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# **BRAIN GAIN, DRAIN & WASTE: The Experiences of Internationally Educated Health Professionals in Canada**

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### Take Home Messages

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- Most of the internationally educated health professionals (IEHPs) that we spoke to approached their migration to Canada with a sense of optimism and hope of being productive members of Canadian society and bringing their skills and knowledge to their new home.
- Most found it difficult to tease apart the 'push' and 'pull' factors that cause IEHPs to emigrate from their home countries to come to Canada. They typically choose Canada as a country of destination as it: 1) has a relatively easy process of immigration; 2) has the reputation of a country with political and economic stability; 3) has fair international politics; 4) promotes multiculturalism; and 5) gives the impression that health care providers are in demand.
- Knowledge of the perceived shortages in health care creates a great deal of confusion to these IEHPs when they face insurmountable barriers to obtaining a license to practice and respond to the health care needs of the Canadian population. Receiving points for their education in their immigration application process further compounds this confusion.
- Those who found it most difficult to integrate into their profession were those who came as refugees, followed by those who came independently in either the economic or family class; those who were recruited – and this was more likely for IENs - were most likely to have largely positive labour market outcomes in the health care sector.
- All of the IEHPs we interviewed faced very similar barriers in terms of their English or French language skills, particularly those which are profession-specific; financial difficulties related to the requirements for licensure which is compounded by the time-consuming and seemingly bureaucratic nature of the process; and the challenge posed by the lack of opportunity to gain Canadian cultural competency. The strongest barrier for IMGs is the lack of residency positions; for IENs it is the level of education; and ITMs are confronted with the small size of their profession, its relative newness and the primary care model of practice.
- Key facilitators to integration include: encouraging IEHPs to make as many arrangements as possible prior to immigration; making appropriately targeted information sessions available at the outset and throughout the immigration and integration process; the creation of more and expanded assessment and bridging programs; and clarifying routes to alternative employment options to utilize IEHPs at their highest skill level.
- Key recommendations for changes to policies or programs include: 1) Improve access to health sector/profession-specific language training; 2) Address financial difficulties through an IEHP-targeted loans program and counseling to improve the labour market positions of IEHPs during the professional integration process; 3) Make information available from *multiple sources* and at multiple points in the integration process and ensure that this information conveys *consistent* messages about the process and likely outcomes; and 4) Increase opportunities to gain cultural competence, both formally and informally.

- Many of our findings and recommendations are consistent with earlier research and policy briefs. This should be taken as an indication of the stability of some of the key issues, and that our participants are not unique in any particular way that would limit the transferability of our findings. Our comparative approach does, however, allow us to make some important and unique contributions to this policy literature.

## **Executive Summary**

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Canada has historically relied on internationally educated health professionals (IEHPs) to address shortages in rural and remote locations and hard to fill positions within its health care system. It continues to do so and, while this has been true for medical and nursing labour in the past, this is now also true for midwives. At the same time, we hear of numerous accounts of IEHPs who are not able to practice their profession in Canada. The barriers to practice for IEHPs – what some have labelled the ‘brain waste’ problem – have recently become a significant concern for Canadians. The difficulties this causes are not limited to the Canadian context – in terms of lost labour, and possible solutions to its human resource crises – there are important implications for the countries from which health care providers migrate.

This study was designed to fill some of these gaps in our knowledge by examining:

- the experiences of internationally educated physicians, nurses and midwives who were pursuing professional integration, who have achieved it, and who have decided to redirect their efforts; and
- the barriers and facilitators they experienced along the way that they feel influenced their relative success at becoming integrated into provincial health care systems in Canada.

From the outset we decided to gather the perspectives of the IEHPs. This was intended to supplement the policy recommendations that have been made through stakeholder consultations, because the issues that have come to the attention of Canadian stakeholders may or may not be a true reflection of IEHP experiences. The analysis took a comparative approach between professions, as it allowed us to contrast the process and outcomes of various models of integration across professions. We conducted interviews with 67 international medical graduates (IMGs), 70 internationally educated nurses (IENs) and 39 internationally trained midwives (ITMs), recruited through a variety of means in four provinces – British Columbia, Manitoba, Ontario and Quebec - and in two languages. Based on these conversations, we traced their experiences, from their decision to come to Canada, through the process they undertook to get here, and then examined the barriers and facilitators to their professional and labour market integration. We include some of their recommendations for policy to improve the situation for others who follow their path.

### **DECIDING TO LEAVE AND COME TO CANADA**

The majority of our IMG respondents came from Eastern Europe, followed by the Middle East and South America, East Asia and Western Europe in equal numbers. The three most common countries of birth for IENs were Western Europe, Eastern Europe and the U.K. Most of the ITMs we interviewed were born in Canada – a fact which largely reflects of the relative lack of Canadian educational opportunities for midwives – followed by Western Africa and Western Europe and then the U.K. close behind.

It is difficult to tease apart the 'push' and 'pull' factors that cause IEHPs to emigrate from their home countries to Canada. Most, however, choose Canada as a country of destination as it 1) has a relatively easy process of immigration; 2) has the reputation of a country with political and economic stability; 3) has fair international politics; 4) promotes multiculturalism; and 5) gives the impression that health care providers are in demand.

### **IMMIGRATION TO CANADA**

The first step for most health care providers is the national system of immigration, although for some, this is a second step, following recruitment. While there are tremendous differences in immigration preparations undertaken by our respondents, it is possible to categorize them into having followed one of four different routes: 1) independent immigration, through one of two possible immigration entry points (economic or family class); 2) immigration to Canada through recruitment agencies (largely economic class), 3) immigration to Canada with the help of agencies that solely provide assistance with immigration per se, without helping immigrants find work (which could be either economic or family class); and 4) entry to Canada as refugees. The largest proportion of respondents came as skilled workers but this proportion is far greater for the IENs and IMGs than for the ITMs. There were almost as many ITMs who came as family as who did so as skilled workers; far fewer IENs and IMGs came as family class than as skilled workers. Those who found it most difficult to integrate into their profession were those who came as refugees, followed by those who came independently. Those who were recruited were most likely to have largely positive labour market outcomes in the health care sector.

### **BARRIERS TO PROFESSIONAL AND LABOUR MARKET INTEGRATION**

There are number of barriers which IEHPs face while seeking to integrate into the Canadian workforce. Some are unique to their individual profession, some are similar across health professions, and some are similar to the migration of highly skilled workers generally. All of the IEHPs we interviewed faced very similar barriers in terms of: their English or French language skills, particularly those which are profession-specific; financial difficulties related to the requirements for licensure which is compounded by the time-consuming and seemingly bureaucratic nature of the process; and the challenge posed by the lack of opportunity to gain Canadian cultural competency.

Our IMG participants described two key barriers specific to their professional integration process. The first relates to the three standardized MCC examinations. The other, more challenging, barrier is the relative lack of access to residency training programs. Many also felt that they were unable to find a temporary position during their transition to practice medicine. Many respondents complained about lack of positions which would allow them to utilize their health care skills working in a related field. Many IMGs felt that since the chances of them getting into medicine were very low, the time that they spent on preparing for the exams would be less likely to feel wasted if they could have found a job in a health care setting.

In addition to the language and cultural competency barriers that were salient for IENs, and the problems with the perceived culturally laden nature of CRNE exam, an additional barrier



unique to this profession is related to level of education – degree or diploma. IENs often have to decide which process of accreditation (LPN, or RN) to take without actually knowing the difference between different levels of nursing in Canada. Another barrier to satisfactory integration cited by IEN respondents is a lack of full recognition of education and work experience.

ITMs in Canada identified two unique barriers to integration: 1) the challenges of the relative newness of the profession, which results in both a low number of available preceptors to date, and, until most recently, a lack of availability of integration programs; and 2) the difficulties posed by the primary care model of Canadian midwifery and its requirement to offer midwifery services in home settings.

There are a number of consequences that directly result from these professional integration barriers for the IEHPs we interviewed. For many, it means *downward professional mobility*. Although some of this may initially be a strategic choice on the part of the IEHP themselves, in most cases, it is imposed. The added dimension of being considered over-qualified for many other positions in health care makes the situation for IMGs particularly difficult.

#### **FACILITATORS TO PROFESSIONAL AND LABOUR MARKET INTEGRATION**

The key facilitators to integration that were most salient to the IEHPS included making as many arrangements for integration as possible prior to immigration. Several of the IEHPs also felt that appropriately targeted information sessions available at the outset and throughout the immigration and integration process facilitated their success. The primary facilitator identified was the various bridging programs that have been established, which not only help to upgrade skills, but also assist with the amorphous cultural competency problems. They nevertheless had some concerns with the accessibility of bridging programs in terms of available spots, geographic availability and financial constraints; and the coordination of those programs, in terms of the design of the program and who is in charge and, in some cases, the content, which they feel should be more adequately tailored to fit the needs of IEHPs. Finally, they described how alternative routes to utilize health professional skills can be both a facilitator to integration, as well as an end in and of itself, for those deciding to redirect their efforts.

#### **POLICY RECOMMENDATIONS**

Our participants suggested the following general recommendations for changes to policies or programs:

- Improve access to health sector and profession-specific language training;
- Address financial difficulties through a IEHP-targeted loans program and counselling to improve the labour market positions of IEHPs during the professional integration process;
- Make information available from *multiple sources* and at multiple points in the integration process – but with a *consistent* message about the process and likely outcomes; and
- Increase opportunities to gain cultural competence both formally and informally.

The IMGs specifically suggested that there be a higher likelihood of a residency position for those who pass MCC exams, approximating chances of Canadian medical graduates who successfully pass exams. IENs suggested that an approach that focuses on competency, rather than 'one-size-fits-all' examination and credential-based approach be considered. ITMs suggested that the range of modalities for midwifery practice be expanded but, in the mean time, allow for some on-the-job shadowing to gain insight into the Canadian primary care model.

### **COMPARISONS & CONCLUSIONS**

Many of our findings and recommendations are consistent with earlier research and policy briefs. This is an indication of the stability of some of the key issues, and that our participants are not unique in any particular way that would limit the transferability of our findings. Our comparative approach, however, does allow us to make some important and unique contributions to this policy literature. With respect to interprovincial differences, although all provinces we studied had relatively similar requirements for obtaining a license, IEHPs immigrating to each of these provinces had somewhat different experiences. The availability of bridging opportunities, the perceived willingness of health authorities to integrate IEHPs, and the availability of informal social networks, made each province different in its perceived readiness to accept IEHPs and integrate them into the local workforce. IEHPs both recognize and denounce some of these jurisdictional differences. They call for simpler, standardized and nationally based licensing requirements. With respect to interprofessional comparisons, although many similarities between professions were found, the logistical structure around licensing varied from one profession to another. While IMGs and ITMs reported the greatest difficulties around licensing, IENs also had their share of struggles, which varied in complexity according to their country of origin and their destination province. Interviewing IEHPs at different stages of the process of integration gave us a unique opportunity to assess the differences in the experiences of IEHPs at these different stages.

### **INTRODUCTION**

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Canada has both historically encouraged, and more recently relied on, internationally educated health professionals (IEHPs) to address shortages in rural and remote locations and hard to fill positions within its health care system. This has been true for medical and nursing labour, and only more recently, for midwives, due largely to our unique historical exclusion of midwifery from our formal health care division of labour. Throughout the 1970s, roughly a third of the physicians practicing in our health care system were international medical graduates (IMGs). Although this has dropped to 23% more recently, we still have a dependence on other countries to train the physicians that work here (Canadian Institute for Health Information, 2003). Canada relies on a smaller percentage of internationally educated nurses (IENs). Six to eight percent of all Registered Nurses in Canada are IENs. However, their numbers are sizeable, at over 22,000 in 2008, compared to nearly 16,000 IMGs. Due to the relatively recent integration of midwifery into various provincial health care systems (i.e., only since 1994), many practicing midwives are

internationally educated, though the exact percentage of internationally trained midwives (ITMs) is unknown.

The profile of IEHPs coming to Canada has shifted over time. In the 1970s, the majority of IMGs came from English-speaking countries, such as Ireland or the United Kingdom. For example, in 1985, 35% of IMGs who entered Canada came from UK and Ireland, but this proportion has fallen to just over 5% in 2000. Now the primary source of IMGs is South Africa. South African IMGs accounted for 24% of those who entered Canada in 2000, up from 9% in 1985 (CIHI 2001). Similar educational systems and proficiency in English made the process of integration of these IMGs relatively simple: their credentials and training could be assessed according to Canadian standards and most were often fast-tracked. Nurses from the Philippines have been one of the primary sources of IENs in Canada, but nurses from the U.K. represent a close second (29 and 21% respectively) (Little 2005), with nurses from the U.S. (7%) and Hong Kong (6%) representing smaller groups. ITMs have been educated in a range of countries, but come to Canada from the U.K. and the U.S. in particular. Due the lack, until most recently, of local educational programs, many of these ITMs are Canadian citizens who have gone elsewhere for at least part of their training with the intention of coming back home to practice.

These numbers only reveal part of the story for IEHPs in Canada: the story of those who have successfully integrated into their profession. Increasingly, we hear of numerous accounts of IEHPs not being able to practice their profession. The barriers to practice for IEHPs – what some have labelled the ‘brain waste’ problem – have recently become a salient topic in the Canadian public arena. Nearly every month the print, radio or television media release a new story about IMGs who, instead of practicing in their field, are delivering pizzas or driving taxis. We even have television commercials that highlight this issue. What these stories typically ask is, ‘why are highly skilled health professionals not being integrated at the same time as Canada seems to be experiencing a shortage of health personnel?’ Media concerns have, however, become mirrored by policy makers at the federal and provincial levels and several initiatives to facilitate the process of integration of IEHPs have been developed (RCPSC 2006; Task Force 2005). These initiatives include: information portals available on the Internet for skilled immigrants to Canada, bridging programs run by the provincial governments, expansion of the number of residency positions accepting IMGs, and other programs designed to facilitate the integration of IEHPs (Bourgeault 2006).

Some researchers have identified one of the causes of this problem as the fact that there are “[c]omplex and interdependent actors in multiple jurisdictions with unaligned accountabilities. Governments do one thing, educational institutions do another, and regulatory authorities do a third” (Fooks 2004). As a result, we have not had (until recently) any nationally or provincially coordinated policy to address the integration of IEHPs. Others highlight how IEHPs are coming from a wider variety of nations making English language proficiency and credential equivalency key issues for health professional regulators tasked with the maintenance of high professional standards and the protection of the public. The absence of coordinated policy and programs in Canada to address the shifting demographic features of IEHPs is notable in light of the

associated problems of lost labour and potential solutions to human resource crises, and also because of the increasingly salient ethical issues associated with the international migration or brain drain of highly skilled health workers (Buchan & Sochalski 2004; Mullan 2005; WHO 2005). Indeed, the ethical issues raised by the increasing migration of health care providers, particularly from developing countries, have moved to the forefront of not just health policy but also foreign policy agendas (Bach 2003).

This study was designed to fill some of the gaps in our knowledge by examining:

- the experiences of internationally educated physicians, nurses and midwives who were pursuing professional integration, who have achieved it and who have decided to redirect their efforts; and
- the barriers and facilitators they experienced along the way that they feel influenced their relative success at becoming integrated into provincial health care systems in Canada.

From the outset we decided to gather the perspectives of the IEHPs themselves. This was intended to supplement the policy recommendations that have been made through various stakeholder consultations. To date, there has been a great deal of media attention paid to the plight of IEHPs coming to Canada – and IMGs in particular (i.e., through newscasts and documentaries like *The Big Wait* (Osborne & Jackson 2010)). The issues that have come to the attention of various Canadian stakeholders may or may not be a true reflection of the IEHPs experiences of policy and programmatic disconnects. We borrow insights from the IEHPs lived experiences to offer another perspective on a) what the key problems are, and b) how to address these problems. This is not to say that recent policy changes have not been appropriately matched to the challenges faced. Indeed, in this report we highlight some of the most promising practices in this regard. We provide additional support for these practices and, through the words of our participants, we urge expansion of these initiatives.

The analysis took a comparative approach between professions. We found that although there is a growing mass of literature devoted to the migration of physicians and nurses, very little explicitly compares the situation across these two professions and even fewer look at the migration experiences of other health professionals, such as midwives. Comparative research of this nature allows us to contrast the process and outcomes of various models created to assist with immigration and integration across professions, and also helps identify key factors, such as gender, that influence the migration process.

### **The Context of Health Labour Migration in Canada**

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Before delving into the insights of respondents, it is helpful to look at a brief synopsis of what we know of the history and current situation of health professional migration in Canada and the key contextual issues that impact upon the integration of IEHPs in Canada. On the *demand* side, there has been a concern with shortages of health human resources presently and projected into the future. This is always acute in rural and remote locations and for some professions more than others (i.e., physicians and nurses). Added to this mix is the issue of interprovincial migration that causes the shortages to be felt more acutely in some provinces than in others. Certain sectors within nursing, for example, are also hard to fill. This has led to an overall

increase in demand on IEHPs, but more so in some jurisdictions and sectors than others. On the *supply* side, shifts in immigration policy have influenced the international make up of the health care workforce. This has become especially true most recently, with the use of the Provincial Nominee Program, a route by which many IEHPs are recruited to Canada, but this also affects those who come to Canada independently or to be reunited with family.

### **A Brief History of Migration & Health Human Resources in Canada**

The ebb and flow of health professionals into Canada is a reflection of policy decisions and the broader policy context of health human resources. Prior to the 1970s, IEHPs were generally welcomed into Canada and made up a significant portion of the health workforce. Many nurses from Britain, particularly those with advanced training in midwifery, were recruited by Health Canada in the 1960s to serve in northern outposts (Mason 1988). Both tighter immigration policies and a change in Health and Welfare Canada policy in the early 1970s to one that required all pregnant women residing in isolated and under populated northern areas of Canada to travel to urban hospitals located in the south to deliver their babies, led to an overall reduction in the number of immigrant nurse-midwives practicing in rural and remote areas of Canada (Bourgeault & Benoit 2004). Unfortunately, unlike the case for medicine, we do not have demographic data readily available to describe these trends.

In the 1960s, there were more IMGs entering Canada than there were physicians being educated in Canada. While this influx dampened somewhat with the expansion of medical schools in the late 1960s and early 1970s, the downward trend in immigration of IMGs in the mid 1970s reflected projections of a surplus of physicians. The number of post-graduate training spaces was limited as a result, along with a number of other measures affecting Canada's attractiveness to IMGs (CIHI 2003). For example, whereas prior to 1975, IMGs were granted the maximum 15 points for occupational demand, a change in policy that year meant that incoming physicians were assigned no points, virtually disqualifying an applicant who could not produce evidence of a concrete job offer (Roos et al. 1976). As a result, the number of immigrants claiming medicine as their intended occupation fell dramatically. These trends were consistent with the recommendations of the National Committee on Physician Manpower who wanted to focus on the goal of *self-reliance* for future physician needs (CMA 1999). The most significant measure to restrict IMGs was the reduction in the recruitment of visa trainees, which in Ontario dropped from 210 positions in 1990/1991 to 77 positions in 1993/1994 (Chan 2002). A retrenchment of numbers was paralleled by a narrowing of the definition of suitable source countries, as Grant (2004) states, "Since 1975, ...admission ...has been highly selective and largely restricted to the graduates of medical schools in former Commonwealth countries where academic standards are compatible with those in Canada." (p. 2)

Data compiled on nurses and IENs since 1980 reveals that the same decrease in numbers of IMGs in Canada can be observed for IENs from almost 10% in 1985 to 6.2% in 2000. Two main factors explain this decrease: 1) nursing, like medicine, was removed from the list which specified the employable trades and professions which were accepted into Canada; and 2) public health sector cutbacks during the 1990s had a significant effect on curbing the demand

for nurses in general (Dumont et al. 2008). Indeed, many Canadian educated nurses migrated to the U.S. during this time period.

### **Health Workforce Shortage: the *demand* side**

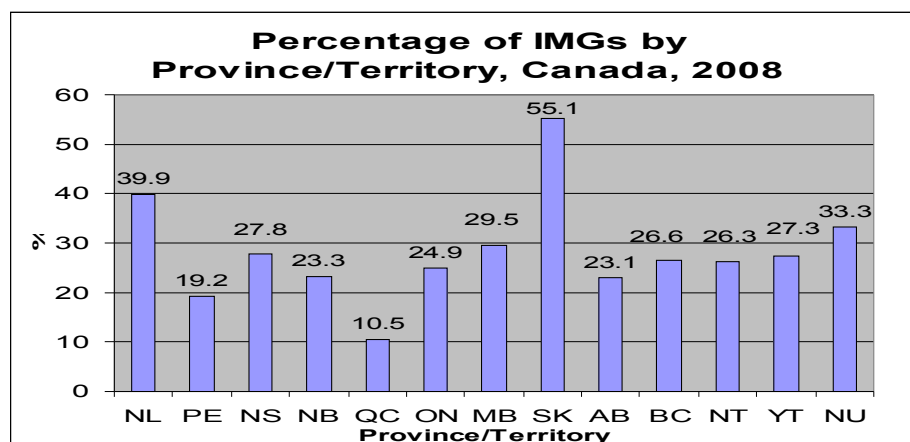
As fear of looming health workforce shortages began to take hold in the late 1990s the number of IEHPs licensed and practicing in Canada has been on the rise. Medical professional associations, working groups and others began to discuss a shortage of physicians. As Grant (2004) states, "After years of seeking to curtail the number of physicians, and foreign-trained physicians in particular, practicing in the country, there is growing support for the view of an impending shortage." (p. 7). Similarly, the demographics of the Canadian nursing population indicate an increasing number eligible for retirement in 2006, which is further indication of the serious and impending nursing shortage in Canada (Shamian 2006). In 2005, the Canadian Association of Nursing (CAN) reported findings from a 2004 OECD study that showed that "Canada had the highest relative nursing shortage of the six countries examined, at 6.9 per cent of the present workforce." (CNA 2005i:4). Various measures are being taken to counter the anticipated shortages of health care professionals in Canada.

