to the growth of a knowledge-based economy, Canadian federal immigration legislation and policies have changed to support a human capital model of immigration that favours the integration of highly skilled and professional individuals. These changes to the selection procedures of recent immigrants have been extremely successful in altering the demographic characteristics of landed immigrants, dramatically increasing the educational attainment level of those entering Canada: At the beginning of the 1990s, less than 20% of those (over age 15) entering Canada had higher degrees; currently more than 60% of newcomers are highly skilled or hold professional degrees. At the same time, increased global migration of highly educated individuals from less developed counties has lead to a shift in dominant source countries for immigration to Canada from the United Kingdom, Commonwealth countries and Western Europe to Asia (including the Middle East). (Statistics Canada, 2007b)

Professionals are now the largest group of immigrants coming to Canada, with the proportion of those intending to work within *regulated professions* increasing from 16 % in 1990 to 42% in 2000. (CIC, 2003). Unfortunately, the dramatic success in increasing the numbers of highly skilled and professional immigrants entering Canada has not been matched with equal success by their labour-market integration. Despite their having higher educational and skill levels, the unemployment rate of recent immigrants (12%) is nearly twice that of the Canadian-born population (6.4%), and although 80% of immigrants find full-time work within two years of arrival, only 42% find employment in their

field. (Tocci 2007) Furthermore, the *low income rate* among new immigrants *rose* from 24.6% in 1980 to 35.8% and has continued to do so since 2000. (Picot,G. Hou, & F. Coulombes, S. 2007) In other words, immigrant poverty has increased and earnings have decreased over the past two and one half decades.

Current research indicates that these dismal labour market outcomes are partially accounted for by economic cycles and the mini-recession created by downturns in the high-tech sector. (Picot et al 2007)The shift in source countries of Canada's most recent immigrants has also been identified as a significant factor influencing low income rates and has particular significance in the context of barriers to professional employment. (Picot,G. et al , 2007, Saunders, P. 2007b, Boyd & Schellenberg, G. 2007, Hall P. et al 2004) Whelan, GP 2006, Baldacchino et al 2007) Recent professional immigrants face greater language barriers and far *greater national differences* between the *methods and length of education and training programs* and between professional *cultures* than those who entered before the 1990s. (Hall, P, 2004, Baldacchino, G et al 2007)As a result, their acculturation is more difficult, and their need for assessment, skills enhancement, bridge programs, and training opportunities as prerequisites for integration to employment is greater. Because capacity development and implementation of such transitional supports have been *uneven across the country* and have *not kept pace* with the rising numbers of immigrant professionals migrating to Canada, access to such programs continues to be highly competitive and varies considerably from province to province. The end result is that many IEHPs are left completely outside the systemic training process. This discouraging situation might in part explain why 67% of immigrants since 2000 who indicated at the time of immigration that they were seeking employment in a health occupation simply did not apply to have their credentials assessed after they have arrived (Statistics Canada, 2007a). As Dale Dauphinee (2005, 2007) has demonstrated, this 'bottleneck' effect is the result of a "failure in corporate memory' that did not recognize the gap between "federal immigration policy and the restrictive workforce policies of the ministries of health"(2007) that left regulatory bodies and educational institutions unprepared for the rapid influx of health professionals whose characteristics and integration needs are very different from those who entered the professions through the 1960s and early 1970s**.** Of the 33% who do have their credentials assessed, 36% obtained full recognition, while 35% received partial recognition of their credentials. (Statistics Canada, 2007a a)

Clearly, if immigrants cannot convert training into productive employment, Canadian immigration and human resource development policies will not meet the expectations of immigrants and the Canadian public alike. Unsurprisingly, there has been no shortage of media coverage of the apparent disconnect between policies that promote a human capital immigration model of further skills enhancement to ensure workplace integration and the stark reality of highly educated immigrants who find themselves working as cab drivers or delivering pizza. When the report concerns an internationally educated doctor or nurse, the tone is likely to turn from baffled incredulity over the waste of human resources to anger fueled by public frustration over shortages of health professionals, and growing suspicions of 'creeping credentialism' and turf protection on the part of Canadian health care professions. (Milne, 2003)[1] Nor should it be surprising that political pressure to quickly address the barriers to professional employment

1 The public tends to assume that problems of access to primary medical care are the direct result of physician shortages and that physicians have done little to dissuade them of this idea. Health Canada introduced an Inter-Professional training initiative at the same time as the IEHPI to address the underutilization of allied health care professionals. For an early, but still relevant, discussion of IMGs in the context of Canadian physician supply and the use (and underuse) of allied health professionals in the context of professional 'turf protection .' see Evans (1976 .).

for internationally educated health professionals has intensified. Quick solutions to the problem of professional immigrant underemployment are, however, difficult to achieve, particularly within the regulated professions where complex and interacting jurisdictional roles and responsibilities must come together to create the required kinds of systemic change. Nowhere is this more true than in the health professions.