### ***Physicians:***

There have been aggressive recruitment campaigns by educational facilities to enrol more medical students. Since 2003, British Columbia has doubled its enrolment into medical school from 128 to 256 in 2007. In Quebec, the rates rose from 450 in 1999 to 700 in 2007. In Ontario, they climbed from 532 in 1999 to 810 in 2007 (Dumont et al. 2008). Interprovincial differences in enrolment and graduation rates have had a direct impact on the number of IMGs licensed by that province. Interprovincial migration of health care workers tends to follow these trends: British Columbia continues to attract health care workers, as has Ontario, until most recently; Alberta has begun to benefit from interprovincial movement; while Manitoba is a net loser and Quebec tends to be relatively stable, largely because of the boundaries created by language (Dumont et al. 2008, p. 30).

Provinces that tend to lose more physicians through interprovincial migration tend to compensate by recruiting and licensing more IMGs (Ryan & Stuart 2007). For example, in 2008, Saskatchewan had the highest percentage of licensed IMGs in the country at 55%, and nearly 40% in Newfoundland and Labrador were trained abroad (see Figure 1). Rates in Ontario, Manitoba and B.C. all hover near the national average. In Quebec, only about 11% of physicians were internationally educated (CMA Masterfile 2008). Numerically, the majority of IMGs in Canada in 2008 worked in Ontario (5,904), followed by British Columbia (2,558), and Quebec (1,721); Manitoba had 687.

**Figure 1: Percentage of IMGs by Province/Territory, Canada, 2008**



\*Note: Excludes residents and physicians over age 80; includes non-clinicians licensed to practice.

Source: CMA Masterfile, January 2008. Accessed at:

[http://www.cma.ca/multimedia/CMA/Content/Images/Inside\\_cma/Statistics/09GradCountry.pdf](http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Statistics/09GradCountry.pdf)

Another motivating factor for several provinces to recruit IMGs is the need to fill the dire shortages in their rural regions. Canadian trained physicians tend to remain in busier urban areas, and rural regions often have a difficult time attracting and retaining a sufficient health work force. CIHI statistics (2007) indicate that the highest provincial proportions of practicing IMGs are found in rural areas or very small urban regions. As an incentive for IMGs to live and work in these underserved areas, some provinces provide an alternative, accelerated route to licensing for these professionals. This pathway is established under the guise of provisional licenses, whereby IMGs enter into an agreement to work in a “specific location for a fixed term” of between two and five years. The duration of the working term generally coincides with the time required in clinical practice before a physician qualifies for a permanent license. Once the term expires, IMGs are generally awarded full licensure and all restrictions on practice and location are then removed (Audas et al. 2005). Thus, the problem of under servicing is not resolved, but simply delayed (Dumont et al. 2008).

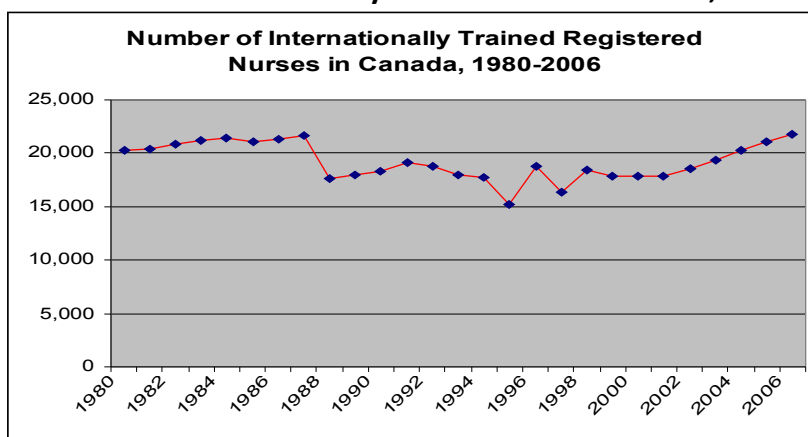
Provinces in Western Canada (British Columbia, Alberta, Manitoba and Saskatchewan) have implemented specific policies designed to attract and retain IMGs (as well as Canadian medical graduates) to small and rural communities, including specific financial incentives, thereby reducing turnover. In Saskatchewan and Manitoba, IMGs who move to rural regions are offered salaried employment, which is more suited to the type of practice found in those regions, rather than fee-for service payment. Manitoba also offers a 5%-10% higher pay scale for physicians working in rural and remote regions. A similar approach has been adopted in British Columbia for physicians working in specific northern and remote regions, but lump sum incentives are added to the increased pay scale (Fournier et al. 2004).

#### **Nurses:**

Studies have been conducted to assess the retention difficulties in nursing. The quality of work-life balance has been identified as a key issue. In 2001, absenteeism among RNs working full-time was 83% higher than in the general labour force (Dumont et al. 2008). Attempts are being

made to address these issues, but in the meantime, there has been a heavy reliance on recruitment of IENs to fill in the nursing gaps in Canada. Recent demographic data on Canada’s nursing workforce confirms that Canada’s healthcare system reliance upon IENs has remained steady over the past twenty years and has increased slightly in recent years following the cutbacks of the mid 1990s (Figure 2).

**Figure 2: Number of Internationally Educated RNs in Canada, 1980-2006**



Source: CIHI. 2008. “Numbers of Internationally Trained Registered Nurses in Canada, 1980-2006.” excel file, edited by Lori Kirby. Ottawa: NDB/CIHI.

British Columbia has the highest proportion of IENs at 15% of all practicing nurses, followed by Ontario with 12%, and Manitoba with 7%. The proportions are only few percentage points lower in most other provinces but are below 1% in New Brunswick (Dumont et al. 2008).

**Midwives:**

The number of midwives remains small but is slowly increasing, and has actually doubled in the last decade. There were only 837 registered midwives in 2009, and only 744 of them were listed as practicing (CAM 2010). The proportion of registered midwives is unevenly distributed with 52% in Ontario (n=487), 20% in B.C. (n=184) and 15% in Quebec (n=139); there are about 44 practicing midwives in Manitoba (CAM 2010). This variation in distribution is due to several factors, including the timing of legislation, the funding of the profession and the number of training programs within each province (see Table 1).

**Table 1: Status of Midwifery by Province/Territory (April 2010)**

| Province/Territory | Legislation/Regulation | Public Funding | Employment Status        | Remuneration       | Registered Midwives | Practicing Midwives |
|--------------------|------------------------|----------------|--------------------------|--------------------|---------------------|---------------------|
| BC                 | 1998                   | Yes            | Independent contractor   | Per course of care | 184                 | 157                 |
| AB                 | 1998                   | Yes            | Independent practitioner | Per course of care | 50                  | 48                  |
| SK                 | 2008                   | Yes            | Employee                 | Salary             | 7                   | 7                   |
| MB                 | 2000                   | Yes            | Employee                 | Salary             | 51                  | 40                  |
| ON                 | 1994                   | Yes            | Independent contractor   | Per course of care | 487                 | 435                 |
| QC                 | 1999                   | Yes            | Employee                 | Salary             | 139                 | 139                 |
| NB                 | In process             | Pending        | Employee (pending)       | Salary             | 4 (pending)         | 1                   |



|            |      |     |                                |              |             |            |
|------------|------|-----|--------------------------------|--------------|-------------|------------|
| <b>NS</b>  | 2009 | Yes | Employee                       | Salary       | 10          | 7          |
| <b>PEI</b> | None | N/A | -                              | -            | N/A         | 0          |
| <b>NL</b>  | None | N/A | -                              | -            | N/A         | 0          |
| <b>NWT</b> | 2005 | Yes | Employee                       | Salary       | 3           | 3          |
| <b>NU</b>  | 2009 | Yes | Employee                       | Salary       | 8 (pending) | 8          |
| <b>YT</b>  | None | N/A | Private practice (unregulated) | Private fees | N/A         | 1          |
|            |      |     |                                | <b>Total</b> | <b>943</b>  | <b>846</b> |

Source: CAM/ACSF (2010)

The entry-to-practice requirements for midwives across those provinces that regulate the practice are a direct-entry undergraduate degree or equivalent. This means that midwives need not have prior training in nursing to practice in Canada. The relatively recent integration of midwifery has also meant that there are only three relatively small university-based schools for midwives: one in Ontario, established in 1993, which graduates 30 to 40 midwives per year; one in Quebec, established in 1999, which graduated its first class of 12 in 2003, and one in B.C., established in 2001, which had its first graduating class of 10 in 2005.

While there are not yet enough midwives to fulfill the demand for their services in many provinces, there are more applicants to midwifery programs than can be accommodated by those programs. A case in point, in 2008-2009 the Ontario Consortium of Midwives received upwards of 650 applications for the 90 training spaces available (CAM 2009-b). To date, no recruitment efforts have been made internationally.

**In sum**, even though efforts to increase enrolment in health professional programs have been successful, there remains a lag in time before those professionals can practise, as well as uncertainty regarding whether or not the number of new graduates will be sufficient to fulfill the healthcare needs of the population. IEHPs can help to fill the gap more immediately. Most recently, the number and proportion of IENs working in Canada has risen by about 25% between 2002 and 2005. An increase in the number of IMGs admitted to residency positions has almost tripled from 369 in 2001-02 to 1065 in 2006-07 (CAPER 2007). International entrants to the midwifery profession have also been recently increasing. These professionals are recruited both the actively and passively.

#### **Shifts in Immigration Policy: affecting the *supply* side**

The change in Canadian immigration policy has impacted both the demographic and the professional make-up of newcomers (Kapur & McHale 2005). The demographics of Canadian immigrants have been slowly shifting from that of predominantly white Europeans to a greater multicultural mix. In the past decade, the vast majority of newcomers to Canada arrived from South Asia and the Pacific region (CIC 2008). In addition to this change, the introduction of the New Immigration and Refugee Protection Act in 2002 facilitated immigration of skilled professionals, allowing more internationally educated health professionals to enter Canada as immigrants (rather than on working visas) (Kapur & McHale 2005).

Federal, provincial, and territorial governments share responsibilities for immigration. This can pose organizational problems for provinces in need of certain professionals who do not have full responsibility for immigration policies. To gain some control over the recruitment of international workers, several provinces have implemented Provincial Nominee Programs (PNP): "The PNP gives provinces and territories the authority to nominate individuals as permanent residents, based on established criteria and assessment to fill regional or local economic needs." (Dumont et al. 2008, p. 43). Several provinces (British Columbia, Saskatchewan, Manitoba, Ontario and Newfoundland and Labrador) target health care professionals via the PNPs. Alberta, through Citizenship and Immigration Canada (CIC), has implemented a pilot program to facilitate immigration for doctors and nurses currently awaiting admission into Canada. In fact, in June 2008, reforms were made at the federal level to the Immigration and Refugee Protection Act to accelerate the application process for skilled immigrants. These reforms include providing more detailed instructions to immigration officers about priority employment gaps to be filled by an immigrant workforce. (Dumont et al., 2008)

Another national level measure to address general worker shortages plays a role in the healthcare sector. The Temporary Foreign Worker Program (TFWP) is a tool which plays an increasingly significant role in filling the gaps in the health workforce. In 2006, Human Resources and Social Development Canada (HRSDC) added a Regional Occupations Under Pressure list to identify occupations that are facing labour market pressures.

For occupations found in these lists, employers are not required to undertake lengthy or comprehensive advertising efforts before being eligible to apply to hire foreign workers. Such lists have been established in Alberta, British Columbia, Manitoba, Nova Scotia, Ontario, Prince Edward Island and Quebec. All these regional lists have confirmed that there is a need for health professionals to address temporary labour and skill shortages. Specialist physicians and general practitioners are included in all of the lists and registered nurses are included in all but two (Nova Scotia and Prince Edward Island). (Dumont et al. 2008, p. 43-44)

Such targeted international recruitment, however, began to generate increasing controversy in the late 1990s spurred on in part by Nelson Mandela's criticism of the U.K. for recruiting nurses from South Africa (Bach 2003), and of Canada by the South African Ambassador André Jaquet when he asked Canada's health ministers to stop the "targeted recruiting . . . that leaves us even less able to grapple with the serious HIV/AIDS pandemic." (Sullivan 2005). One example noted in the literature details how the recruitment of two South African anaesthetists by a Canadian hospital led to the closure of the Centre for Spinal Injuries in Boxburg, near Johannesburg, South Africa - a referral centre for the entire region (Martineau & Decker 2002). This did not go unnoticed by Canadian stakeholders. In the Final Report of the IMG Task Force (2004), it was noted:

It is wrong for Canada to actively recruit, or "poach" physicians from developing nations. Any active solicitation of physicians from countries that have a great

need for physicians is troubling. Improving Canada's lot, at the expense of healthcare delivery in countries who are less fortunate is not a Canadian healthcare policy goal (p. 4).

Similarly, while many nursing recruitment initiatives have existed in the various provinces across Canada for several years, the CNA recently made a policy statement on ethnical recruitment, emphasizing the need to make recruitment efforts in developed nations with sufficient health workforces and not actively recruit from developing nations who have health workforce shortages. The statement implies a move away from international recruitment and towards self-sufficiency:

CNA supports health human resources planning strategies that lead to self-sustainability in Canada. The active recruitment of IENs from developing countries is unethical, and CNA condemns this practice. CNA encourages governments, employers, recruiters and others to respect ethical recruitment practices (CNA 2009, p 2).

Thus, it is clear that Canadian HHR policy is intricately connected with the issue of the migration of health professionals, but these issues also have broader global implications.

### **Insights from the Literature on Health Labour Migration**

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Although our health care system heavily relies on the support of IEHPs, we know surprisingly little about their experiences during and after their integration into Canadian workforce. The vast majority of research dealing with international migration of health care providers concerns itself with outflows of health care workers from developing countries and analyzes motifs and patterns of migration of health care professionals as well as assesses the impact of their migration on global and local health care economies (Connell 2008; Grant 2006; Kapur & McHale 2005; Labonte, Packer, & Klassen 2006). Some literature addresses the reasons why health care providers migrate, highlighting the traditional push and pull factors. "Pull" factors include better and more comfortable living and working conditions, higher wages and opportunities for advancement (Aiken et al. 2004). Overall, poor wages, economic instability, poorly funded health care systems, the burdens and risks of AIDS, and safety concerns are factors that "push" health care providers to leave developing countries (Aiken et al. 2004; Kronfol et al. 1992; Phillips 1996; Robinson & Carey 2000). Although this model is often used in migration literature, the relationship between "push" and "pull" factors and the dominance of some factors over others are yet to be determined. It was noted, for instance, that "pull factors" (although a list of attractive features of the destination countries) do not solely account for mass exodus of health care professionals from the developing world (Kingma 2006).

While the push-pull factors model combines political, economic and personal motives for migration, there have been theoretical attempts to link migration of individuals (and health care workers in particular) to economic forces. In this realm, the opponents of migration of IEHPs usually highlight the losses to the developing countries of their highly qualified health care personnel (Ahmad et al. 2003; Buchan 2004; Jeans 2006; Kapur & McHale 2005; Labonte et al. 2006), while the proponents of such movement highlight the economic benefits that remittances of migrant health care workers return to their countries of origin (for discussion on the role of remittances in the economies of sending countries,

see Guarnizo 2003). Similarly, the cost-benefit analysis of the use of the imported health care workforce in the countries of destination, has demonstrated how the recruitment of health care workers from abroad helps developed countries to save millions on the training of health care personnel (Labonte, Packer, & Klassen 2006).

The drain of capital from the developing nations to the developed world can hardly be seen as a new phenomenon. Some researchers link these flows to the colonial nature of the relationship between countries. Indeed, the historical analysis of the colonial past of the Philippines explains the current pattern of migration of Filipino nurses into the English speaking world (Choy 2003). In a similar vein, Ishi (1987) stresses the importance of demands of the service economy in high income countries, their cultural, political, military, and economic hegemony over low income countries, and immigrants' experience of uncertainty over their futures in their homeland. Drawing on the post colonial theory, McNeil-Walsh (2004) seeks to explain the movement of South African nurses to UK. The historical context in which migration of health care workers was established from the colonies to the first world cannot be reduced to simple economic explanations. For instance, scholars found the culture of migration to be firmly rooted in Nigerian and Ghana physicians' visions of their medical future, who expect to move to the West upon completion of their education (Hagopian et al. 2005, p. 1754).

Generally, the studies looking at migration of health care professionals are interested in a large-scale analysis, and pay little attention to the experiences of individual migrants (Aluwihare 2005; Brown & Connell 2006; Cooper 2005). In the past decade researchers also became interested in the experiences of health care workers in their countries of destination. The majority of these studies deal with the racism and discrimination that health care workers face in the country of destination (Alexis & Vydellingum 2004; Calliste 1996; Collinds 2004; Flynn 1998; Giri 1998; Hagey et al. 2001; Larsen 2007). Qualitative studies often explore how immigrant health workers are being discriminated against according to race and denied career opportunities (Allan, Larsen, Bryan, & Smith 2004; Diccico-Bloom 2004; Turrittin, Hagey, Guruge, Collins, & Mitchell 2002). The instances of discrimination and racism at the workplace are especially evident in the nursing literature. Diccico-Bloom (2004), for instance, explores how Indian nurses are discriminated against in US health care facilities. IENs of colour in the UK also report discrimination based on racial identity (Allan et al. 2004). Similarly, nurses from African countries interviewed in Quebec and Ontario, reported racist and discriminatory experiences (Calliste 1996; Hagey et al. 2001). Evidently, racial discrimination of immigrant nurses is a problem faced by nurses of all ethnic backgrounds coming to different countries (Kingma 2008). A study looking into the experiences of South-Asian women physicians working in Canada reported instances of racism and discrimination faced by the newcomer doctors (Giri 1998).

### **Professional Integration Experiences**

While experiences of racism and discrimination of health workers have been documented by researchers, little is known about the process of establishing practice in a new country. Indeed, much of the literature on health labour migration neglects the psychosocial experiences of health care immigrants and how they negotiate the labyrinth of policies and procedures to practice their profession. A great deal of what we know comes from the studies undertaken by Shuval and her colleagues (Bernstein & Shuval 1998; Shuval 1995, 1998, 2000) of the massive emigration of physicians from the Soviet Union to Israel when it had an open, non-selective

migration policy. Not surprisingly, these studies found that, those IMGs working as physicians had significantly higher well-being scores than those not working as physicians. For those physicians who were working, however, many were dissatisfied with their allocation to less prestigious practice settings, the lack of recognition of their professional backgrounds, and the questioning of their authority by patients. Gender also has an impact. Some researchers have found that women physicians seem to adjust to a new system better than men (Remennick & Ottenstein-Eisen 1998), but others have noted psychological distress among female health immigrants (Factourovich et al. 1996).

There are several insights that we can garner from the Canadian health policy literature regarding integration experiences. First, there is no typical or usual way in which health care providers who are trained elsewhere enter into the Canadian health care system. As noted by the Barer and Stoddart (1991) study of physicians, internationally trained health care providers can include Canadians who pursue training elsewhere, graduates who enter Canada as refugees or who otherwise meet immigration requirements, trainees who pursue post graduate position in Canada and providers who are recruited (often through temporary visas) to meet the needs of particular geographic and specialty areas where shortages are most severe. Their ability to practice their profession here in Canada is dependent on these entry factors, the province into which they intend to become integrated, and a whole host of other factors.

Several barriers to the integration of internationally trained health care providers have been noted in the policy literature including: 1) poor information available to prospective immigrants overseas, especially with regards to what they must do to legally practice their profession in Canada; 2) a lack of information available in Canada about professional standards and registration that is clear, transparent, and understandable for a newcomer; 3) difficulty in having educational credentials recognized due to, for example, difficulties in getting official transcripts from institutions outside of Canada; 4) difficulty in navigating through the policies, practices and procedures for licensure/registration; 5) a lack of adequate bridging programs which candidates may be referred to once gaps in competencies or education are identified in assessments; and 6) the amount of time and cost associated with being assessed (Martin 2004).

Specific barriers experienced by IMGs that were noted in several of the documents include the following: “While some lack the required preparation, knowledge and skill, others have been unable to confirm or demonstrate their skill levels due to tight workforce policies, limited access to assessment and/or training opportunities and lack of support to understand the licensure requirements in Canada” (Report of the Canadian Task Force on Licensure of International Medical Graduates 2004, p. 1). One of the key barriers is the above noted limitation in the number of residency training positions (Yelaja 2000; Immen 2004).

In 2004, the Canadian Nurses Association (CNA) established the Diagnostic for the National Assessment of International Nurse Applicants Project called IEN-DP. In the report, published in 2005, the IEN-DP identified the major barriers for IENs wishing to become licensed to practice in Canada as language and culture. A lack of coordinated policy and examinations has been

identified as another culprit with regard to the successful integration of IENs. In a press release in 2005, Lisa Little, Chair of the Steering Committee of the Diagnostic Project for the International Educated Nurses (IEN-DP) explained:

Navigating through the maze of licensure is complex. We know, for example, that there are no fewer than 25 regulatory bodies for the three regulated nursing groups. While most are similar in their assessment approach, the subtle differences cause a number of inefficiencies. We need to find a way to better integrate IENs into the Canadian health system, starting with a national, coordinated, responsive and centralized assessment process that is part of a larger pan-Canadian health human resources strategy (CNA 2005 p. 2)

Some of the key policy responses called for, in such documents as the recommendations of the Canadian Task for on the Licensure of IMGs, include: 1) increase the capacity to assess and prepare IMGs for licensure; 2) work toward standardization of licensure requirements; 3) expand or develop supports and programs to assist IMGs with the licensure process and requirements in Canada; 4) develop orientation programs to support faculty and physicians working with IMGs; 5) develop capacity to track and recruit IMGs; and 6) develop a national research agenda, including evaluation of the IMG strategy. Such policy responses would include the evaluation of the IMG licensure recommendations and the impact of the strategy on physician supply. Similarly, the national IEN “Diagnostic Project” (2005) recommended: 1) the establishment of a national assessment service to create an evidence-based standardized approach to the assessment of IENs; 2) the establishment of nationally standardized and flexible bridging programs to ensure IENs have the competencies required to meet Canadian nursing standards; 3) the development of strategies to address the financial challenges incurred by IENs who enrol in bridging programs; and 4) the development of a central source of information such as a Web site specific to IENs to access complete, clear and easily understood information related to immigration and nursing licensure/registration.

Beyond this policy research, there is little theoretically informed literature that addresses IEHPs’ professional integration experiences.

### **Theoretical Inspirations**

Traditionally, immigration studies concentrated on the assimilation of immigrants into a local community (Levitt & Jaworsky 2007). While the degree to which immigrants had successfully integrated into a local community varied between developed nations (i.e., Canadian cultural mosaic vs. the United States melting pot), the assumption that the measurement of successful assimilation should be somehow developed within the hosting community remained. In the past several decades, this approach to immigration had changed (Anderson 2001; Joppke 2004; Levitt & Jaworsky 2007; Sana 2005). Since more and more people maintain ties with their homeland, the migration studies had been slowly transformed into transcultural studies inquiring into patterns of communication between migrants and, both their home countries and the countries of destination (Landolt 2001; Sana 2005; Takacs 1999). Currently, the debates are

formed around the practices of transnational communication and the impact of migration on the home and hosting countries' economies and cultures (Landolt 2001; Levitt 2007; Morawska 2004; Orum 2005; Smith 2006).

While transnational studies incorporate many aspects of inquiry to better capture the dynamic of the relationship between migrants, hosting countries, and the countries of origin, scholars continue to engage in methodological and theoretical debates about what constitutes "transnationalism", as well as how it should be studied and measured (Levitt & Jaworsky 2007). Although the definitions rendered by researchers of the transcultural movement vary, it seems that vast majority of scholars came to a consensus that the research on migrants should contextualize the agency of migrants in the structural and institutional dynamics of both countries. Defined as transnational living, this analytical approach suggests that:

While transnational living foregrounds migrants' agency, it also involves relations initiated by nonmigrant - individual and institutional - actors aimed at establishing and maintaining multifaceted cross-border engagements that help shape migrants' living conditions abroad. Transnational living signifies an active, dynamic field of social intercourse that involves and simultaneously affects actors (individuals, groups, institutions) located in different countries. Transnational living is shaped by the historically determined social, economic, political, and cultural micro and macro structures of the societies in which the lives of migrants are embedded (Guarnizo 2003, p. 670).

This new approach is reflected in many works looking into the experiences of immigrants in their countries of destination. Scholars often link migrants' personal experiences to the structural forces in their home countries and modes of communication that shape their experiences as newcomers in their countries of destination (Ajrouch & Kusow 2007; Behnke, Taylor, & Parra-Cardona 2008; Calavita 2006; Lewin 2005; Waldinger, Lim, & Cort 2007).

In looking at the experiences of migrants in their countries of destination, however, researchers usually have to concentrate on a particular ethnic group or a particular country which hosts immigrants (Behnke et al. 2008; Gallo 2006; Lewin 2005) leaving the global patterns of migration to large-scale, macro studies. Those studies usually link the global movement of migrants to political and economic relationships between developing countries and the developed world. Although such studies cover a wide range of topics, researchers have found general trends in global movement of human capital (Castles & Miller 2003). According to Castles and Miller (2003), for instance, the differences between traditionally studied migration and the current, globalized movement of migrants, can be summarized as: 1) the globalization of migration (more countries participate in migratory movements and they are more affected by it); 2) the acceleration of migration (reflected by large volume of migrants and controlled by nation-states); 3) the differentiation of migration (skilled workers, refugees, visa workers, etc.); 4) the feminization of migration; and 5) the growing politicization of migration (reflected in bilateral agreements and security policies of nation-states) (pp. 7-9).

In researching these avenues, critical race theory and post colonial studies contributed tremendously to the analysis of movement of human capital from the global east and south to the global west and north (Ball 2004; Clark, Stewart, & Clark 2006; Romero 2008). This is especially true in the context of migration of health care providers, whose migration is reflected not only in remittances sent back to their countries of origin but also in poor health conditions and the drain of health care systems of developing nations (Buchan 2006; Chen & Boufford 2005; Kapur & McHale 2005). This phenomenon, as alluded to earlier, has become known as “brain drain” in professional and academic literature and one of the dominant issues in the literature on migration of internationally educated health care providers (Ahmad et al. 2003; Aiken, Buchan, Sochalski, Nichols, & Powell 2004; Aluwihare 2005; Astor et al. 2005; Buchan 2006).

**In sum**, we suggest that successful analysis of migration patterns of health care workers should include the analysis of economic, cultural, and individual factors leading to migration and to be contextualized in a larger socio-political context. In other words, “the satisfactory theoretical account of international migration must contain at least four elements: a treatment of the structural forces that promote emigration from developing countries; a characterization of the social forces that attract migrants into developed nations; a consideration of the motivations, goals, and aspirations of people who respond to these structural forces by becoming international migrants; and a treatment of the economic structures that arise to connect areas of out-and in-migration” (Hirschman, Kasinitz, & DeWind 1999, p. 50).

### **Our Methodological Approach**

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We employed a largely qualitative approach to this study, as it was deemed most appropriate for the experiential and comparative research questions under investigation. A qualitative design allows for a greater appreciation of embedded and multifaceted nature of the phenomena under investigation and the contextual influences on these phenomena. In addition to the comparative dimension of professions, we also chose to examine the experiences across four key provinces.

### **Selection of Comparative Provinces**

Given that professional regulation in Canada is a provincial jurisdiction, it was important to include more than one province, and some variability in migration policy, practices and experiences, in the data gathering process. The provinces of Ontario (with a very high number of IEHPs, many of whom are not *yet* integrated); Quebec (with a unique system of immigration policy and language issues affecting migration); British Columbia (another province heavily saturated with IEHPs – but from somewhat different source countries than other provinces); and Manitoba (a regionalized health care system that actively recruits internationally trained providers) were chosen as the provincial referents for this study. All four provinces encompass variability in the policies for IMGs, IEN and ITMs and all four provinces have regulated forms of midwifery. For each of these provincial case studies, data were collected through key policy



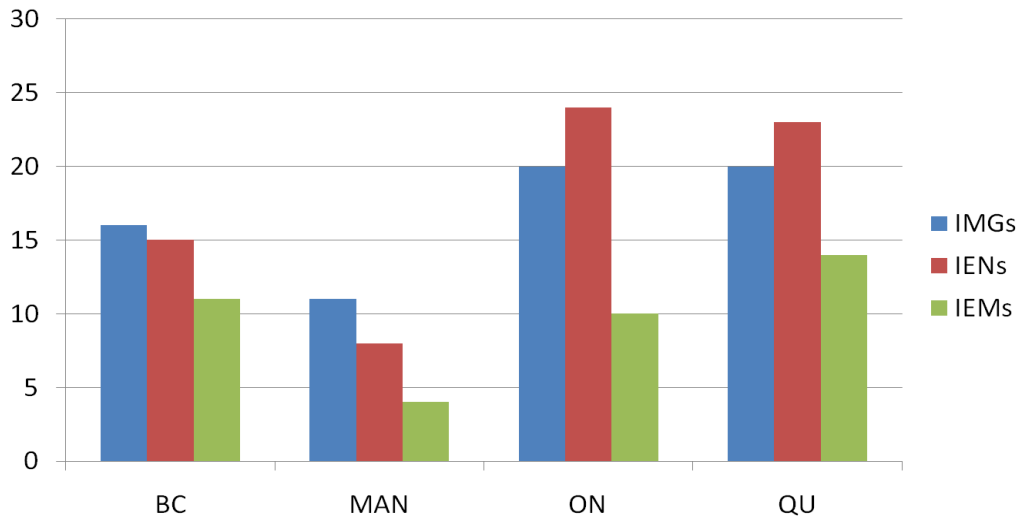
documents and interviews with IMGs, IENs and ITMs who were pursuing professional integration, had achieved it or had decided to redirect their efforts.

### **Data Collection**

The study started by analyzing policy documents and mapping out the system that health care professionals have to navigate to obtain licensure in Canada. For each province, we identified the major stakeholders that facilitate or regulate the process of integration of IEHPs. In addition to the reliance on the analysis of policy documents, our research team also worked on learning to navigate the system of regulation in the same way as IEHPs. We collected the information about professional integration by visiting the websites of regulatory Colleges and professional associations for medicine, nursing and midwifery. We collected documents and information brochures available for IEHPs in each province, analyzed them and built a model of step-by-step integration process for each profession in each province. We also consulted the information provided by provincial professional associations, to gain a better understanding of the experiences of IEHPs and identify specific difficulties that they may face on the way to integrating into the system. This information proved to be invaluable during the interviews with IEHPs. For instance, armed with knowledge about a particular bridging program or about a particular organization that was designed to facilitate the process of integration for IEHPs, we could directly inquire into the experiences of IEHPs who attended the program or joined the organization.

We secured interviews with 176 IEHPs in the provinces of British Columbia, Manitoba, Ontario and Quebec. To recruit these professionals, we advertised our study in local immigration centres, newspapers, immigrant community centres, and other locations with high proportions of newcomers. We also used snow-ball sampling, recruiting participants from the networks of our respondents. The interviews were conducted in person and on the phone and usually lasted between one and two hours. The interviewees could choose to be interviewed either in English or in French. We acknowledge that this strategy limited our access to IEHPs who were relatively fluent in one of Canada's official languages, but because we were largely interested in the experiences IEHPs who were seeking or who had sought integration in health care system in Canada, we felt this limitation appropriate. The interview guide was designed to address the following research areas: 1) the decision to immigrate to Canada and navigation through the immigration system; 2) the process of gathering information and navigating through professional integration; 3) the input of IEHPs on gaps in the system of integration; and 4) their recommendations on how this system can be improved. For the vast majority, the interviews were transcribed verbatim for analysis. We also had participants fill in a short demographic survey so that we could better understand their personal and professional background. Figures 3 to 7 provide a profile of the study participants.

### **Figure 3: IEHP Participants by Profession and Province**



**Figure 4: IEHP Participants by Profession and Status**

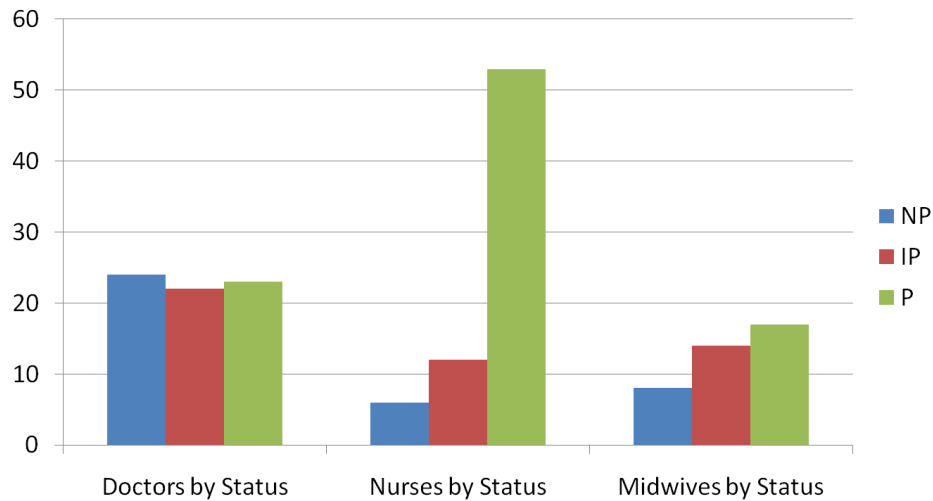
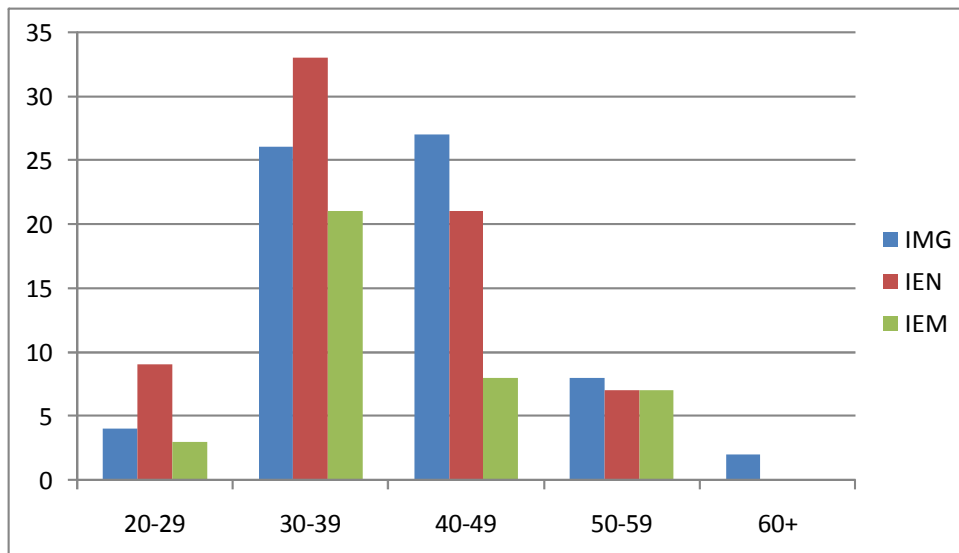


Figure 3 reveals that we had a larger number of participants from Quebec and Ontario. This is largely reflective of the national distribution of IEHPS. Figure 4 highlights how many more IENs are in practice when compared to ITMs and especially IMGs. This may be reflective of the broader population, but there are little data to which we can compare our participants, to substantiate this theory. It is important, however, to keep this in mind when interpreting our findings across profession as it may be reflective of status.

**Figure 5: Age Distribution of IEHP Participants by Profession**



**Figure 6: Gender Distribution of IEHP Participants by Profession**

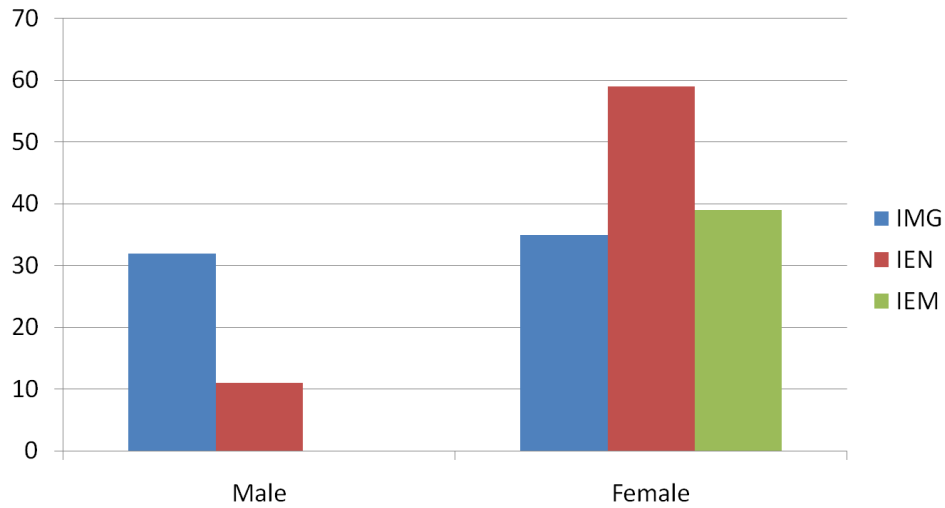


Figure 5 shows the age distribution of our IEHP participants by their profession. This indicates that our IMGs participants are slightly older than IENs and ITMs in this study. Figure 6 shows the gender distribution with roughly equal distribution of men and women for IMGs, a disproportionate distribution for IENs and an exclusive distribution of women ITMs. This is largely reflective of the population, but perhaps the study sample has an exaggerated proportion of males in the IEN category and females in the IMG category. Finally, Figure 7 outlines self-identified visible minority status by profession. Across all professions our participants were more likely to state that they were not a member of a visible minority group.

**Figure 7 Self Identified Visible Minority Status by Profession**

**Data Analysis**

Data collected through the documents and interviews were analyzed sequentially using typical procedures of thematic and constant comparative analysis. This involves an iterative process of going back and forth between documents and interviews to produce a multi-layered description of the context and experiences of IEHPs in the each of the provinces. We began with the analysis of the documentary data to help frame the context. Then the transcribed interview data were entered into QSR-NUD\*IST 6 for analysis. Our research team developed a preliminary coding scheme which highlighted the major themes discussed in the interviews and emerging from the contextual analysis. The coding scheme was then distributed among research assistants to use as a guide in developing a more detailed coding scheme. Each research assistant analyzed five interviews using “free coding,” identifying major themes emanating from the interviews. These themes were then categorized and developed into a comprehensive coding scheme that was used during the analysis. To test the scheme, each research assistant recoded three interviews originally coded by other team member, to ensure that the codes used in the analysis were consistent among the team members. In the second stage of the analysis, the interviews were analyzed using the new, comprehensive coding scheme. In the process of the analysis, the research team made additions to the existing coding scheme but overall, all interviews were coded under the same categories. Key segments from the documents were excerpted according to this final scheme to help flesh out and form the backdrop for the experiential data from the IEHPs we interviewed.

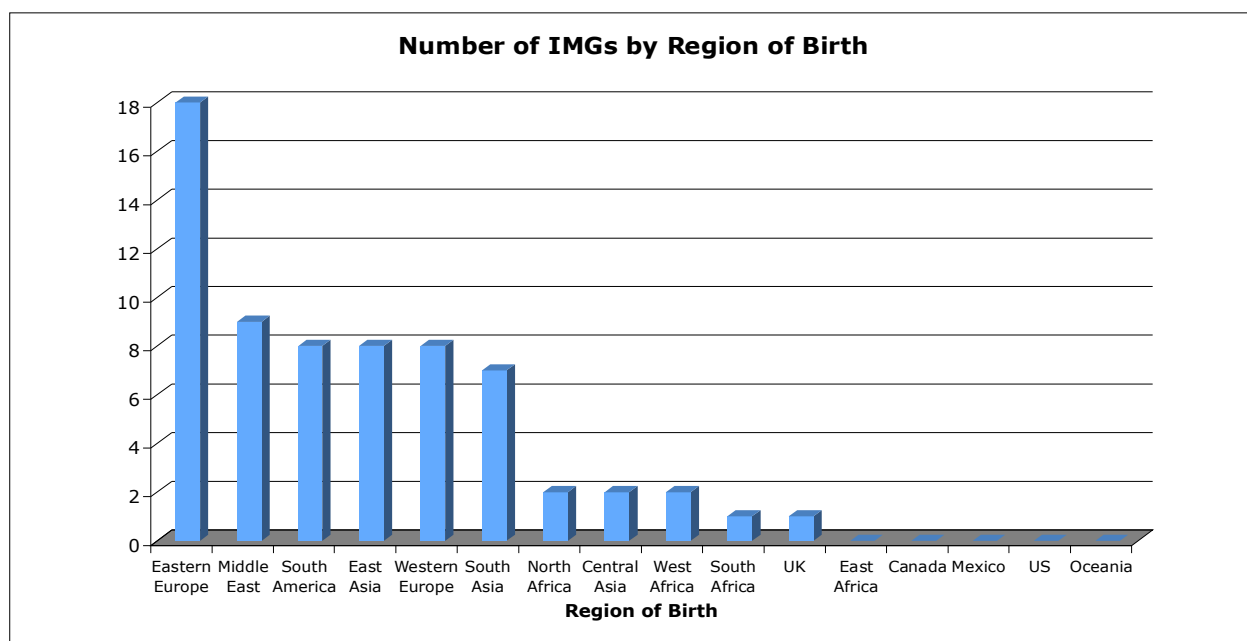
In the sections that follow, we trace the experiences of the internationally educated physicians, nurses and midwives that we spoke to. We begin with their decision to come to Canada, the process they undertook to get here, and the barriers and facilitators to their professional and labour market integration. We conclude with some of their recommendations for policy to improve the situation for others who follow their path.

**SECTION 1: DECIDING TO LEAVE AND COME TO CANADA**

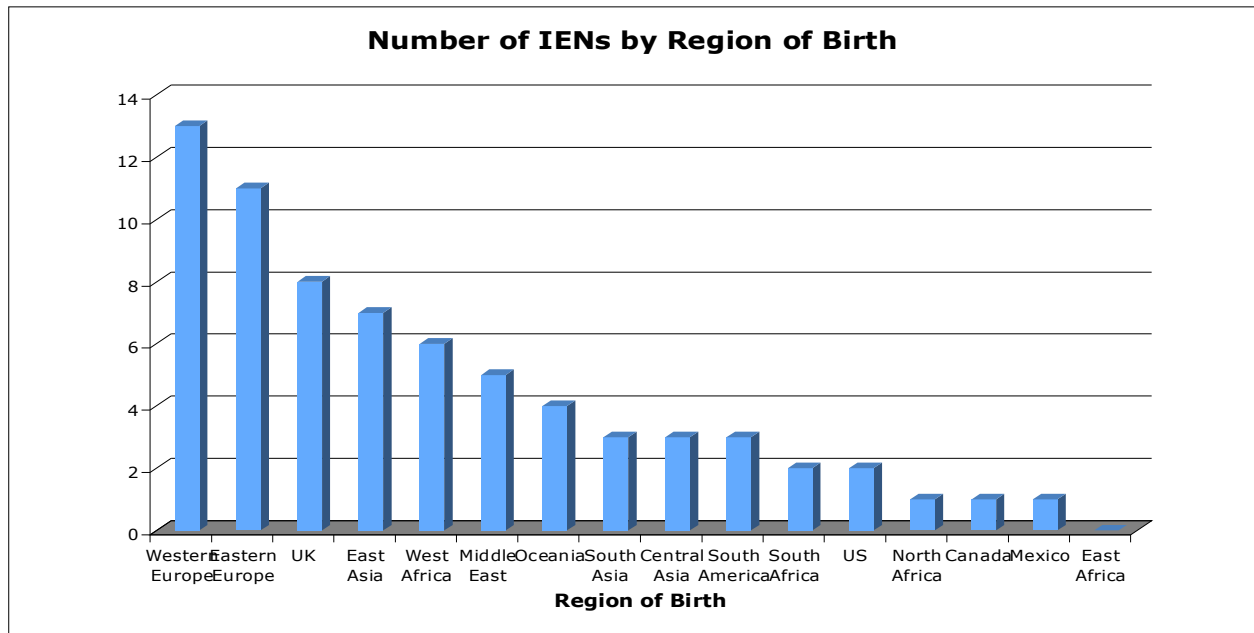
Each of the internationally educated health professionals that we interviewed had a fascinating story that began with a discussion about how and why they decided to leave their country of origin and/or training and come to Canada. The findings are organized in terms of the traditional ‘push’ and ‘pull’ factors evident in much of the literature, but as stated in the introduction, we fully appreciate that these are difficult to tease apart and further, there are broader contextual factors at play both in the decision to migrate in the first place, and the country of intended destination. Equally, some of our participants felt uncomfortable at times with this distinction, insisting instead that they took a more holistic view in making their decision to come to Canada.