Context of the pilot study: Internationally Educated Health Professionals in Nova Scotia: issues and challenges

In 2003, Nova Scotia's Department of Health mounted a new initiative called "Your Health Matters," which includes reducing barriers to employment and increasing the number of IMGs and IEHPs in practice as one of five strategies for addressing the province's health workforce needs. (Nova Scotia Department of Health,(2005-2006) The primary challenges for Nova Scotia in meeting this goal are limited training capacity in health professional education programs; the relatively low numbers of IEHPs in the province, which has implications for the sustainability of various assessment and support initiatives; competition from the rapidly expanding options for assessment and bridge to employment outside the region; and the historical difficulty of the Atlantic region to attract and retain immigrants.

Although immigration to the region has been growing, -- by 38% for the region, 34% for Nova Scotia, in 2006-- Nova Scotia's share of Canadian immigrants is only 1%. All four Atlantic provinces have problems retaining immigrants, but Nova Scotia has the lowest rate of retention at only 40% (Nova Scotia Office of Immigration, 2007).

The Nova Scotia Office of Immigration announced an immigration strategy in 2005 with the ambitious goals of more than doubling the number of immigrants entering the province – an additional 3,600 over four years--and increasing the retention rate from 40% to 70% by 2011. It also identifies the recruitment of health professionals, particularly specialists, as a key initiative. If successful, Nova Scotia's immigration initiatives would contribute directly to the attraction and retention of IEHPs.

During 2005-2006 (2007 figures were not available), 111 internationally educated health professionals came to Nova Scotia, more than 50% of whom were physicians. In the seven health professions prioritized by the IEHPI and IEHP Atlantic Connection, the totals were as follows: medicine-59 (family physicians-19, specialists -40); nursing-14; medical laboratory science & medical radiation technology-4; pharmacy-8; physiotherapy-3 and occupational therapy-1 (Nova Scotia Office of Immigration, 2008).

Physicians are clearly the dominant group. As of January 2008, Nova Scotia had 2,729 active physicians, of whom 757 (29%) had received their medical degree outside Canada (IMGs), more than double the number (314 or 12%) of licensed IMGs in Nova Scotia in 2000. Close to half (46%) of those currently in professional practice hold restricted or temporary licenses.

In 2005, Nova Scotia, the first province to have undertaken such a 'practice ready' program, began a curriculum for IMGs through the College of Physicians and Surgeons of Nova Scotia's "Clinical Assessment for Practice Program' (CAPP). Nova Scotia thus has taken an important and successful first step in attracting much needed IMGs to the province. What remains to be seen is whether their

integration into and retention in the communities they enter will succeed. Most CAPP physicians will join rural communities where very few settlement services and few immigrant networks exist to help in their integration. This qualitative pilot study will explore the factors that influence IMG integration into Nova Scotia communities, particularly rural communities, and how these factors may affect their decision to stay.

2. Method

This research pilot was funded by the Atlantic Metropolis Centre (AMC) as part of the 2005-06 pilot grant competition whose mandate was to support initial research in support of submission of fully developed research grant proposals.

The researchers obtained ethics approval from Dalhousie's Health Sciences and Humanities Human Research Ethics Board (Protocol # 2006-1295) in June 2006 and developed a questionnaire of open-ended questions designed to explore participants' experiences of integration and professional practice in Nova Scotia's rural communities in one-on-one interviews.

Research participant groups: We hoped to recruit 11 CAPP IMG physicians (total number of successful candidates in the first assessment) who were entering Nova Scotia rural communities in the fall of 2005, 15 IMGs who had been practicing on Defined Licenses in rural Nova Scotia for more than five years, and 15 IMGs who had left rural practice in Nova Scotia permanently to relocate elsewhere. A list of potential participants and contact information was developed with the assistance of the CPSNS. In the fall of 2007, potential participants were recruited by direct mailing a letter of invitation to 42 individuals. Those who responded were contacted by the researcher by email or phone to arrange an interview time. Three interviews were held in the fall of 2007.

In January 2008, a second mailing was sent to potential participants, and three further participants responded. Two were interviewed in March 2008, and the third withdrew. In total 42 potential participants were contacted. This number represents all of the actual members of each identified subject group.

The response rate was clearly very low. Only one out-of-province internationally educated physician responded, and in the end, he declined to be interviewed. The remaining five were all recently arrived internationally educated physicians and all participants in the CAPP program, one of whom also decided to withdraw from the interview after it was completed. No respondents were recruited from the group of IMGs who have been practicing in the province for more than five years.