Figures 1.1, 1.2, and 1.3 outline the regions of birth of our participants by profession. The majority of our IMG respondents came from Eastern Europe followed by the Middle East and South America, East Asia and Western Europe in equal proportions. The three most common countries of birth for our IEN participants were Western Europe, Eastern Europe and the U.K. Most of the ITMs we interviewed were born in Canada – a fact which largely reflects of the relative lack of Canadian educational opportunities – followed by Western Africa and Western Europe and then the U.K. close behind.

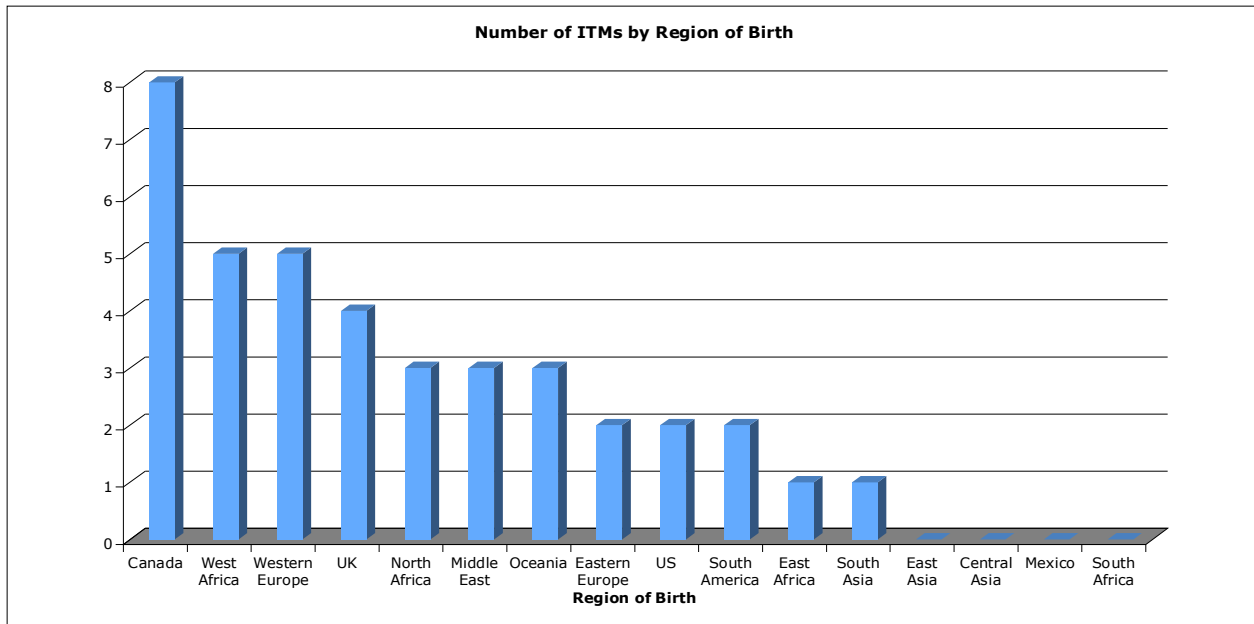
**Figure 1.1: Number of IMGs by Region of Birth**



**Figure 1.2: Number of IENs by Region of Birth**



**Figure 1.3: Number of ITMs by Region of Birth**



### **“Push” Factors: Why Leave?**

There are a number of reasons why people decide to emigrate from their home countries. Economic and political instability, security, limited educational and/or career opportunities, family reasons, and a desire for new experiences, were all listed by our respondents as motivation to move to another country. In many cases, the decision to emigrate was inspired by



multiple reasons, such as poor political and economic conditions along with a lack of professional opportunities in the country of origin:

*Deux raisons : la raison personnelle, financier, ça veut dire que le salaire d'un médecin en Roumanie était de 300,00 \$ environ par mois. La deuxième chose c'était que la profession, ma profession, la radiologie, n'était pas du tout bien, bien organisée, bien dotée comme plateau technique en Roumanie. Donc j'avais fait ma spécialité en France et si je choisissais de retourner en Roumanie, j'utilisais seulement 20 % de mes connaissances.*

[Two reasons: The first was personal-- financial-- I mean, a doctor's salary in Romania was about \$300 a month. The second was professional: my profession, radiology, was not good at all, not well organized or well equipped as technical support in Romania, and so I did my specialization in France. If I had chosen to go back to Romania, I would have used only 20% of my knowledge.] [Québec IMG #8, practicing]

For many respondents it was hard to separate motivation for migration into specific “push” factors. Usually, it is the combination of different factors that contributed to the decision of our respondents to leave their country:

*In my opinion it doesn't matter what sort of dictatorship you have to deal with, bureaucratic or militarism, it doesn't matter. What it brings to the society is hopelessness, instability, unfair access to social opportunities and all of this means a hazy and clouded future for you and your children. So I can say the main reason [for my immigration] is the future of the children. But I'm not going to say this is the only reason. Living under an oppressive system [leads to] a corrupt society... After a while you even don't trust your neighbour. Because a corrupt system wants everybody to corrupt. Even you yourself, even [if] you try your best to stay clean you are not able to do so and you don't know how to protect your child. You have to teach him or her to do some mischiefs, to pretend something that you are not. And it's so sad. [Ontario IMG #1, in progress]*

Although in most cases, the decision to migrate was rooted in the combination of factors, in some situations, our respondents identified the political regime of their country as being the major push factor for their decision migrate. This was particularly true for those coming to Canada as refugees or from politically unstable regions:

*My family was ambushed. And I was the target. My wife died and one of my daughters was wounded. And we went into hiding and I recovered and then after I recovered from the wounds, uh, and then I went into hiding. For some time stayed that way but by January it seemed that it wasn't working too well. They kept coming. [There were] the signs that they were coming after us so we decided to immigrate out. We left as tourists and we arrived here March 1 and on March 8 I went to immigration and declared for refugee status. My present status is as a refugee claimant together with my three*

*children. But a final hearing will be probably this January and that will determine whether I'm in or not and whether... if they approve my case, uh, I would, if we passed I could apply for permanent residency [British Columbia IMG #15, no longer pursuing integration].*

Once the decision to move to another country was reached, or in the case of refugees, once they had sought asylum, our respondents started to check possible avenues for their migration.

### **“Pull” Factors: Why Canada?**

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For many, the decision to emigrate was influenced not so much by the current political situation of their home country, but by the possibilities a move abroad would provide. Some of these possibilities were linked specifically to Canada, whereas others had more to do with the migration experience itself. Some of the IENs we interviewed decided to immigrate to Canada simply because they were seeking a change and were looking for adventure:

*I guess we had what my husband and I call ‘itchy feet’ syndrome in that we just, we wanted to travel. So we wanted to experience a different part of the world. We didn’t want to stay in one place our whole lives and then wake up one day and go ‘Oh we should have seen the world when we were young.’ [Manitoba IEN #3, practicing]*

*Donc mon voyage au Québec, mon immigration au Québec ça s’est fait au travers d’un cheminement plus dans le sens de découvrir d’autres cultures puis au travers de mon métier aussi de pouvoir découvrir les soins dans différents horizons.*

[My trip to Quebec, my immigration to Quebec, was more out of an interest in discovering other cultures, and for professional reasons, in discovering other approaches to care in different places.] [Québec IEN #7, practicing]

Canada, like many other destination countries, offers educational opportunities not available in some other countries. Such opportunities were the ‘number one’ incentive for some:

*J’ai décidé d’immigrer parce que je voulais faire une maîtrise et puis je suis intéressée par tout ce qui est communautaire et le Canada c’est réputé pour le communautaire. Donc je suis venue ici pour faire en fait ma maîtrise, ce n’était pas nécessairement pour travailler.*

[I decided to immigrate because I wanted to complete a master's degree. I'd become fascinated by everything to do with the community matters -- and Canada has a reputation for its community orientation. And so I came here to do my master's, not necessarily to work.] [Québec IEN #6, practicing]

Some of the more Canada-specific reasons cited included the relative ease of immigrating to Canada, in contrast with some other possible destination countries. As one of our IMGs told us:

*After my graduation I started to learn English and I was fascinated with the different world... it opened my mind. I would like to see what a foreign country looks like. And I*

*heard a lot about Canada, [that it] is much easier for foreigners than the States, United States, more friendly. That's why I chose Canada [Manitoba IMG #11, no longer pursuing integration]*

Our respondents described that, while the process of immigration into Canada can take long time, it is relatively straightforward. Many applied for permanent residency simultaneously in number of countries (i.e., Australia, US, and Canada) and simply waited to see which one would make an offer first. As one IEN stated:

*When my children were grown up they were asking me ... [to] go somewhere ... that we'll be together, you know. So I applied to the U.S.A. I applied to Australia. I applied to Canada. Now the first, the application that was approved came first from Canada so I decided to come to Canada although it's cold. I really was preparing to go to Australia because there is no winter there, but then the papers from Canada came in first [Manitoba IEN # 1, practicing].*

Others stated that the immigration process in Canada better enabled their family to be together and have permanent residency status. Indeed, some immigrants chose Canada as their country of destination because they had family or friends who suggested that they would follow them to Canada.

*Je vais vous dire c'est très simple, j'ai de la parenté ici .... il venait visiter ma grand-mère et m'entendant que je faisais mes études d'infirmière. Il m'a dit viens donc travailler au Canada...*

*[It's very simple: I have relatives here... I had just visited my grandmother and heard that I'm in nursing school. She said I should come and work in Canada.]  
[Québec IEN #4, in progress]*

*C'était pour suivre mon conjoint. Des raisons purement personnelles à la base, oui.*

*[I followed my spouse here. Yes, basically, my reasons were purely personal.]  
[Québec ITM #32, practicing]*

The multicultural and perceived friendly nature of Canada was another key pull factor. Many of our respondents suggested that Canada is reputed to be friendlier to visible minorities and immigrants than European countries and the US. This theme was especially salient among immigrants who self identified as visible minorities:

*Because, you know, [immigration] is not that much convenient for people who come from Africa especially. But here it's a multi-diverse country. There is a respect here. I like Canada so I decided to stay here [Ontario ITM #1, no longer pursuing integration].*

*Et comme le Canada c'est un pays disons on a appris que le Canada était un pays où il faisait bon vivre, où on respectait vraiment les droits de l'homme, en tout cas on nous a dit que les Canadiens sont des gens très accueillants et sociables, et tout ça...*

*[And since Canada is a country, I mean, we found out that Canada was a good country to live in, that it truly upholds human rights, anyway, we were told that Canadians were very hospitable and sociable people, and all that.] [Québec IEN #4, in progress]*

Similarly, many respondents compared Canada with the US (another potential choice) and found Canada to offer a safer environment, a better standard of living, especially with respect to its public programs, and in turn, a better future for their children:

*I liked my training in the U.S. It was a great experience...and I liked [the] U.S., but I thought it was not the best country for me and my wife and kids. So I thought, you know, why not try Canada. It's such a great country, you know, nice people, very stable country. The government protects people in the health care, all this protection that your government gives you. I think it would be the better [choice] for me and my family. So that was the main reason [Manitoba IMG #1, practicing].*

Finally, another key pull factor was the appraisal that Canada is in need of health professionals. Many of our participants received information through their friends, relatives or recruitment agencies about the possibility of practicing in Canada:

*Canada was a good choice for us because we had friends who were here and they encouraged us to come because, um, mainly because they said that I'd be able to work easily because of the, um, they needed nurses. [Manitoba IEN #3, practicing]*

This factor, however, in addition to the points that IEHPs get for their education in the immigration application process, caused much confusion when they ultimately faced barriers in the professional integration process in Canada, as we discuss more fully below.

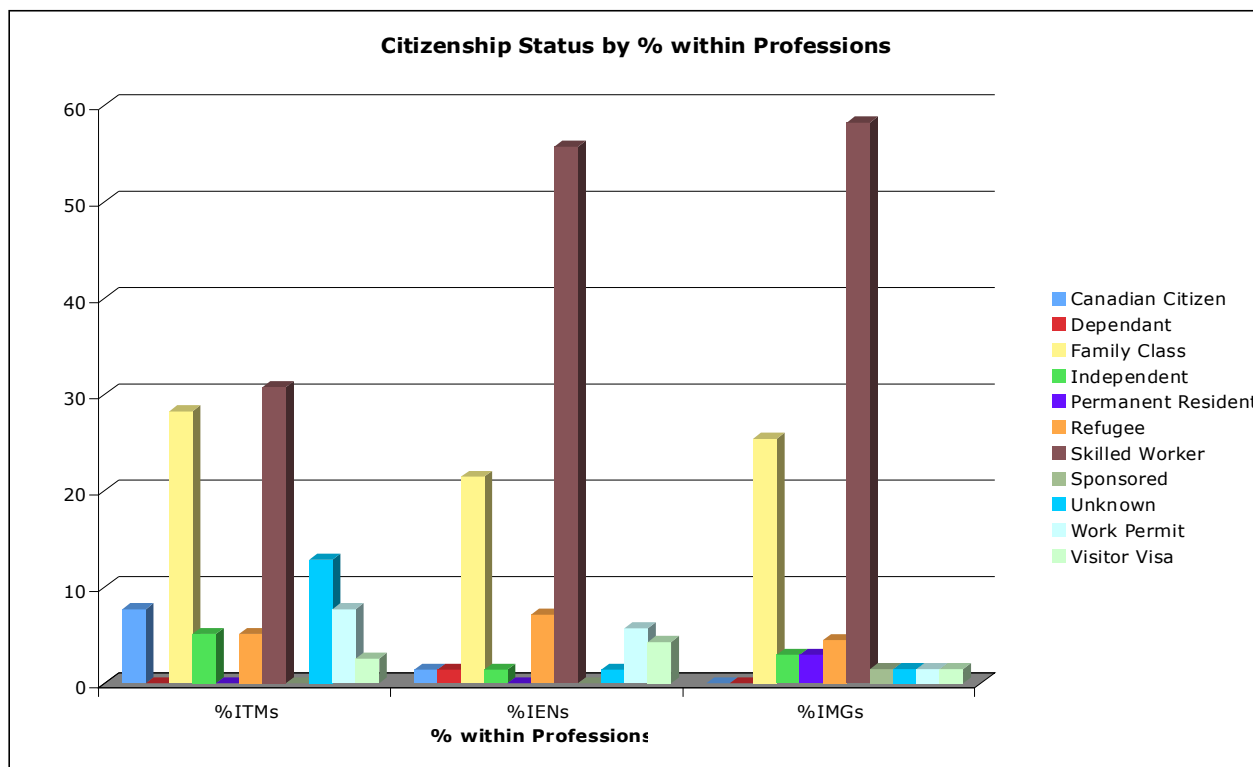


**SECTION 2: IMMIGRATION TO CANADA**

Once the decision to immigrate to Canada was reached, our respondents began their preparations to do so. The first step for most health care providers is the national system of immigration, although for some, this is a second step, following recruitment. While there are tremendous differences in immigration preparations undertaken by our respondents, it is possible to categorize them into having followed one of four different routes: 1) independent immigration, through one of two possible immigration entry points (economic or family class); 2) immigration to Canada through the recruitment agencies (largely economic class), 3) immigration to Canada with the help of agencies that solely provide assistance with immigration per se, without helping immigrants find work (which could be either economic or family class); and 4) entry to Canada as refugees.

First, it is important to outline the citizenship status of our respondents by their profession. Clearly the largest proportion of respondents came as skilled workers but this is far greater for the IENs and IMG than for the ITMs. Family class was a very close second for ITMs but a distant second place category for IENs and IMGs.

**Figure 2.1 Citizenship Status by Percent within the Profession**



**Independent Immigration**

The majority of IEHPs in our sample came to Canada independently, that is, without the assistance of a recruitment or immigration aid organization. Citizenship and Immigration Canada

(CIC) officials assess applicants using a point system. Points are awarded to prospective immigrants' applications according to a social capital model that includes the applicant's age, language ability, whether they have arranged employment in Canada, the type of work they intend to do here along with their skills, qualifications and experience in that area, and whether their occupation is in demand in the Canadian labour market (Brouwer 1999). This is, however, but one step in the integration process and one which can send mixed messages to applicants. For example, as Brouwer (1999) states,

Unless informed otherwise by a visa officer, many immigrants who are accepted as skilled workers understandably mistake the federal government's granting of 'points' for their occupation, education and training as recognition and approval of their qualifications. These immigrants assume that they then will be able to practise their profession or trade in Canada. In fact, however, the number of points granted by a visa officer and the Department of Citizenship and Immigration has no bearing on an individual's ability to practise an occupation in Canada.

Those that immigrated independently faced a range of policies and procedures which in turn reflect the variety of countries of origin, background and circumstances of the immigrating IEHP and their skills and language proficiency. There was great variability in the timing and costs associated with migration. For example, each country of origin necessitates different types of visas and this in turn, has associated costs. Each step of the process of independent immigration requires some amount of money. For some, it was not clear at the outset what the full cost would be:

*You have to pay a processing fee first in order for them to be able to process your papers and then after that once you get interviewed and they will give you your visa you have to pay them a landing fee. I don't know what that's for. He said it's a landing fee for adults except children less than 18 years old. And then after that you have to show money that they require you. I think they required us... I don't know how much... Oh. I think it's 16 to 18 thousand Canadian dollars that you have to bring with you [British Columbia IEN #2, practicing].*

*It did cost more than I anticipated...because I'd applied for my work visa and then I suddenly realized the children needed student visas just to go to school here. So there's, you know, lots of little bits get added on and in the end it's sort of hundreds of pounds, ... Perhaps I just didn't research that enough to start with. I don't know." [British Columbia IEN #13, practicing]*

The immigration process can take an unpredictable length of time. While some people received their status within a year, the process took much longer for others:

*I had to wait like six months to get the HRDC letter that would say 'Yes, we do need nurses and she is welcome to come' because without this letter I wouldn't be able to get*

*the work permit. So six months to wait. Waiting. Like every little thing, you would submit something, you had to wait at least a month. Now we need a criminal record [check]. Oh no, this one is the wrong one [British Columbia IEN #10, practicing]*

Some of the respondents shared stories about their documents being lost in the application review process . Many applicants had to wait as long as five years to have their documents reviewed by the local embassy. Many IEHPs would continue living their lives throughout the application period:

*And then we decided to immigrate. ... then, we applied to Canada but nothing happened. And I decided to do Nursing, because nursing is a degree with which you could go anywhere. So, I took the Nursing there and we're not even sure that we will come to Canada, we thought that maybe we should also apply to US and Australia. But then we received a paper. And we decided to go to Manitoba, because it was easier for us to go to Manitoba, and it was easier for me to become a doctor there. [Manitoba IMG #2, no longer pursuing integration]*

*I came back to Iran. I applied for immigration to Canada but it took much longer than my expectation. That was supposed to be done in 3 years. We heard nothing after three years. I felt it's a lost deal so I forgot it. For some reasons after about five years they called us and said they take us. We were supposed to participate in an interview but they even waived that. They said we did not have to participate in interview. They just said you can come. We'll give you visa. Just like this. [Ontario IMG #1, in progress]*

Indeed, a frequently expressed frustration was with the level of bureaucracy in the immigration process, which seemed particularly unnecessary to the IEHPs we interviewed:

*I can tell you that I am very surprised and very dissatisfied by how things are working in Canada regarding those administrative things. And I find it to be unbelievable how slow are the administrative and bureaucratic procedures in Canada. ...I am not talking about speed only. It's speed and efficiency and professionalism and accuracy. Many things. [Ontario IMG #3, no longer pursuing integration]*

Despite the differences in procedure, there were some remarkably similar experiences among our participants in that it took a long time to work through the immigration process, there were high costs involved, and both the length of time and amount of money required were unanticipated.

### **Immigration to Canada through a recruitment agency**

For those who were recruited directly by a recruitment agency, the process of immigration and professional integration was much easier and faster. The recruitment process could be what some have described as *passive*, that is, where positions are advertised; in other cases it could be *active*, through recruitment drives which seek out IEHPs in their country of origin (Labonte,

Packer, & Klassen 2006; McIntosh, Torgerson, & Klassen 2007). In Quebec, for example, the government agency - *Recrutement Santé Québec* (RSQ), established in 2003, both recruits actively through sending delegations seeking nurses to French speaking countries in Europe, and passively through its website (RSQ 2010b).

Many IEHPs chose to come to Canada through a recruitment agency to address concerns about the instability of being a newcomer in a new country. For these respondents, the prospect of having immediate employment seemed a good choice:

*Brandon kind of found me. ... I'd seen the job in Brandon for the midwife...on the Internet. And I'd said to my husband 'That looks like that would be a good job'... [then] one of the guys from the recruitment agency actually lives in Winnipeg and he had contacts within the Brandon Regional Health Authority and had kind of said 'I've got a nurse coming but she's actually a midwife. Have you got any vacancies?' And they said 'Well we're looking for a midwife.' ... We were kind of moved along very quickly then. And we had got no intention of coming to Manitoba. We didn't even know where Manitoba was. But then when they said, you know, 'If you come, there's a job as a midwife'. I wasn't going to turn that down because I knew it would be so difficult to get here [Manitoba ITM #1, practicing].*

Usually, an agency takes responsibility for contact with Canadian authorities, collection of all required documentation from the applicant and (in some cases) payment of travel expenses and accommodation. The RSQ, for example, takes care of the immigration paperwork for recruited IENs, puts these nurses in touch with various teaching hospitals, and in most cases, covers travel expenses, and organizes work visas and temporary work permits.

*Recrutement Santé Québec chez moi qui en fait je suis rentré en contact avec elle, puis elle m'a aidé à faire les démarches, tout ce qui est au niveau immigration, immigration c'est elle qui m'a cherché aussi ma, pas qui m'a cherché mais qui a fait les démarches pour moi pour qu'au niveau de l'hôpital où je suis actuellement.*

*[Recrutement Santé Québec came where I lived and so I came in contact with her and she helped me take steps, get through all the immigration procedures. Immigration also came looking for me, not searching for me per se, but took steps on my behalf with the hospital where I currently work.] [Québec IEN #11, practicing]*

A similarly smooth process was described by other IENs and ITMs who communicated directly with local health authorities or provincial program officers (e.g., BC Health Match), recruiters in their home country, or international bodies, such as the UN, for refugees. As one IEN told us, these kinds of arrangements help to ensure the maintenance of some of the job-related benefits for the IEN:



*Donc j'ai commencé à creuser un petit peu tout ça, puis je me suis aperçue qu'il y avait quand même des accords entre la France et le Québec et qui permettaient de garder un peu, de ne pas tout perdre au niveau de la retraite, au niveau de plein de choses comme ça, que bon la façon de pratiquer était relativement similaire et il y avait aussi des accords avec le ministère de la Santé qui nous permettaient quand même, bien d'arriver et d'avoir [un poste] très, très rapidement quoi.*

*[I started looking into it a bit and I saw that there were agreements between France and Quebec that would let me hold on to a little, I mean, not lose everything as far as retirement goes, and lots of things like that, that professional practice was relatively similar, and that there were also agreements with the Department of Health that would allow us to come here and get a [position] very, very quickly.] [Québec IEN #7, practicing]*

IMGs, on the other hand, generally do not experience the same formality of immigration assistance as their nursing counterparts. Indeed, in Quebec, before the establishment of the RSQ in 2003, it was almost impossible for IMGs to become integrated, since there was no formal process in place. Now, once a hospital agrees to hire the IMG, the institution becomes that physician's sponsor and assists with the temporary work visa and permit. Direct recruitment of physicians does occur in two of the provinces studied - BC and Manitoba – and many employment agencies are operating online (Health Match BC 2009). As a general rule, this path is open to physicians who received their training in United Kingdom, Switzerland, South Africa, Hong Kong, Singapore, Australia, New Zealand and the USA (CanAm 2008).

Up until relatively recently, the provinces under study were recruiting IMGs (*primarily from South Africa*) through a variety of means. A number of legal issues pertaining to discrimination of physicians made provincial Colleges cease the practice of direct recruitment and unify the process of integration, making it (at least on paper) relatively similar for physicians coming from different parts of the world. At the same time, as other provinces (Saskatchewan and Alberta) continued hiring South African physicians, many of the IMGs we interviewed who came from other countries complained about the preferential treatment given to these doctors.

Québec-based recruitment agencies are active in some French speaking countries (i.e., France, Belgium, Switzerland), and those representing other Canadian provinces are active in a number of English speaking countries (i.e., the Philippines, India, and, lately, Korea and China). Immigrants from Eastern European, South American, and many African countries, where the system and the language of education are considered to differ greatly from Canadian standards, often do not have the opportunity to come to Canada through recruitment agencies. Agencies do not often operate in those countries where the language skills and credentials of their residents cannot be defined as "ready to practice" in Canada.

While recruitment agencies often facilitate the process of obtaining necessary credentials to enter the country and start practicing, they often recruit IEHPs for practice in lower rank positions or offer them placement in rural or remote areas (Health Match BC 2009). This is especially true in the case of IENs. Recruitment agencies often offer employment in a lower nursing rank to potential immigrants coming to all provinces. In the following quote an IEN

described how she and her fellow nurses were recruited to fulfill the positions of LPNs even though they would qualify to practice as RNs:

*We are all graduates from a four year to a five year program and you finish with a degree in Bachelor of Science in Nursing. But ...when you come to Canada you have to go back to school because Canada's standards are really, really high... So we took the opportunity [offered by recruiters] and we signed in as licensed practical nurses. Before I came here I surfed through the internet if there is any association of registered nurses like we were introduced to the Manitoba Association of Licensed Practical Nurses. And then I wrote them an e-mail saying that if they could review our program ... So they did and then they said that 'Well your program is pretty much a university program so you can challenge the RN'. But because this agency ... did not allow us to challenge the RN exam. Instead they wanted us to come as LPNs. So when we got here to Canada we worked. We had job offers and we started right away full time as LPNs on a two year contract. So that's what happened [Manitoba IEN #2, practicing].*

Very few IEHPs enter Canada through private recruitment agencies. Up until recently, Canada was recruiting physicians to come and practice, but in the past few years, the provinces of British Columbia, Manitoba, Ontario, and Québec standardized the process of integrating IMGs which made it impossible to come and immediately start practicing medicine. As a result of the revised and now more complicated procedures, private recruitment agencies seem to have lost interest in bringing IMGs into those provinces. Similar to some other provinces, the Québec government itself took over from the recruitment agencies and regulated the recruitment and integration process with the creation of the RSQ.

The process of immigration and integration can often be facilitated by recruitment agencies. As our respondents suggest, however, recruitment agencies would not often bother to actually find a tailored fit between the qualifications of an applicant and a particular position in Canada. On occasion they recruit IEHPs to fill positions where their skills would not be fully utilized. Furthermore, they sometimes mislead IEHPs as to the length of the process of obtaining permanent residency.

### **Immigration to Canada with the help of immigration assistance**

Some Quebec respondents reported being drawn to the idea of migrating by an advertising campaign conducted by a Canadian recruitment agency. However, it was not exclusively focused on health care professionals. According to these respondents, agencies such as *Accès Canada* do not promise to find respondents work, but only to facilitate migration to a country (Canada) which seeks their services.

*O.K. la première, je ne sais pas c'était vraiment volontaire. J'ai vu à la télé. On faisait la publicité que le Québec et le Canada demandaient des immigrants pour venir travailler. Je me suis dit mais pourquoi ne pas venir là parce que au pays on est, on ne peut pas dire qu'on n'est pas bien, on est bien mais je voulais avoir une autre, je ne sais pas comment dire, venir voir d'autres affaires, ... et puis quand je lis un peu on me dit que les sages-femmes sont bien ici et puis il y a beaucoup d'autres affaires, ici on a plus de matériel pour pouvoir travailler*

*[O.K. first, I don't know if it was really intentional, I saw some advertising on television that Quebec and Canada were looking for immigrants to come and work. I thought, "Why not me?" Things in our country were not bad, but I wanted something else, I don't know exactly what it was, but I wanted to come and see something different, ... and when I read up on it a little, I found out that midwives are treated well here and lots of other things. Here, we have more material to work with.] [Québec ITM #3, no longer pursuing integration].*

These kinds of agencies – which exist in many provinces – are often operated by immigration lawyers and paralegals that assist hopeful immigrants to collect and complete all necessary documentation for immigration and then follow the progress of their file. For a fee, they can assist prospective immigrants with obtaining a work visa. After that, immigrants are left to their own devices and expected to make and pay for all travel, lodging and employment arrangements themselves. There are, however, several difficulties associated with this pathway into Canada.

Those who came to Quebec through a recruitment agency, such as *Accès Canada*, reported a lengthy immigration processes. In fact, most respondents using the services of these types of agencies report a four to six year wait before being eligible for migration.

*Il y a eu Accès Canada et qui a dit que vraiment le Canada avait besoin de personnel qualifié.... Donc c'est eux qui se sont occupés ... qui se sont occupés d'immigration, pour là-bas aussi c'est vraiment dispendieux et vraiment c'est long. C'est long. Moi ça m'a pris pratiquement cinq ans*

*[Access Canada said that Canada really needed qualified employees... So they took care... they looked after the immigration. Back there, immigration is very expensive and very long. It's long -- it took me almost five years.] [Québec IEN #5, in progress].*

The cost associated with using the services of this type of recruitment agency can be very high, because, unlike agencies seeking immigrants to fill specific positions, travel and visa expenses are incurred by the immigrant and not the hiring institution. On many occasions, these agencies also receive a fee for their application processing services.

*Interviewer: Donc c'est un processus qui est quand même assez dispendieux, j'ai l'impression vous arrivez ici, vous avez dépensé tous vos sous pour venir?*

*Respondent: Tous, tous, tous nos sous, ça nous prend presque 6, 7, 8, ça dépend des gens mais ça passe 8 000 euros, 8 à 9 000 euros.*

*[Interviewer: So the process is fairly expensive. I get a sense that by the time you arrive, you've spent every penny to just to get here?]*

*Respondent: Every single penny, it takes almost 6, 7 8, it depends on the person, but it's over 8,000 Euros, 8 to 9,000 Euros.] [Québec ITM #2, no longer pursuing integration].*

Some of our participants also felt that the information provided by these agencies regarding potential employment is vague and often overstated. Some respondents report having had high hopes for employment opportunities which were subsequently dampened upon their arrival.

*Oui mais d'abord avant notre départ et puis quand on avait entamé la procédure mais on a vu que vraiment il y avait un besoin très, très, très important des agents de santé au niveau du Canada et moi ce que je me disais c'est que pour moi quand j'allais arriver au Canada ici bon déjà j'allais commencer à travailler. Mais c'est lorsque je suis arrivé ici que je me suis rendu compte d'une autre réalité. Que d'abord ce n'était pas aussi immédiat de quitter un autre pays et de venir commencer à travailler ici.*

*[Yes, but before we left and after we started the process, we were led to believe that Canada was in desperate need of health workers, and I thought that was why I was coming to Canada -- in my mind, I thought that once I arrived in Canada, I would start working. But when I got here, I realized it was a different story, that it wouldn't necessarily be automatic, to leave one country and to start working here.] [Québec IEN #4, in progress].*

Immigrants' experiences with agencies that recruit workers to Canada without pointing them toward specific job opportunities have, to some extent, been perceived as misleading. This is, in large part, because the agencies do not make clear and detailed information available to immigrants in the health care field about access to work in Canada.

### **Seeking asylum in Canada: the case of refugee IEHPs**

Although refugees constitute about 11%-13% of immigrants arriving in Canada yearly (CIC 2007), there is considerable discussion about them in academic literature and among policy makers. Those researchers who examined cultural and employment integration of refugees suggest that there are serious policy gaps which delay the process of integration of Canadian refugees (Presse & Thomson 2007; Walsh, Este, & Krieg 2008; Yu, Ouellet, & Warmington 2007).

While government assisted and privately sponsored refugees arrive in Canada with established refugee status and thus receive support from the government and private organizations, those who apply as refugees from within Canada are not eligible for most integration programs nor can they receive services from organizations working with newcomers (Yu et al. 2007). Refugees applying from within Canada constitute roughly two thirds of refugee applicants. (approximately 10,000 to 15,000 people per year) (Yu et al. 2007).

Out of the 176 respondents who participated in our study, 10 were refugee claimants. The majority of them applied for refugee status from within Canada. This process significantly limited their ability to start their professional integration, since permanent resident status is often required for passing professional examinations and moving through the process of integration. When the application of a refugee claimant is under review, it is nearly impossible to start professional integration:

*Now we are under the support of welfare. And we already worked on the interviews that had to be held at immigration. Now I am going to start working very fast [to obtain] the work permit. And after I get the work permit I have to again focus my time in all these jobs that I could be on. I have to put [my medical career] aside for the moment, because I am not a Canadian citizen. I am not a resident. (Ontario IMG #4, no longer pursuing integration).*

Lack of financial resources and an inability to begin the process of professional integration are unique to the refugee population. Although refugee claimants receive assistance from the government while their case is under review, there are specific barriers that are faced by refugees in terms of obtaining employment:

*I have like two co-workers in my company that they came as refugee and they have such really bad time. They couldn't find enough paperwork ... when you come as refugee you have human resources give you... a SIN number. It's a different SIN number. With that SIN number you cannot just go and work [British Columbia IMG #16, in progress].*

The majority of our refugee participants applied for refugee status from within Canada. On one hand, it allowed them to escape persecution in their home country and await the refugee claimant decision in Canada. On the other hand, while their documents were reviewed by CIC, they could not fully participate in the process of professional integration. Moreover, a lack of finances, difficulty in obtaining relevant documentation, and a lack of permanent resident status placed additional barriers to professional integration.

**In sum**, many of the IEHPs we spoke to outlined challenges with the immigration process. Our primary focus, however, was not so much on the immigration process per se but how it influenced the professional integration process. In what follows, we describe the actual process of becoming a professional here in Canada, highlighting major barriers and facilitators on the way to professional integration.

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### **SECTION 3: THE PROFESSIONAL INTEGRATION PROCESS**

The professional recognition process is intricately connected with the immigration process and not all of our respondents started to prepare for professional recognition while still in their countries of origin. Applying from abroad or from within Canada each present their own unique challenges and complexities. Moreover, while immigrants whose English or French skills are good can start professional integration even before they land in Canada, those individuals who do not speak English or French very well often have to postpone their integration until they gain sufficient language competency. Our findings show that those individuals who started preparing for integration earlier, usually had better chances of obtaining employment in Canada. We found this to be more common among IENs than with IMGs and ITMs. The different routes to licensure are described below, along with the types of associated assistance.

#### **The IMG Integration Process**

To become fully licensed to practice medicine in Canada, IMGs have to fulfill numerous requirements: 1) provide proof of completion of an undergraduate medical degree (M.D.) program in an approved university (listed in either the International Medical Education Directory or the World Health Organization World Directory of Medical Schools) and demonstrate English or French proficiency; 2) pass a set of three standardized exams - the Medical Council of Canada Evaluating Exam (MCCEE) to demonstrate equivalent general medical knowledge, and two MCC qualifying exams (MCCQE I and MCCQE II); 3) take one to five additional years of postgraduate medical training (depending on background and intended specialty), of which the number of residency places is limited, particularly for IMGs; and finally 4) pass a certification exam in either Family Medicine (through the College of Family Physicians of Canada (CFPC)) or a Specialty (through the Royal College of Physicians and Surgeons of Canada (RCPSC)). In general, the process for becoming licensed is the same across Canada with slight provincial variations. Table 3.1 provides a general overview of that process.

**Table 3.1 Registration to Practice Medicine in Canada. Full Licensure**

|          |  |   |
|----------|--|---|
| <b>1</b> | <b>Undergraduate Medical School</b>  |   |
| <b>2</b> | <b>Equivalency Exams</b>   |   |
|          |  | Provide Proof of Language Proficiency   |
| <b>3</b> | <b>Postgraduate Training*</b>  |   |
|          | Canadian Resident Matching Service   | IMG – specific Programs   |
| <b>4</b> | <b>Certification</b>   |   |
|          | Family Physician must pass the College of Family Physicians of Canada certification Exam | Specialists must pass the Royal College of Physicians and Surgeons of Canada Certification Exam |
| <b>5</b> | <b>Licentiate of the Medical Council of Canada (LMCC)</b>                                |   |
| <b>6</b> | <b>Provincial/Territorial Registration</b>   |   |

\*Some specialists may be permitted to take the certification exams without additional postgraduate training through special assessments by RCPSC.

\*\*Clinical observations period (usually 3 to 6 months, depending on jurisdiction) could lead to further postgraduate training or lead to provisional/supervised licensure. (Source: Dumont et al. 2008).

Study participants reported that the major stumbling block in this process tends to be step 3, that of obtaining postgraduate training. Many IMGs who apply for licensure successfully complete the evaluation of credentials and examinations, only to fail in their attempts to secure a residency position. The process of awarding residency positions across the country has changed in recent years. The Canadian Resident Matching Service (CaRMS) is a computerized matching system used to bring together those seeking a residency position in a particular field with the positions available in any given province. The two-step CaRMS process is run annually. The first step matches the majority of applicants with their first residency choice. The second iteration compiles all unmatched applicants and remaining residency spots, and matches positions with the applicant's first, second or third listed choice. All provinces, except Alberta, provide IMGs with access to residency spots through CaRMS. Alberta matches IMGs to reserved residency spots through its own AIMG (Alberta International Medical Graduates) program. Two provinces have reserved spots for IMGs. There are approximately 200 reserved spots for IMGs in Ontario and 18 in British Columbia. Before 2006, CaRMS, first iterations were reserved solely for Canadian graduates, and IMGs were matched only in the second iteration. Since 2006, IMGs have been allowed access to residency positions in both the first and second iterations. Table 3.2 below provides a provincial breakdown of the CaRMS matching system for IMGs.

**Table 3.2 Summary of CaRMS intake criteria for IMGs by province**

Updated November 5, 2008

| <i>Province</i> | <i>1<sup>st</sup> Iteration</i> | <i>Positions</i> | <i>Return of Service</i> | <i>2<sup>nd</sup> Iteration</i> | <i>Positions</i> | <i>Return of Service</i> |
|-----------------|---------------------------------|------------------|--------------------------|---------------------------------|------------------|--------------------------|
| <i>NFLD</i>     | Yes                             | P                | Yes                      | Yes                             | C                | Yes (2)                  |
| <i>N.S.</i>     | Yes                             | P                | Yes                      | Yes                             | C                | Yes (2)                  |
| <i>QC</i>       | Yes (1)                         | C                | No                       | Yes (1)                         | C                | No                       |
| <i>ON</i>       | Yes (4)                         | P                | Yes                      | Yes (4)                         | C                | Yes                      |
| <i>MAN</i>      | Yes                             | C                | No                       | Yes                             | C                | No                       |
| <i>SK</i>       | Yes                             | P                | Yes                      | Yes                             | C                | Yes (5)                  |
| <i>AB</i>       | No                              | -                | -                        | Yes (3)                         | C                | No                       |
| <i>B.C.</i>     | Yes (6)                         | P                | Yes                      | Yes                             | C                | Yes (2)                  |

**P= Parallel:** IMGs apply to a separate stream of positions than Canadian graduates in one or more disciplines.

**C= Competitive:** IMGs apply to the same positions as Canadian graduates in all disciplines

1. Must be pre-approved by la Conférence des vice-doyens aux études postdoctorales des facultés de médecine du Québec;
2. Return of Service for individuals matched to positions in IMG Stream only (i.e., Canadian Medical Graduates (CMG)s or IMGs who are matched to a position in the IMG Stream in the Second Iteration will have a Return of Service attached). It should also be noted that IMGs matched to a position in the CMG Stream in the Second Iteration will not have a Return of Service attached.
3. IMG applicants to vacant positions in the Second Iteration must be assessed by the Alberta International Medical Graduate Program (AIMG).
4. IMGs holding return of service (ROS) obligations must disclose at time of application. IMGs who have undischarged ROS obligations may not be eligible to begin Ministry-funded training positions in Ontario. Such individuals may wish to contact the Ministry for further



information. IMGs who have accepted Ministry-funded physician assistant (PA) positions as part of Ontario's PA demonstration project are not eligible to apply for Ontario positions that begin during their 28-month commitment to the project. IMGs who accept Ministry-funded PA positions in any future time-limited projects will be similarly ineligible.

5. Vacant positions in the IMG stream are available in the 2<sup>nd</sup> Iteration only to IMGs with a Return of Service attached. Vacant positions in the CMG stream are available to CMGs and IMGs with no Return of Service attached.
6. IMG's must have an assessment from the [BC IMG Assessment Program](#) to be eligible for First Iteration. (Taken from: [www.carms.ca/eng/r1\\_eligibility\\_prov\\_e.shtml](http://www.carms.ca/eng/r1_eligibility_prov_e.shtml) on August 13th, 2009).

### Alternate Routes to Licensure for Some IMGs

Prior to 1993, there were two categories of IMGs, depending on where they went to medical school. *Category I* IMGs had studied in the United States, Great Britain, Ireland, Australia, New Zealand or South Africa. IMGs from any other country were classified as *category II* and were required to take additional training. Milne (2003, p. 28) details how:

In a pivotal legal case, called Bitonti, physicians from Italy, Romania, the Philippines and Russia who had been unable to secure employment as physicians in BC, argued they were discriminated against by the College of Physicians and Surgeons of British Columbia. Category I and II distinctions were abandoned in 1993 and now all applicants for full registration must complete two years of postgraduate training in Canada.

The standardized set of requirements for all IMGs applying for licensure changed to a process of professional integration for IMGs from all countries with medical education systems deemed to be equivalent to Canada's. Although the process has become standard for all doctors, there continues to be a feeling that an informal (or more subtle) preferential treatment continues to pave a somewhat different route for professional integration of IMGs from certain countries:

*I do think there's discrimination until people get to know that you know what you're doing. Now I don't think that's a racial discrimination. I think that's more of a professional discrimination because... and I see it with... you know, I go to Thompson and do locum work up there and there's a lot of physicians up there that have come from Libya and Egypt and places like that where maybe it's viewed that their training is not as substantial as say doctors that come from the U.K. or from South Africa. So I think within the profession there's a certain amount of discrimination in regards to 'Well they've obviously not got such a good training so they're probably not good practitioners.' So you have to prove yourself as a practitioner I think based on your ethnicity and cultural background [Manitoba ITM #1, practicing]*

All four of the provinces included in the study have alternative routes to licensure available (see *Appendix B*) and some form of provisional licensure:

Provisional licenses enable physicians to practice, and in some cases, without having already passed the Medical Council examinations and completing the required Canadian post graduate medical training. Provisional licenses differ

across all provinces with some being called “restricted”, “defined”, “conditional”, or “temporary” and each one holds with its special conditions such as having a sponsor or supervisor for a specific length of time, a return of service agreement, requirements to work in an underserved area or a stated time limit to write the licensing exams (Dumont et al. 2008, p. 57)

In Quebec, as noted above, the RSQ can recruit IMGs directly and award a restrictive work permit which allows them to undertake specific professional activities in a pre-determined medical establishment (RSQ 2010b). The IMG must demonstrate competencies to the CMQ. Hospitals offering teaching positions (which include both research and clinical work) are often permitted to allow the physician to bypass the equivalency examination process altogether (RSQ 2010a).

In Ontario, in addition to entry level positions available to IMGs via CaRMS, there are more advanced training positions for IMGs who have completed their postgraduate training. Training for such individuals can take between 6 months (streamlined) to 1-2 years (advanced level) (CEHPEA 2009). Ontario also offers a form of licensure which requires a Return of Service agreement of up to 5 years.

Opportunities in Manitoba include: the MLPIMG program (Medical Licensure Program for International Medical Graduate), established in 2002, which provides bridging opportunities for IMGs; Assessment for Conditional Licensure (IMGACL), established in 2007; and other programs that facilitate the integration of IMGs (University of Manitoba 2010). The numbers of IMGs accepted for MLPIMG program have rapidly increased over the years, from only three students in 2002 to twenty in 2010 (see Table 3.3 below). In Manitoba, an IMG may obtain a renewable provisional license to work in an underserved area and continue to renew it indefinitely rather than apply for full registration (Dumont et al. 2008).