IEHPs are risk averse for a number of reasons, including their professional vulnerability while they are still in the registration process, their difficulty gaining access to the Canadian health care professions most of them have experienced since arrival, and their desire to not be labelled as IEHPS/IMGS once they have gained Canadian credentials. In addition, the total population of known IMGs in Nova Scotia is relatively small, and, as a result, the same individuals are approached repeatedly to participate in research studies. This is particularly true for those for internationally educated physicians who have been the focus of most IEHP research. Finally, IMG professionals' workload prevented them from

participating. Our lack of success in recruiting participants, despite follow-up efforts, reflects this reality.

3. Results:

As all four interview participants were new to the province and were current participants in the Clinical Assessment for Practice Program (CPSNS), the objective of exploring factors affecting retention by comparing the three identified subject groups was not possible. While the experiences recounted by the four participants were interesting, the lack of any comparative data and the very limited number of participant interviews made it impossible to fully complete the study.

Therefore, because the interview data were insufficient to provide reliable and meaningful results, they were not formally coded for thematic analysis. The interview responses did, however, provide general insights into the experiences of recent newcomer internationally educated physicians, particularly in terms of the role of mentoring in supporting community integration and IMGs' general perceptions of strengths and limits of rural community and the Atlantic region more generally. Notably, three of the four participants indicated that the lack of anonymity in the study had made them think twice before responding to the invitation to participate, a concern eventually outweighed by the desire to improve the situation of IMGs in the province. These responses confirm both the value, and the real difficulty, of conducting qualitative research with 'at risk' or vulnerable groups.

4. Dissemination and Pilot Contribution to Developed Research Proposals:

The informal results of the pilot study were presented at a conference (Saunders, 2007a, Saunders, 2007b) and a symposium (Saunders& Frank, 2006).

Contribution to New Research Proposals:

Although it did not generate enough data to provide reliable conclusions, this research was nevertheless useful for informing the development of a subsequent research proposal for a survey-based study of factors influencing the attraction and retention of internationally educated health professionals in Nova Scotia and the other Atlantic provinces. That study--*Internationally Educated Health Professionals in Nova Scotia: Why they come, why they stay and the challenges they face*. – was part of a research collaboration among the Atlantic provinces. In 2007, it was successfully submitted for funding to the IEHP: Atlantic Connection, Nova Scotia Department of Health, by Patricia Saunders and completed in March 2008.

5. Future Research Directions:

Strategies for retaining both IMGs and IEHPs have received much less attention than efforts to reduce the barriers to employment for the obvious reason that without these efforts, there will be few IEHPs to retain! IEHPs are often discussed as though they were a homogeneous group, but differences in profession, gender, age, amount and type of previous education and practice experience, to name only the most obvious, all form particular sub-categories with the group as a whole. While little research has attempted to examine these differences more closely, a recent study of retention of IMGs in rural

Australia is a notable exception and has direct relevance to this report. Based on interviews with 57 IMGs on return for service contracts in rural locations, the researchers identified four types of IMGs categorized by their degree of integration into rural communities. They are 'satellite operators' (city-oriented), 'fence-sitters' (affiliated with city fringe areas), the 'ambivalent' (unsure about their future settlement place), and those 'integrated' into rural communities. (Han, G. and Humphries, J., 2006).Those most integrated into rural locations were the most aware of the requirement that they begin practice in a rural location at the time of immigration, did not regard relatives as a key influence in determining where to live, were able to live comfortably as a minority in a foreign culture (accommodating occasional discriminatory comments or acts), were pragmatic about the limits of rural life, and valued what they perceive to be the collegial and co-operative work environments in rural communities. At the other end of the spectrum, 'satellite operators' are likely to attempt to live in the city and commute to their rural practice. They rarely remain past their mandatory period, returning to the city, which is the centre of their family's cultural needs. "Fence sitters' live within 60-100 kilometers of the city and experience living between cultures –rural and urban—as having the best of two worlds, a lifestyle we earlier suggested was a possible attraction and retention feature Nova Scotia is well placed to promote.

Finally, those who are ambivalent remain unsure whether they will remain but can sometimes be persuaded. Often, educational opportunities for children or spousal employment are the source of uncertainty rather than a desire to be in an urban environment. For brevity's sake, the typology the researchers present has been simplified, but even in reduced form, it usefully points to the heterogeneity of IEHPs and the unlikely success of 'one size fits all' policies for addressing retention – or recruitment—challenges.

These findings are supported by the region-wide survey-based study that has been completed. Future research on IEHP/IMG recruitment and retention might usefully focus on the development, execution and assessment of strategies and initiatives for IEHP/IMGs physicians that target those *most likely* to stay.

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