**Table 3.3: MLPIMG applications and acceptances (2002-2010)**

| Year         | Applicants | Repeat applicants | Accepted  | Acceptance Percentage |
|--------------|------------|-------------------|-----------|-----------------------|
| 2002         | 4          | 0                 | 3         | 75.0%                 |
| 2003         | 15         | 0                 | 8         | 53.3%                 |
| 2004         | 11         | 2                 | 10        | 90.9%                 |
| 2005         | 28         | 5                 | 5         | 17.9%                 |
| 2006         | 33         | 4                 | 10        | 30.3%                 |
| 2007         | 52         | 10                | 9         | 17.3%                 |
| 2008         | 76         | 27                | 12        | 15.8%                 |
| 2009         | 99         | 26                | 20        | 20.2%                 |
| 2010         | 148        | 30                | 20        | 13.5%                 |
| <b>Total</b> | <b>466</b> | <b>104</b>        | <b>97</b> | <b>20.8%</b>          |
| 2011         | 225        | pending           | pending   |                       |

(University of Manitoba, 2010)

In British Columbia, IMGs can apply for Temporary Registration which awards a provisional licence restricting their practice to supervision in an underserved area or a specified community.

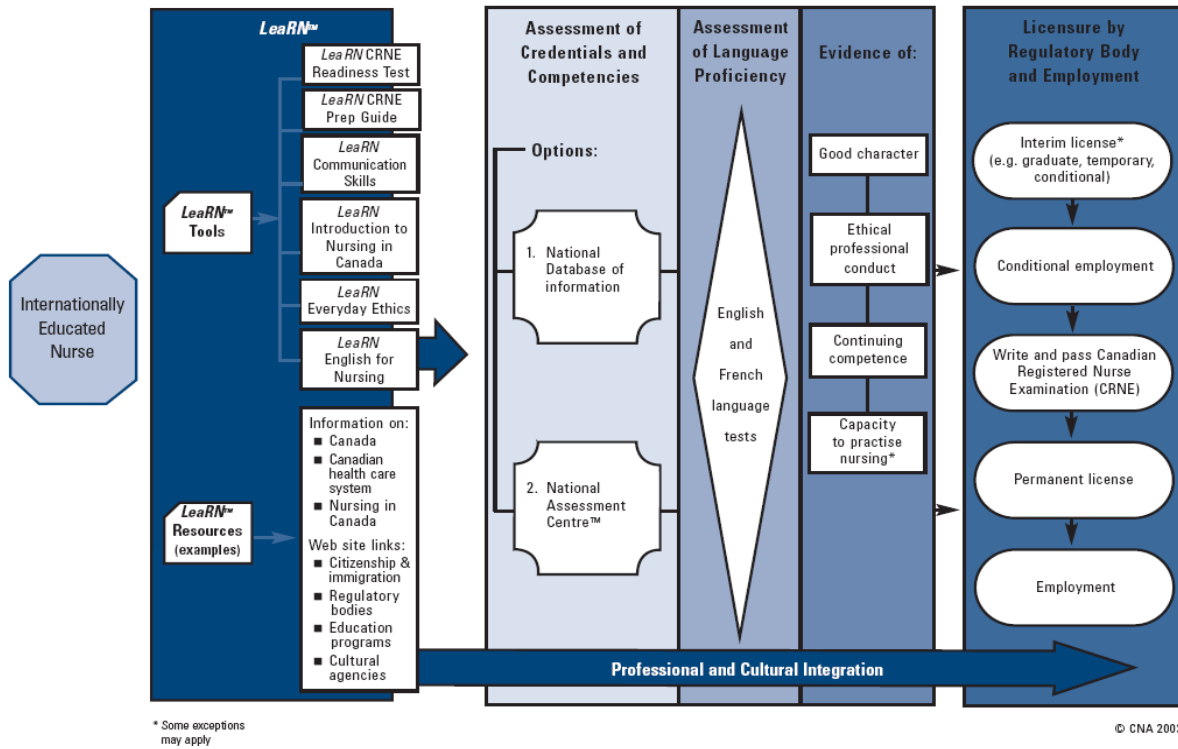
### **The IEN Integration Process**

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The process of qualifying as a nurse in Canada as an IEN involves fewer steps than of the process for medicine (see Figure 3.1). This discussion focusses specifically on obtaining a Registered Nurse (RN) designation, though some IENs attempt to gain entry and experience first through becoming a Licensed Practical Nurse (LPN). As a first step, candidates must apply for registration with their provincial or territorial regulatory bodies (the application process presently differs across provinces and territories see Table 3.4), have their credentials assessed (some contact a credential evaluation service for advice), and then must pass the Canadian Registered Nurse Examination (CRNE) in provinces outside of Québec or *l'examen professionnel de l'Ordre des infirmières et infirmiers du Québec* if they wish to practice in Québec (CICIC 2006). Many nurses make applications to more than one province, making accurate statistics of the total number of IEN applicants in Canada difficult to assess.

**Figure 3.1**

Regulatory Framework for the Integration of International Applicants



**Table 3.4. Documentation Required for IEN Applications by Province, 2004**

|     | CAF | Lng | Ver 1 | Ver 2 | Mar | Tra | Pas | Dip | NPC | Emp 1 | Emp 2 | Ver 3 | Cri 1 | Cha | Cri 2 |
|-----|-----|-----|-------|-------|-----|-----|-----|-----|-----|-------|-------|-------|-------|-----|-------|
| BC  | x   | x   | x     | x     | x   | x   | x   | x   | x   | x     | x     | x     | -     | x   | x     |
| AB  | x   | x   | x     | x     | x   | x   | x   | -   | -   | -     | x     | -     | -     | -   | -     |
| SK  | x   | x   | x     | x     | x   | x   | x   | x   | x   | x     | -     | -     | -     | -   | -     |
| MB  | x   | x   | x     | x     | -   | x   | x   | -   | x   | -     | x     | x     | x     | -   | -     |
| ON  | x   | x   | x     | x     | x   | x   | x   | x   | x   | x     | x     | x     | x     | x   | x     |
| QC  | x   | x   | x     | x     | x   | -   | x   | x   | x   | x     | x     | -     | x     | x   | x     |
| NB  | x   | x   | x     | x     | x   | x   | x   | x   | x   | x     | x     | x     | -     | x   | -     |
| NS  | x   | x   | x     | x     | x   | x   | x   | x   | x   | -     | x     | -     | -     | -   | -     |
| PEI | x   | x   | x     | x     | x   | x   | x   | -   | -   | -     | x     | -     | -     | -   | -     |
| NL  | x   | x   | x     | x     | x   | x   | -   | -   | x   | x     | -     | x     | -     | x   | x     |

Source: IEN-DP Registrar Survey, 2004.

Note: (x) indicates document is required; (-) indicates document is not required.

CAF – Completed Application Forms

Lng – Proof of Language Proficiency

Ver 1 – Verification of Original Registration in Home Country

Ver 2 – Verification of Current Registration

Mar – Marriage/Birth Certificates

Tra – Course Transcripts

Pas – Passport, Photo ID

Dip – Diplomas, Certificates from Programs of Study

NPC – Nursing program confirmation

Emp 1 – Employment references/ Regulatory bodies request

Emp 2 – Employment references/Applicant request

Ver 3 – Verification of all Registrations

Cri 1 – Criminal Record Check

Cha – Character Reference

Cri 2 – Criminal Record Review

## The ITM Integration Process

There are two main paths to integration for ITMs. In Ontario, there is an *International Midwifery Pre-Registration Program* (IMPP) which is a one-year bridging program offered at Ryerson University in Toronto. It is designed to offer assessment and upgrading of 20 to 25 ITMs per year, to ensure that they meet the required standards of practice for Ontario. The content of the nine to 12 month program includes a midwifery language proficiency test, two ESL courses, and workshops which orient the ITMs to midwifery in Ontario. Once they have completed the program, graduates are registered in the ‘Supervised Class’ to provide them with sufficient experience to meet the number of clinical births required by the College. Supervision will typically last anywhere from six to 12 months (IMPP, 2005).

The second path is through one of the *Prior Learning Assessment* (PLA) or *Prior Learning and Experience Assessment* (PLEA) processes available in the provinces of Quebec, British Columbia and Manitoba. The PLEA processes are labour intensive and typically include: the submission and review of a portfolio to determine if the ITM is eligible to sit for written and clinical exams. If successful, the ITM then follows a module which introduces the specific provincial practice contexts. The PLEA program in Manitoba has had a very small intake of three ITMs per year.

Unlike the IMPP, most of the applicants to the PLEA program are Canadians who have sought midwifery training elsewhere.

Recognizing the capacity limitations of low enrolment in each province's midwifery integration programs, and an equally low availability of preceptors to supervise new ITMs, the Canadian Midwifery Regulators Consortium (CMRC) undertook a National Midwifery Assessment Strategy (NAS) from 2003 to 2006. The aims of this strategy were to: *increase* ITM access to the profession; build on the high degree of similarity in professional requirements and standards across the country to create an effective inter-jurisdictional process; honour the unique aspects of midwifery in each province and territory; and support each regulator in carrying out its legislated responsibility to protect the public.

One of the outcomes of this process is the recently established *Multi-Jurisdictional Midwifery Bridging Project* – a collaboration with the University of British Columbia, Mount Royal College and l'Université du Québec à Trois-Rivières - which started its piloting phase in 2009. Accepting applicants wishing to practice in British Columbia, Alberta, the Northwest Territories, Nunavut, Manitoba, Saskatchewan, and Quebec, the program offers a general stream and an accelerated option for qualified candidates. The program is designed as a seven-month project (for regular enrolment) during which the midwives attend online education classes and courses available in their community (i.e., English classes available in their hometown). In addition, one to three-week midwifery intensive courses are offered through the University of British Columbia. The ITMs are also required to undertake a three-month placement. Table 3.5 outlines the intended number of ITMs to follow these programs in 2010.

**Table 3.5: Assessment and Bridging Programs for ITMs (April 2010)**

| Program | Funded Seats | Current enrolment | Graduates to date | Anticipated graduates |
|---------|--------------|-------------------|-------------------|-----------------------|
| IMPP    | 20           | 19                | 100               | 12                    |
| MMBP    | 24           | 22                | 7                 | N/A                   |
| UQTR    | 18           | 16                | 2                 | 5                     |
| TOTAL   | 62           | 54                | 109               | 17                    |

Source: CAM (2010). Midwifery Education in Canada 2010.

[http://www.canadianmidwives.org/DATA/DOCUMENT/FACT\\_SHEET\\_Education\\_updatedApril2010.pdf](http://www.canadianmidwives.org/DATA/DOCUMENT/FACT_SHEET_Education_updatedApril2010.pdf)

**In sum**, although there are alternatives to the typical entry to practice processes outlined here, these are few and far between. We now turn to the barriers experienced by the IEHPs we interviewed, along with what they felt facilitated their integration process. We end with a section on recommendations for further action.



## SECTION 4: BARRIERS TO PROFESSIONAL INTEGRATION

Most of our participants approached their migration to Canada with a sense of optimism and hope, which is remarkable considering how long some of them had to wait to get here. This section examines the barriers to professional integration that the IEHPs experienced. Barriers to immigration were addressed in an earlier section.

There are number of barriers which IEHPs face while seeking to integrate into the Canadian workforce. Some are unique to their individual profession, some are similar across health professions, and some are similar to the migration of highly skilled workers generally. First, we describe the difficulties that all IEHPs face when coming to Canada followed by the difficulties unique to each profession.

### General Barriers Faced by IEHPs

All of the IEHPs we interviewed faced very similar barriers in terms of: their English or French language skills, particularly those which are profession-specific; financial difficulties related to the requirements for licensure, which is compounded by the time-consuming and seemingly bureaucratic nature of the process; and the challenge posed by the lack of opportunity to gain Canadian cultural competency.

#### Language Skills:

Not surprisingly, language is seen as the biggest barrier for many IEHPs when it comes to professional integration. The practice of all of the professions studied requires extensive communication skills. Our respondents faced difficulties in preparing themselves for communication with clients and co-workers. While this is faced by all immigrants, regardless of occupation, this is particularly salient in a health care context where often intimate information needs to be shared:

*You can't ask people about all the intimate things that you need to ask them about, not just about the physical side of it but, you know, psychological aspects and all that sort of thing, you couldn't have a proper discussion with a woman and establish what was really going on for her unless you're fluent in that language. It's hard enough to communicate with people who do speak English never mind [British Columbia ITM #4, in progress]*

To obtain their professional license, applicants whose education was in neither of Canada's official languages are required to pass one or more language tests. A number of our interviewees, however, challenged the assumption that passing a language test makes them ready to communicate in their workplace. Language differences, even among native English or French speakers coming from outside Canada, had been defined as a barrier to effective workplace communication:

*There is still a language barrier even though we speak the same language... One thing I've noticed here there's an awful lot of abbreviations for things which in the U.K. has*



*been stopped over the last 10 years. We don't abbreviate stuff. So you know, you'll hear a lot of people within the work force talking about certain abbreviations and you're kind of like 'Well what does that mean?'...The drugs are different here. Different names for the same drugs but completely different names... Language, I mean it must be even harder for people that don't have English as their mother language [Manitoba ITM #1, practicing].*

Language barriers are an issue for all IEHPs, but are a particularly tricky problem for ITMs in Québec, where proficiency in both French and English is required.

It has already been suggested (Baumann, Blythe, Rheaume, & McIntosh 2006) that language is one of the biggest barriers to professional integration and that current tests used by professional colleges may not accurately evaluate the knowledge of professional language. We found that IEHPs overwhelmingly felt unprepared for the communication taking place at the workplace, even once they passed or were exempt from the language exams. This was especially true among nurses, who are usually integrated into the system more quickly than IMGs and ITMs:

*From a cultural standpoint, um, sense of humour was a little bit different. ... that took a little bit of getting used to. ...and another thing I found that was kind of a little hard was, um, the way certain things were pronounced was different ... even medication names we pronounce a little differently. Like rocephin in South Africa it's called 'rossefin' and so you would say it and it sounds like you're saying it wrong to somebody who says it differently which then almost makes you look like you don't know what you're talking about. So I found that a little hard. And then when you start to adjust your language and your spelling, like you know we spell certain words like paediatric is spelled with an 'a' in it and words like dysmenorrhea, diarrhea they have an 'hoea', um, on the end. So having to drop letters and then change the way I pronounce stuff ... that took me a bit of getting used to [Manitoba IEN #3, practicing].*

*J'apprends les expressions drôles avec des fois je dis des trucs aux enfants qui me regardent avec leurs grands yeux, ils ne comprennent pas ce que je leur dis. On leur explique c'est comme je ne sais pas moi, je vais appuyer un peu sur ton ventre puis il regarde sa mère mais non on va peser sur ta bedaine, c'est rien. C'est des petites expressions.*

*[I learn funny expressions and sometimes I say things to the children and they look at me with their eyes wide open. They don't understand what I'm saying. We tell them, I don't know, like I'm going to put a little pressure on your stomach and then he looks at his mother but no, I'm going to press on your tummy, it's nothing. It's little expressions.] [Québec IMG #1, practicing].*

### **Place of Origin/Practice Differences**

Another one of the strengths of our approach which was inclusive of IEHPs from various source countries is that we were able to examine the impact of ethnicity across professional groups. What is typical of the experiential research in this domain is the tendency to look at one

particular group – like the South Africans (Collinds 2004; Flynn 1998; Giri 1998). What we found was that the place of origin or education of IEHPs played a significant role in successful or unsuccessful professional integration. It is often assumed that the fluency in an official language of Canada plays the most significant role in successful professional integration. While our findings do not deny the importance of language, it is not the only factor determining success. Racial and ethnic background continues to be viewed as posing barriers to professional integration.

Among IMGs, it was often the case that the South African physicians are the fastest to integrate into the system. Although in all provinces under the study, the process of obtaining medical licenses was streamlined, many IMGs claimed that South Africans have better chances to do better on the personal interview and to be offered a position. Those IMGs who immigrated from Iran, on the other hand, were, for the most part, fluent in English, but they often felt that their ethnicity was seen as a barrier for professional integration. Many felt that “being non-white” decreased their chances of receiving a placement or doing well on a residency interview. In Quebec, the racism among employers was considered to be even more prevalent from the perspective of our IEHP participants.

The system of education (especially for nurses and midwives) in the country of origin was yet another important factor. Many IENs coming from Eastern European countries, for example, had a different model of nursing and a different model of education and therefore had difficulties in adjusting and having their credentials meet Canadian standards.

Another component was the variations in professional practice in different countries. IEHPs coming from a different model of practice, understandably, had more difficulties in practicing their profession here in Canada. It would take these professionals the greatest amount of adjustment to align their practice routines and habits with those of Canadian professionals.

Finally, the transferability of credentials was often evident in comparing the responses of IEHPs coming from different countries about their perceived chances of practicing their profession. While IENs from Philippines, the UK and Australia, and IMGs from South Africa were directly recruited to come to Canada, IEHPs from other jurisdictions were often actively discouraged from seeking professional integration in Canada.

Thus, place of birth and of professional education placed some IEHPs at advantage, while they made the process of integration especially challenging for others. Lack of communication skills, and discrepancies in education and credentials, but also racism and cultural intolerance, all played a role in the process of integration of IEHPs.

### **Financial difficulties**

Another big barrier that cut across the professions we studied is the financial demands of preparations for professional examinations and class and course attendance. Although many of our respondents arrived in the country as skilled workers with a certain amount of money to

spend on preparations for the exams, they very soon realized that their resources were insufficient. The amount of money spent on examinations in many cases went well into the thousands of dollars:

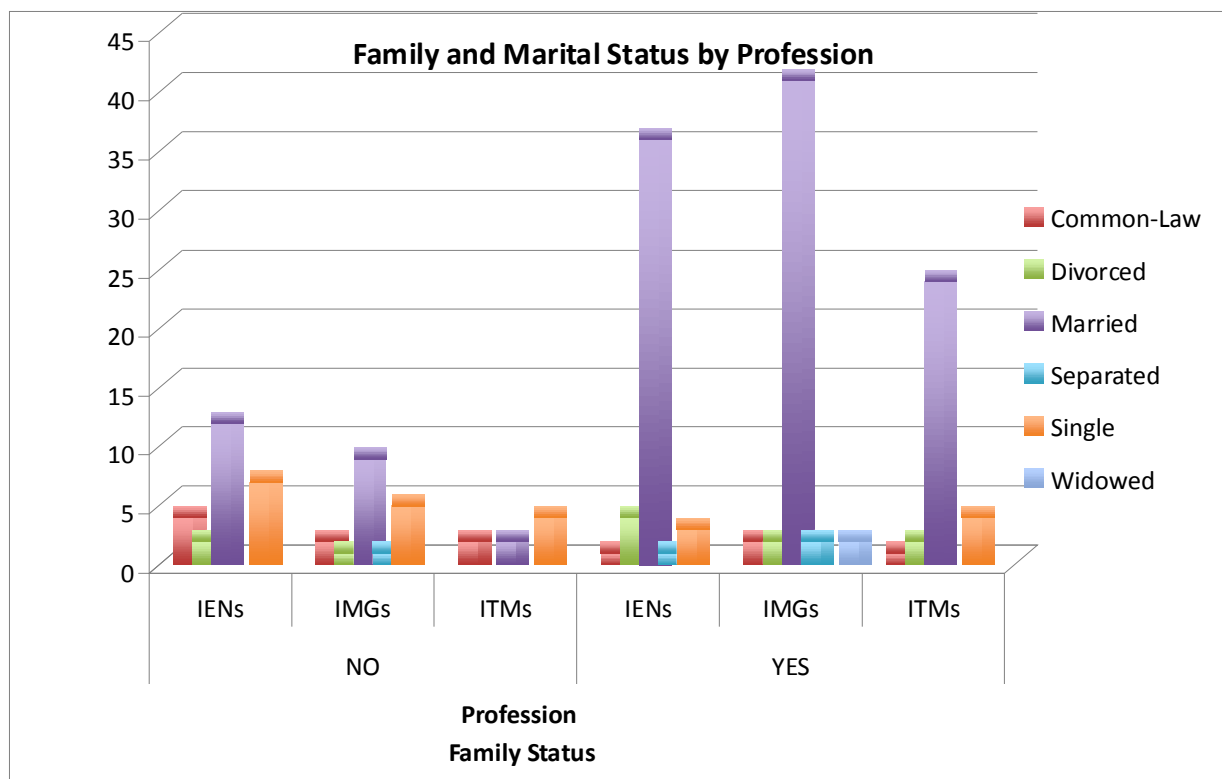
*I think in all the process for me probably to get my license, and this is nothing compared to what the physicians pay, probably from start to finish was about \$15,000. And I know physicians can pay hundreds of thousands. I honestly think it's a money making process for some of these provinces, 'cause I mean there's a lot of immigrants who want to come here. I mean Canada is not easy to get into. We've often laughed about it and said 'You know what? If we'd been refugees we would have got in a lot easier than if we'd been, than being skilled workers.' You know. It seems to me they make it as difficult as they can, almost so they can make more money out of you. [Manitoba ITM #1, practicing]*

The inability to get a student loan was also mentioned by our respondents. While Canadian students can receive loans with good borrowing and repayment terms, expecting to repay the bank once they finish their education, the vast majority of IEHPs have to apply for general bank loans, which often demand high levels of interest, related to their lack of a Canadian financial history, and require them to make monthly payments while they are studying:

*We ended up paying about \$3,300. every month for our loans... And those were not student loans because we were international medical graduates and we had no security that we'll become doctors so nobody will give us any student loans... In our case our future is, you know, it can be very bright and it can be very dark. So we have no guarantees there so nobody will give us any kind of student loan because they don't know where we will end up. So we have to take regular loans with high interest rates, 18.5 and things like those [Manitoba IMG #2, practicing].*

As a result of the costs involved, many IEHPs had to work while preparing for the exams. They were not working in their profession, instead having to take positions which often did not pay well. This ultimately affected their examination success which in turn, affected their chances of receiving a professional license.

**Figure 4.1: Family Status (*i.e.*, *having children*) and Marital Status of IEHPs by Profession**



Financial difficulties and the problem of finding time to prepare for exams were especially salient for these IEHPs who immigrated to Canada with families, which was the case for many of our participants (see Figure 4.1). On one hand, our respondents often commented that immigrating with family was an advantage, since it often provided emotional support that was not available to single people. On the other hand, immigrating with the family meant spending more time and money to integrate family members, straining already limited resources:

*One of my friends, he's my classmate, so he passed the three exams and he ... is doing part time job in some clinic, some walk-in clinic. So he is just making I think three days a week or two days making one thousand dollars of income doing that. So he is managing just to care take. So I thought... and he's dependent, like his in-laws supporting him. Like he live with his wife but in his in-laws' basement so he is not paying rent and his wife is working. ...So she is supporting the kids and so the kitchen and the rent, everything he is not worried about. But my situation was totally different. I had to support my family hundred percent. Like no chance someone would support me. [Ontario IMG #5, in progress].*

### Gender Differences

We found that the gender of the immigrant health care professional could play a significant role in the process of integration. Interestingly, gender played a significant role in the integration of female physicians. Even in the case of IENs and ITMs who immigrated with their families, they

were usually either regarded as primary breadwinners by their family members and partners, or were following their husbands and looking for professional opportunities near their the husband's job:

*Actually it was hard because, um, ... he's qualified as an electronic engineer. That was what he did in South Africa. But coming over, um, there's no sort of shortage necessarily in his field so we were relying on me to get my work visa and then he could work as my dependent. Then he could work anywhere. So we did need to get my visa first. He, because we were so remote, um, it was hard for him to get anything in his field. He ended up working at Canadian Tire eventually just to have something to do but that ended up doing really well for him. ... So that ended up working out okay, but no, it wasn't easy for him to get work [Manitoba IEN #3, practicing].*

*He has been supportive and the decision was for him to be at home while I worked ...So he stays home and that has been a blessing. Like I wouldn't be doing this job at all if he wasn't willing to do that because I have no desire to put my baby in child care. People do it and that's fine but it's expensive... It has not been easy to be a mother, a full time midwife, and now pregnant [Manitoba ITM #3, practicing].*

On the other hand, female IMGs were often discouraged by their partners and family members to pursue professional integration:

*My family did not support me in this process. My husband is an engineer and he did not really want me to go through all this. It's been 10 years now. We did want to have more children, but we were waiting and waiting, and it is too late. And now, it is more coming, this feeling that I am struggling for nothing. [Ontario IMG #3, practicing]*

### **Age Differences**

Integration can be particularly difficult for those who come to Canada later on in life. Not only do they face complications due to their immigrant status, but also to their age. Some respondents reported being discriminated against on both of those fronts.

*Ah c'est différent d'une place à l'autre, c'est différent avec chaque personne, c'est vrai qu'il y a beaucoup de racisme, c'est vrai qu'il y a des préjugés par rapport à l'âge. Je me suis fait dire plusieurs fois qu'est-ce que tu fais ici, à ton âge, combien d'années tu penses travailler avant la retraite. Je me fais dire ça comme étudiante, je me fais dire ça comme professionnelle, comme infirmière auxiliaire. Il y a beaucoup de préjugés par rapport à l'âge et il y a aussi beaucoup de racisme.*

*[It's different from one place to another and it's different with every person. True, there is a lot of racism. True, there is age-related prejudice. I've been asked many times, "What are you doing here, at your age? How many years are you still planning to work before you retire?" I get asked that as a student, as a*

*professional, as a licensed practical nurse. There is a lot of prejudice about age, and a lot of racism.] [Québec IEN #3, in progress].*

### **The time-consuming nature of the process**

Exacerbating the financial difficulties experienced by the IEHPs interviewed, were complaints about the length of time required to obtain a license to practice their profession in Canada. Whether because of wait times between steps in the lengthy process, lack of availability of residency or *stage* placements, or length of updating or preparatory courses, the length of the integration takes between one to two years for some ITMs and IENs and five or more years for some IMGs. During this time, IEHPs feel that they become out of practice and lose the edge in some of their technical skills. For all the professional groups we studied, it was necessary to stay in practice. Some, who could, had to go back to their home country to practice so that they would remain eligible. The following quote comes from an interview conducted in December 2008:

*On nous a classés comme date d'inscription comme je vous ai dit que je me suis inscrite dans l'Ordre depuis 2005, alors j'étais la sixième dans la liste pour avoir mon stage. Pour le moment on ne sait pas quand est-ce que moi personnellement je dis je ne sais pas quand est-ce que je vais commencer mon stage, à partir de février, selon la disponibilité. Et normalement trois mois de stage, au moins trois mois de stage. On va encore, je ne sais pas à partir de février ou c'est pour l'été, on n'est pas au courant encore*

*[They categorized us by registration date, as I told you, I registered with the Ordre in 2005 and I was sixth on the list to get my practical training. For the moment we don't know when, I personally don't know when I'm going to start my training, beginning in February, depending on availability. And there is usually three months of training, at least three months of training. We're still going, I don't know starting in February or in summer, we don't know yet.] [Québec ITM #8, in progress].*

While waiting for integration, many IEHPs resort to working outside of the health care field altogether. As one IMG related:

*J'attends mon stage, alors. Pour m'occuper, je fais du soutien scolaire. J'aide les enfants à... des petits cours. Je surveille un petit peu les enfants. C'est pas loin de l'endroit où j'habite. L'école est sympathique, les enfants, je connais bien.*

*[I'm waiting for my training, so to keep busy, I do school support work. I help the children ... little classes. I monitor the children a little. It's not far from where I live. The school is nice, I know the children well.] [Québec IMG #1, in progress]*

In an attempt to increase their chances of eventual integration, some IMG respondents decided to accept work in the health care field that does not require them to have their license as a physician but allows them to work in the system and be integrated to some extent.

*You know, if you want just to stay at home, they say they don't like the person just stay at home and not taking part in any activities, any scientific activity. So the best option – and they are so sensitive about it – and so the best option that some persons try is ...to have the kind of, I say health job, I call it health job because it can be, I don't know, the research, medical research or science research or anything that tries to afford the families. .... We were not far from the science, we are not far from the medicine. [Québec IMG #1, no longer pursuing integration]*

When IMGs work in other health care fields, their employers and co-workers, who are aware of their medical background, sometimes take advantage of it. For instance, one IMG, who does not yet have his license to practice medicine in Canada, was hired by a long-term residence as a nursing coordinator. On top of his duties in the capacity as coordinator, he unofficially uses his knowledge and skill as a physician to make things run more smoothly in the facility:

*Yes. The doctors appreciate, because I go there and assess the patient. And I know what to look for. So when I'm talking with a specialist, ... I already know the way he thinks, the way a doctor thinks. So, sometimes they ask me what do you think the patient has? Because I already assessed the patient. [or] Sometimes they'll bring a nurse in for needles and, because they are old, they have tiny veins, they cannot set IVs and the patient needs an IV because he's dehydrated. So then they call me and they told me, sorry, but they cannot do it because, and I go there and I cannot do it myself, because it's not legal. I don't have the licence to do that, but I go there and I look for a bigger vein and I told them, look, I think you can do it with this ...So they feel more confident and they do it and then it works for them. [Québec IMG #2, in progress]*

Eligibility for obtaining a license often expires before the process is completed (e.g., in most jurisdictions in Canada, IMGs must have practiced for twelve consecutive months within the past three to five years, which is a similar requirement for IENs and ITMs). Some IMG respondents observed the experiences of colleagues who waited years and spent thousands of dollars to only to find out that they were refused a residency spot.

*I passed the test and I think with good grades and with my experience and my age, I know that I'm young and I thought that, yes, there is no way because I saw that my friends with the same situation, maybe a bit more, a bit less, they couldn't enter the system so I tried not to waste my money and my time. So I didn't participate for the last part. ...It's making a logical and make a wise decision. [Québec IMG #1, no longer pursuing integration]*

As a result, these respondents chose to give up before even finishing their equivalency process, and thus will never be integrated as practitioners in the health care system.

### **The bureaucratic nature of the process**

A frequently expressed frustration concerns the level of bureaucracy in the professional integration process, which is experienced in addition to the frustrations of the immigration process. One of the ITMs we interviewed said, "*I can totally get that they have to be very sort of, um, careful...but sometimes it feels like they're just downright obstructive.*" [British Columbia ITM #4, in progress]. Another one recounts her experiences with the integration process:

*The individuals in the College have been very helpful, very friendly, very supportive, but the overall College rules, I mean that was just ridiculous ... [someone from the College] called me up and saying 'Oh you know, the documents didn't get sent up properly.' And I said 'Well I'm sorry. The school didn't realize. They sent it to me and I sent it on to you.' And she goes 'Oh well, you'll have to do it again.' And I said to her 'Look. You know what? I don't even need to do this. So you either accept what I've given you or I'm done.' [laughs] And it was 'Well let me look into that. Let me look into that.' Next thing you know 'Oh no, it's fine. Don't worry about it. It's fine. But that was the kind of stuff that they were pulling. [British Columbia ITM #5, in progress]*

Many respondents complain that there is a lack of communication between different stakeholders and a lack of transparency in the integration process. Some of our participants noted a lack of communication between employers and the regulatory bodies, and in turn a lack of communication with the IEHPs. For example, in the Québec *stage* placements, an IEN described the confusion and misunderstanding:

*Respondent : Par exemple quand j'ai appelé le ministère, le ministère au départ donc pour avoir des renseignements pour immigrer, etc., au départ on ne m'a pas parlé d'examen de l'Ordre. On m'a dit si vous avez un permis en France et que vous avez un permis ici il n'y a pas de problème. Moi je pensais qu'au début j'allais avoir un temporaire d'un an puis qu'après hop.*

*Interviewer : Automatiquement.*

*Respondent : Très vite je me suis aperçu que ce n'était pas ça. Autre chose aussi on m'avait dit, on m'avait dit que vu le niveau d'études que j'avais, j'aurais mon niveau académique serait reconnu comme un baccalauréat en sciences infirmières. Ça n'a pas été le cas, on m'a reconnu une technique en soins infirmiers*

*[Respondent: For example, at first when I called the Department, the Department to get information about immigrating, etc. in the beginning no one mentioned Ordre examinations. I was told if you have a licence in France and a licence here, there is no problem. In the beginning, I thought I would have a one-year temporary licence and after that, away we go..*

*Interviewer: Automatically.*

*Respondent: I soon realized that it didn't work that way. Another thing I was told, I was told that given my level of education, my academic standing would be considered the equivalent of a bachelor of nursing science. That wasn't the case; I was recognized for vocational nursing.] [Québec IEN #4, practicing]*



A following section outlines barriers that IMGs have experienced from the residency matching process. This also speaks to the issue of a seemingly overly bureaucratic process.

### **The challenge of cultural competency**

While Canada provides a multicultural environment, it has its own unique cultural dimensions and colloquialisms. According to some respondents, the opportunities open to IEHPs can depend on the individual's fit with the implicit, tacit, and even inchoate aspects of what comes to be recognized as Canadian culture. Indeed, "cultural competence" is emphasized in the bridging program discussed more fully below. This section explores how a lack of understanding of cultural subtleties in reading people and situations can pose a barrier to the ease with which and IEHP is able to integrate into their chosen profession:

*I've seen the full spectrum. But actually I've seen lots of extremes. I've seen people that really want to embody this country and, you know, become Canadian and maintaining maybe their culture but, you know, adopt this country. And some people that basically were very resistive and they want to, you know, retain their own culture at all costs and kind of impose their culture on the Canadian system. Those are the ones that I've seen least successful, most aggressive, and I have to say a small number [British Columbia IMG, practicing].*

One of the first instances where IEHPs face the limits of their cultural competency is in the licensing exams. While language is a challenge for many nurses, the biggest difficulty is not the language of the CRNE, or the OIIQ in Québec, but its cultural dimensions. According to many of our respondents, the failure of IENs to pass the exam is not attributable to their lack of nursing skills. In their opinion, it is the questions related to the Canadian nursing environment and culture that make it difficult for IENs to pass the exam:

*The short answer was sort of crazy because you just have to present the sentence they have... and some of those things from my home nursing, some of them were like off limits. ... In Nigeria you don't advise the physician. You just inform. Advise and inform, they are two different things. In Canada you have to put 'advise'. Whereas in my home nursing, the physician you just inform. You can only advise your colleagues, nurses just like you... You inform the physician patient's results. You inform and not advise. Advise is like you being the authority. [Manitoba IEN #2, practicing].*

IENs also told us that they are expected to know how to navigate the administrative system. In their opinion, it was not fair to evaluate their knowledge of system navigation prior to their actually working in it:

*They have too many cultural questions [on the] exam. For example ... they asked me about the Jehovah Witnesses. It's the religion and I knew that they don't do the blood transfusions. [It's] against the religion and they say well like if you had a patient and they are Jehovah Witnesses and this is their kid and they have to do the transfusion and*

*the parents have refused and what are you going to do about that? Are you going to do the transfusion or are you going to the Child Aid? Like [there are] too many questions when you have to really understand the culture to know how to answer these questions [Ontario IEN #1, no longer pursuing integration].*

The biggest concern of IENs, however, had to do with culturally biased questions that, in their opinion, had little to do with nursing:

*They test different areas of knowledge and I think that the answers, I think it's just a cultural barrier. ... For example I'll never forget, I had this question about what toy would be more appropriate for a child with autism, toy or game. Merry-go-round, jack-in-the-box, and a couple more things like this, okay? I didn't know what to answer because I didn't know what any of those games were, toys, were so I just randomly picked whatever. I had no idea. So I mean that is an insensitive question. They really should not ask a question like that because it pretty much is designed to weed out people who never heard of those toys so what would be the purpose of that? They should have rephrased the question and explained do you want an interactive game, do you want, you know, a game where he plays a role or things like that. So that wasn't fair. And there are many questions like that [Ontario IEN #1, practicing].*

While bridging programs and preparation courses can teach IENs how to navigate the system, some IENs believed that the culturally biased questions in the exam put them at a unique disadvantage: unless they had an exposure to North American culture, they would have difficulty answering these questions and in turn, have difficulty in becoming licensed.

The problems of obtaining cultural knowledge unique to the Canadian health care system were widely acknowledged by our interviewees. IENs, for example, became integrated quickly via bridging programs available for nurses. Not all IENs go through this process and not all bridging initiatives fully cover the cultural uniqueness of the Canadian health care sector. Usually, it is up to the employer to decide, whether a nurse should go through orientation prior to the start of practice and (if so), how long this process should take:

*Every place is different. So if the hospital or any place that it is if they give more opportunity [to] extend probationary period or orientation period it's better for an international nurse. Because we don't know Canadian culture. [Manitoba IEN #3, practicing]*

As this nurse suggests, it is up to the employer to determine the length of the orientation given to a nurse. Some of our respondents, however, told us that they did not have any orientation at all. Others suggested that this orientation took one to two days which meant that they started working within a week of their arrival in Canada. Knowledge of his type of limited orientation experience motivated some of our IENs to seek the position of health care aide in the hospital in order to get acquainted with local hospital culture before pursuing their nursing career:

*I started working as a health care aide in different hospitals here and trying to learn the kind of nursing here in Canada, you know, while I am working. That's why I decided to work as a health care aide. At least I am in an environment where I can see how the nurses are working and what kind of work do they do. [Manitoba IEN #1, practicing]*

Establishing cultural competency was also important for IMGs and ITMs, but because their integration processes typically took longer than for IENs, they had the opportunity to become acculturated prior to practicing. The IENs who integrated more quickly typically had to acquire cultural competency while on the job.

This section has reviewed the difficulties that IEHPs face when entering practice across different professions. We found that language barriers, financial difficulties, the time consuming nature of the process, Canadian bureaucracy, cultural competence, the inability to obtain health care experiences, and a lack of alternative routes for practice, all become barriers for health care workers. In what follows we describe profession-specific barriers that make it difficult for IEHPs to start practice.

### IMG Specific Barriers

Our IMG participants describe two key barriers specific to their professional integration process. The first relates to the three standardized MCC examinations. The other, more challenging, barrier is the relative lack of access to residency training programs. We discuss each of these in turn.

**Table 4.1 Pass rates of IMGs at different stages of the licensure process, 2006**

| MCCEE | CaRMS | MCCQE1 | MCCQE2 |
|-------|-------|--------|--------|
| • 65% | • 16% | • 70%  | • 75%  |

Source: Dumont et al. 2008

### Medical Licensure Exams

Part of the barrier created by the Medical Licensure Exams is that they are very expensive and time consuming. This is not unique to licensing exams for IMGs, as we discuss in the nursing section, below. Another part of the barrier is the relatively low success rate (see Table 4.1).

Beyond the success rate, many IMGs feel that the exams do not actually test their knowledge of medicine since they were designed for young Canadian medical graduates and not for IMGs who usually have years of experience. They complain in particular about the evaluating exam which IMGs are required to pass:

*Medical Council of Canada Evaluation for Foreign Graduates... was already publicly criticized. Foreign-trained doctors consider it to be very not fair... because Canadian graduates, they sit 2-days exam and they pay \$650, foreign-trained graduates for pre-*

*requisition for qualifying exam, they have to pay \$1,000 which is actually very considerable money for most IMGs. And this is for just 6 hours exam. And all you get is the possibility to be eligible to apply for qualifying part 1. Many foreign graduates ask a question "Why do we need this pre-requisition exam at all? Why can't we start from qualifying part 1? Or, even if we do, why can't we be charged less or at least the same for six hours exam as Canadian graduates for their 2-day exam? It really sounds like if you are a foreigner you should pay twice as much and only what you get is the eligibility for the real exam [Ontario IMG #1, practicing].*

Changing regulations and information becomes an additional barrier for IMGs navigating this complicated process. Many of the IMGs we spoke to felt that the system is designed for them to fail. They had to obtain information about constantly changing rules and meet deadlines placed unrealistically close to each other:

*The problem is every year they are changing the regulations. For example, last year you could register for the OSCE which was in September just by proving that you registered for the QE1, for example, in October. This year without any announcement, they change it. And they said okay you have to pass QE1. Okay. No problem. But the problem is right now I haven't received my paper [results]. The deadline for the registration is 5th of July. So it is next week. So it is a very, very short period that you get your results and apply. One more thing. There are four days for the exams and right now the last one that I checked the website there are only 14 free seats available and I am sure that there are more than 200 people like me waiting for their results. So you can imagine if the matter is the qualification. Okay, I am ready to participate in any exam that you want to participate. It's your right. But I think it is not acceptable that they say 'Sorry, we don't have enough seats for you.' Okay. They can say 'Okay, we can have a very difficult exam.' That's okay. That's absolutely acceptable. But they cannot say 'Okay we have those exams and sorry we don't have enough seats.' And if you couldn't participate in this September you have to wait till next September. So I think it is not fair and it is something that most of the IMGs they are bothered from that [Ontario IMG #2, in progress].*

A similar capacity issue was found for ITMs in terms of availability of preceptors, discussed below.

### **Residency Placements**

The biggest problem of all for IMGs is the bottleneck created by the lack of residency positions. As noted in Section 3 above, residency positions are usually divided among medical graduates through CaRMS or through provincially established programs for IMGs. Formal complaints have been made by IMGs regarding the limited number of residency positions awarded to them.

The highly competitive nature of the residency matching process for IMGs, coupled with the absence of a feedback mechanism, means that many IMGs did not have a clear understanding

of why a particular candidate was selected and another not. Indeed, many IMGs felt uncertain (and sometimes even hopeless) about the prospects of securing a residency spot:

*The most difficult part is here in Canada if you want to practice as a doctor you are told that you should be trained. You should pass the exams, the exams that I have already passed, okay? And you should go through a specific training program. That's okay. That's obviously acceptable logic. But the problem is there are not enough residency spots... So I think the most frustrating part is this process... [is that] there is no supports in no terms, not financial supports, not psychological supports, no training supports. We don't even know what are the expectations of the Canadian systems from foreign medical graduates... Statistically only 5 to 10% of IMGs will be lucky enough to get in the system. So 90% will remain. You stay here and you get prepared, you pass the exams, which takes two or three years. When you want to apply for a residency position you're already three years, five years, six years out of practice. Then they say okay, you're out of practice and you don't have the Canadian experience. But was there an opportunity that I get a Canadian experience? Because if you want to go to a hospital and say I want to do something, you are not licensed so you cannot do anything. How can I get a Canadian experience without the license? So it is very, very frustrating process. [Ontario IMG #2, in progress].*

**Figure 4.2 Number of Successful IMGs in the CaRMS Process and Percentage Successful of the Total Number of IMG Applicants (source: CARMS 2010)**

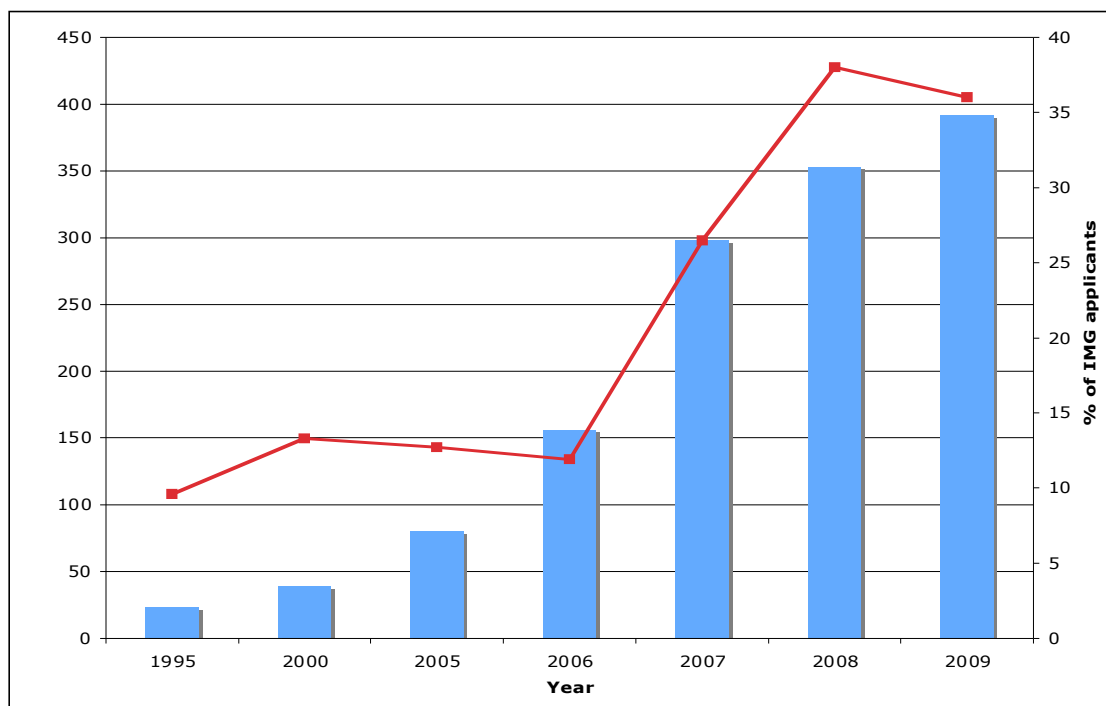


Figure 4.2 indicates that the number of IMGs in residency positions has increased as of late – largely due to major efforts made in Ontario to accept more IMGs into specifically created residency programs and to open up the first iteration of CaRMS to IMGs – as has the percentage of those who are accepted. (CaRMS 2010a, 2010b). Although these figures indicate improvement, there is the outstanding issue of residency spots left *vacant* while at the same time, a number of IMGs are left without a placement. In 2007, 2008 and 2009 there were 154, 121 and 126 spots left vacant respectively, and the numbers of IMGs not awarded residency positions were 1056, 881 and 1001. The greatest proportion of vacant residency positions is in Quebec – accounting for 56% of the vacancies in 2007 – followed by Ontario. Although vacancies in Ontario have been decreasing, the number of spots in Quebec has remained relatively constant. In 2009, they accounted for 75% of vacancies (CaRMS 2009a & b). One reason given by residency program representatives for the number of IMGs left without a residency spot is the perceived lack of preparedness for the Canadian work environment among IMGs. To bridge the gap between general medical knowledge and working knowledge of the Canadian health care system, several provinces have created alternative routes to licensure which either require supervision, or restriction of the type of practice permitted for IMGs (see *Appendix B*).

Even though CaRMS now allows IMGs to participate in the first round of the residency matching process, many of the IMGs we spoke to did not believe that participation in CaRMS actually improved their chances of getting a residency spot. Part of the issue has to do with the appearance of being a value free system. However in the opinion of the following participant, it can be quite value-laden:

*They say that it's computerized. ... Yes, it is computerized but it is the sorting mechanism that is computerized. Okay? It doesn't, uh, it will put you in the computer list in the sorting mechanism only... they put the criteria in there, right? If somebody has this then he gets these many points. If somebody has this he gets this many points, things like those, okay? And then after that sorting mechanism even if you are called for interview, who is taking interview? Is there a robot? Or is there a doctor? A Canadian doctor? Okay. I have my friend who went to this kind of interview ... and he was told that they are looking for foreign medical graduates who are better than Canadians. Only those doctors will be hired... They want doctors but very exceptionally good doctors. [Manitoba IMG #2, practicing].*

*I knew in Manitoba there were like nine positions or something, eleven positions ...And I went there and the department head told me even if there are some positions left we will leave them unfilled because we don't want foreign graduates. ...We don't want foreign graduates. We'd rather leave positions unfilled but we won't take foreign [British Columbia IMG #14, practicing].*

Many compare getting a residency position to winning a lottery:

*You go to [the] lottery store and you know that the odd of winning a lottery ticket is one in 14 million. You buy it. That's your choice. But I mean, not any physician who comes to Canada knows the odds of being a physician in Canada. Maybe it's one in 10,000. And I am pretty sure those who want to be physician in Canada if they see their odds is like that and they don't want to bet on this odd. [British Columbia IMG #7, in progress]*

The following IMG interviewee, decided to apply for and repeat medical school in Canada instead of taking a chance with the residency matching process:

*Actually once I decided to get back to medicine then I decided to go back to medical school because IMG spots, like the CaRMS match spot is so limited. At the time Manitoba only had six spots each year and I know that people have passed the MCC part one. We have more than 120 persons, people living in Manitoba waiting for these spots, these six spots every year. So I thought, you know, I am young so I might just as well go back to medical school so that's why I took the MCAT and went through the interview and got into medical school [Manitoba IMG #3, practicing].*

The uncertainty of success adds to frustration and stress, leaving many feeling resentful and undervalued. One of the common themes in the interviews with IMGs in particular was the feeling of failure, the fear of not getting a residency, and regret about spending family money on something that would never be achieved:

*The biggest problem for us is money. We are working as security guards and cab drivers and writing the exams simultaneously and there is a lot of pressure on us. Our future can change from being a cab driver to becoming a doctor. And so we are very anxious. We cannot sleep. We cannot study. We have a lot of problems. We don't have time to study because we are working, you know, as a security guard. We are not working in a hospital. We are working in the taxi as a cab driver. Okay? So and during that time we are writing exams. It definitely, definitely is going to affect the results, okay? So why don't you solve that problem? We don't want to come here and practice without passing exams. We want to pass the exams too. But solve the problem of our economy, you know, our economic problems. Solve that. How can you do that? [Manitoba IMG #2, practicing]*

Some even reported having gone through periods of depression during the integration process, as this one IMG who was ultimately able to practice recounted:

*Oui je sais que je suis très chanceuse mais quand même j'ai traversé une période très difficile, juste avant de rencontrer ce travailleur social parce que quand même il y a une longue liste là-bas pour voir cette personne et c'était très difficile et je crois en tout cas ma belle-famille, mais avec ma belle-mère, avec son conjoint ils étaient très gentils, je sais mais avec ... j'ai presque décidé de consulter à quelqu'un parce que je dormais tout le temps, moi je pense que j'étais très près de dépression et je dormais tout le temps,*

*parce qu'il y a, j'avais pas beaucoup d'attraits pour faire des choses et je me suis forcée de apprendre langue française, c'était très difficile*

*[Yes, I know that I'm very lucky, but still, I went through a very difficult time just before meeting with this social worker because there is still a long waiting list to see her and it was very difficult and I think, anyway my in-laws, but with my mother-in-law and her spouse, they were very kind, but with ... I almost decided to consult someone because I was sleeping all the time, I think I was very close to a depression, and I was sleeping all the time, because there was, I wasn't interested in doing things. I forced myself to learn French. It was very difficult].  
[Québec IMG #2, practicing].*

Many resented, in particular, any sense of preferential treatment, which they referred to as *source-country discrimination*:

*Somebody coming from South Africa working for three years. He came here. He got the license right away. And then he is working and during this time, during three years ... But for us who come from Europe or Germany or ... France, ... nobody recognizes our training. Nobody. ... like South Africa is not like big difference than France and Germany.  
[British Columbia IMG #9, no longer pursuing integration]*

IMGs recognized that medicine is practiced differently in different countries. Because of this, however, they felt that physicians in Canada tend to judge physicians from developing countries with more scrutiny (as being unfamiliar with western way of practicing medicine in terms of such things as use of technology, communication, and the like), and are less apt to accept them as equals. IMGs denounced this opinion as unfair, since, given a chance, new practices and different approaches are quickly learned. Furthermore, they felt that Canadian physicians have difficulty recognizing the value that this additional information could bring to a medical team;

*I think there is an undertow of that because somehow a lot of doctors feel that they get better education when they are getting a Canadian education so they sort of have the default in their mind which I think it's natural. But ...actually a lot of IMG are much better, are much hard[er] working, and much [more] skilled physicians. ...I know that it is very hard in Canada to get into medical school but just consider China. Like it's one in 100 person can get into university let alone medical school, let alone a very good medical school. So consider that competition. It's totally not at the same level [Manitoba IMG #3, practicing].*

Clearly, the biggest barrier for IMGs is obtaining a residency position. Many also felt that they were unable to find a temporary position during their transition to practice medicine. Many respondents complained about lack of positions which would allow them to utilize their health care skills working in a related field. Many IMGs felt that, since the chances of them getting into medicine were very low, the time that they spent on preparing for the exams would be less



likely to feel wasted if they could have found a job in a health care setting. We discuss this issue in more depth in the facilitators section below.

### **IEN Specific Barriers**

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In addition to the language and cultural competency barriers that were particularly salient for IENs, and the problems with the perceived culturally laden nature of CRNE exam, an additional barrier, unique to this profession, is related to level of education. In some countries – and indeed institutions within countries – the title of nurse is earned with a college diploma, whereas in others, it requires a university degree. Thus, the title of nurse is awarded to one level of education in some countries and a different level in others. Beyond level, some respondents argue that nursing training is not equivalent in all countries:

*They were saying 'We're not going to accept your education. You have an associate degree in nursing and that's not equivalent to anything here, you know, a college degree. And so I said 'Well I have 15 years of nursing practice and I'm not going to go back and sit for the exam so we need to figure out how to come to agreement on this.' So once I got an advocate and I just, you know, sent them all the information about all the different courses that I'd gone to over the years and my certification as a clinical research associate and also as a certified case manager in the States and the baccalaureate degree which was not in nursing but it was in biological sciences as well as the biomedical writing degree then they did decide that they would do a reciprocity so I did not have to sit for the exam. [Ontario IEN #3, practicing]*

Others highlighted how IENs can have advanced knowledge in comparison to Canadian nurses. For instance, nurses in the Ivory Coast have extra training in tropical diseases, yet when they come to Canada they nevertheless must undertake a minimum of six months of updating courses.

*Abidjan c'est la capitale de la Côte d'Ivoire, c'est un pays de l'Afrique de l'Ouest. J'avais, donc moi j'étais responsable clinique et j'étais responsable de 25 personnes dont 20 infirmiers. Ils ont de très bonnes connaissances par exemple. Mais moi je dirais que leur formation académique ne correspond pas à la formation académique des pays comme le Canada ou la France ou l'Angleterre. Donc ils sont très bons dans les maladies tropicales par exemple mais dans le diagnostic infirmier je pense que j'ai pas, je ne suis pas allée fouiller ou chercher vraiment le programme d'études de l'infirmière ivoirienne. Mais je suppose que dans le programme il voit y avoir des lacunes.*

*[Abidjan is the capital of Ivory Coast, a country in West Africa. I was the clinical lead and responsible for 25 people, including 20 nurses. Their knowledge was very good, but I would say that their academic training was not the same as academic training in countries like Canada, or France or England. They are very good with tropical diseases, for example, but in nursing diagnosis, I didn't, I didn't go and look into it or really research the Ivory Coast curriculum, but I suppose that there are gaps in the curriculum.] [Québec IEN #12, practicing].*

IENs often have to decide which process of accreditation (LPN, or RN) to take without actually knowing the difference between different levels of nursing that we have in Canada.

Another barrier to satisfactory integration cited by IEN respondents is a lack of full recognition of education and work experience. Often, IENs are led to believe that the level of education obtained in their home country will be recognized in Canada. A university degree in their home country may only be recognized as a technical college level education here, often leading to a demotion in status and salary:

*Respondent : Mais dans le sens qu'en arrivant j'ai été reconnu comme une, vous avez deux formations au Québec. Celle de l'université puis du collège. Alors j'étais reconnue comme une infirmière qui venait du collège et puis enfin mais j'avais déjà une idée de me spécialiser d'une façon ou d'une autre et puis là j'ai vite compris qu'il fallait que je refasse deux ans d'université si je voulais avoir le statut d'une universitaire pour avoir accès à d'autres choses.*

*Interviewer : Même si votre formation était de quatre ans.*

*Respondent : Exactement.*

*Interviewer : Et non le trois ans qu'on exige ici [au niveau universitaire].*

*Respondent : Voilà*

*[Respondent: I mean that when I arrived, I was recognized as one, you have two training programs in Quebec--the university program and the college program. I was recognized as a nurse with college-level training, but I had already thought of specializing in one way or another, and I soon realized that I would have to do another two years of university if I wanted to obtain university status to open the door to other things.*

*Interviewer: Even though you had taken the four-year program?*

*Respondent: Exactly.*

*Interviewer: And not the three years required here [at the university level]?*

*Respondent: That's right.] [Québec IEN #2, no longer pursuing integration].*

In Québec, many IENs had difficulty finding a clinical placement. A *stage* (or minimum 40 day orientation period) is required by the OIIQ, but finding a placement in a teaching hospital is left up to the IEN. Places are not always easy to come by, and IENs have no means to evaluate their options before beginning.

*Là où j'ai trouvé que c'était difficile c'est que c'était à moi de trouver l'établissement qui aurait bien voulu m'accepter en tant que stagiaire, ça aussi ça a été très difficile parce que j'ai envoyé des lettres de demande de stage à tous les hôpitaux de Montréal, il n'y en a pas un qui m'a offert de me prendre en stage...donc je pense qu'il y a un trou entre le devant de l'Ordre et le service offert par les centres hospitaliers. Là je pense que l'Ordre normalement, je pense à mon avis, j'aurais beaucoup apprécié que l'Ordre m'aide à trouver l'établissement peut-être qu'elle soit en convention avec des établissements qui*

*acceptent les infirmières que l'Ordre exige qu'on fasse des stages. Moi je ne demande pas à faire le stage, l'Ordre exige de le faire.*

*[What I found difficult was that it was up to me to find an establishment that would agree to take me on as a trainee--it was also very difficult because I sent training application letters to every hospital in Montreal and not one offered to take me on as a trainee... So I think there is a gap between the Ordre and the services offered by hospitals. I think that the Ordre normally, in my opinion, I would have appreciated the Ordre's help in finding an institution, maybe if it had agreements with establishments that will accept the nurses that the Ordre requires to take training. I'm not the one asking to take the training--the Ordre is the one that requires it.] [Québec IEN #12, practicing].*

Those nurses who were integrated quickly through the recruitment agencies usually found that their orientation process was often too short or overwhelming and did not give them a chance to actually get to know the Canadian health care system:

*That one [orientation] I cannot even remember a single thing. All I remember is the pills are on racks and they're in bubble packs. That's all I remembered. And then I remembered that if there is a fall you have to report, and if there is anything that you are not sure of you have to report. That's all. We started [to work] after four days... Like we came on November 26th. December 1st we were working [Manitoba IEN # 2, practicing].*

Those IENs who went through the process of finding work on their own in Canada, on the other hand, struggled to find the place that would agree to hire them:

*When I came, first came and I was looking for a job they were asking me 'Do you have Canadian experience?' I said 'Where do you expect me to get Canadian experience? I just got my license, you know. You want me to have the Canadian experience? No. You people just have to give me an opportunity. I just need somebody to start me off.' And they were like 'Okay, okay, we'll get back to you.' And they never did [Manitoba IEN #2, practicing].*

IENs' experience of profession specific barriers varies considerably by whether they are recruited overseas or not. Nevertheless, there are some commonalities which include concerns with the CRNE exam and recognition of their experience despite the level of their education.

### **ITM Specific Barriers**

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ITMs in Canada identified two unique barriers to integration into the system: 1) the challenges of the relative newness of the profession, which results in both a low number of available preceptors to date, and a lack of availability of integration programs until most recently; and 2) the difficulties posed by the primary care model of Canadian midwifery and its requirement to offer midwifery services in home settings.

### Newness of the profession

Because midwifery is a newly recognized profession in most of Canada, and is indeed yet to be recognized in some Canadian provinces and territories, integration processes for ITMs have only been established recently (see Section 3 above). In Quebec, for example, prior to 2003, ITMs were asked to take an equivalency exam established by the Université de Montréal – a university not linked to the OSFQ (Ordre des sages-femmes du Québec) or UQTR (Université du Québec à Trois-Rivières) where the training program for Canadian midwives is situated. There was no assistance provided to ITMs in preparation for this exam and, as a result, the vast majority of them failed. Between 2004 and 2008, there was no exam process whatsoever, effectively closing the doors completely to ITMs in Québec. Only most recently was the assessment process re-established.

The relative newness of the profession creates other barriers: the low availability of integration processes and the low number of available preceptors. This affects not only ITMs but also Canadian trained midwifery students:

*Respondent: Donc on est dix-huit dans la promo actuellement. Donc la formation théorique jusqu'à fin janvier, ensuite selon les personnes, selon les personnes on a des prescriptions de stages, donc moi j'ai trois mois, c'est le minimum que j'ai eu droit et j'ai trois mois de stages en maison de naissance. Parce que le stage en maison de naissance c'est une sage-femme pour une étudiante sage-femme. Donc il y a des problèmes parce qu'il n'y a pas beaucoup de perceptrice.*

*Interviewer: Non, puis il y a le programme à l'UQTR aussi qui demande [des préceptrices].*

*Respondent: Exactement, donc on finit notre théorie en janvier, fin janvier, et on ne sait pas quand on va faire notre trois mois de stage. Ça peut prendre un an et demi.*

*[Respondent: There are eighteen of us in our current class. We have theoretical training until the end of January, then depending on the person, we have training requirements, I have three months, it's the minimum I could get, I have three months of training at a birthing centre. Because the training at a birthing centre is one midwife for one mid-wife student, there are problems because there are not many tutors.*

*Interviewer: No, and the UQTR program is also looking for [tutors].*

*Respondent: Exactly, and so we finish our theoretical training in January, late January, and we don't know when our three months of training will start. It could take a year and a half.] [Québec, ITM #3, in progress].*

The small numbers in the profession also limits access to integration programs; there are insufficient students to justify running the program more than once per year. Since the number of students attending the program is small, the stakeholders have had to find ways to fund the program initiative using external funding, which is sometimes difficult to arrange.

### Primary care model

Canadian midwives can be the first point of contact with the maternity care system for those women who have access to, and choose, midwifery care. This – referred to as a *primary care model* – means that midwives are not supervised nor do midwifery clients need to see another maternity care provider unless complications arise in the ante- or intra-partum period. The Canadian midwifery model of practice further stipulates that midwives follow the women to her choice of birth place. Hence, midwives must be able to practice and often maintain competencies in both in hospital and home settings. Although some countries provide this as a training and practice option for midwifery practice, this is presently the *only* model in those Canadian provinces where midwifery is regulated.

The majority of our respondents came from countries where midwifery is a part of nursing. Midwives practiced only under the supervision of a physician and would rarely promote home birth. This model of practice is very different from the Canadian one, and many midwives found it difficult to adjust to this model without extensive preparation:

*What I realize now is that in Belgium we really have the choice whether we wanted to do primary care or whether we wanted to be hospital staff and so that's the big down point I believe here, and that's why a lot of midwives that are midwives back in their countries work here as nurses, because they just can't do the primary care. Or, like primary care being on-call, right? So, that's why I think that not many midwives that are actually here are working as midwives [Ontario ITM #1, practicing].*

While some ITMs feel uncomfortable practicing primary care midwifery, for others the problem of such a model of care lies not in the culture of Canadian midwifery per se, but in the difficulties reconciling family responsibilities with both the integration process and the model of practice.

A related barrier to the model of practice is the requirement of community based, or home birth practice:

*My biggest thing would be that they need to be really thorough with the assessment before you write the exam to check that, and really insist that people have to have community experience cause having gone through that and having gone through the trauma of not getting through it [the assessment] twice, um, I wouldn't wish that on my worst enemy. ... So I would definitely say that they need to make sure that that's a stipulation before anybody pays a single dollar, invests any of their time in this process. You have to have community experience because the model here is community focused. If they had the hospital midwives that would be totally different, but here we are community focused. We're primary health care providers. [Manitoba ITM #1, practicing]*

Thus, many ITMs can find it difficult to adjust to Canadian practices. They feel unprepared to practise within the primary care model. The programs for ITMs require time and money for

individual ITMs because there are so few who are eligible. Some respondents felt that the time commitment involved in enrolment in such programs is extremely difficult to manage for women with families. At the same time, there is some flexibility of credentials required to attend these programs. Indeed, among our participants were other health professionals that became licensed as a midwife in Canada because of this flexibility.

### **Some of the Consequences of these Barriers**

There are a number of consequences that directly result from these professional integration barriers for the IEHPs we interviewed. For many, it means *downward professional mobility*. Although some of this may initially be a strategic choice on the part of the IEHP themselves, as we outline in the facilitators section below, in most cases, it is imposed. This can be the source of much frustration and hurt:

*Well it's personal for everybody. You know, it depends what everybody wants and how much they, you know, they're ready to [take on] It's very hard. It took me eight years before I started practicing. ...It's quite a long time and a lot of frustration, a lot of hard work, and a lot of times you, you know, you already achieved and it's not easy to achieve what you achieved in any other country. Like in any other country to become doctor is big achievement. It's big competition. ...Huge competition. And you achieved it. And suddenly [here in Canada] you become nobody. [British Columbia IMG #14, practicing]*

The added dimension of being considered over-qualified for many positions makes the situation for IMGs particularly difficult. Degrees that were highly-valued social capital in their countries of origin can become a liability in Canada:

*One thing that many people don't realize is that when you are an MD you cannot be anything else. ...Because for most things they consider you, what's the term they use in English? Over-qualified. In any case you don't have the skills to do anything else. Like even competing for a job. ... But I was just expressing that I was actually shocked when I tried to get a job. I was calling different companies, the private companies that are doing that home care, whatever, you know. And when I asked them they said to me 'No, we are sorry but you are over-qualified to do the job.' And I says 'Come on people. I need a job because I've got two kids. ... I need some kind of job. I'm ready to do whatever.' They said 'No. We are sorry.' And I tried to do that, maybe 20 times I tried to apply. They just simply say we are sorry, you are over-qualified. And I said I don't mind if I'm over qualified. I just need a job. [British Columbia IMG # 4, practicing]*

We already noted above how the situation facing many IEHPs has led to frustration and indeed depression. The following participant had an ever more tragic story to tell:

*And one of my colleague[s], he committed suicide and nobody even know about this thing. He was very much depressed. ... He was very, very upset, very, very depressed. He was 45 years old. He was having a one and a half year old child and six month old child.*

*And he committed suicide because of this discrimination, injustice, and I mean all these things you know. And he was very knowledgeable, well experienced person... We are trying our best and still you know I am in the face of struggling. And I have courage to fight and I think I have so many harder and still I have only want harder to get into a system. Just not for the sake of money. Just for not the sake of the other thing. We have skills. ...like in paediatrics, obstetrics, gynaecology and working as a family physician I develop an advanced knowledge and skills and I passed all the exams here. I know about ethical emotional issues of the patient, each and everything, and I want to apply those skills. I want to educate the people in appropriate health because I love to make people well. I love to provide care to people. [Ontario IMG #4, in progress]*

Although there is greater recognition of foreign credentials, in nursing or midwifery, than medicine, different forms of frustration remain. Formerly senior nurses find themselves in the position of new graduates:

*The impression that I've got, um, that they want me to prove myself, that I don't have to go through any other critical care nursing education which I am not too excited about doing it over again. [British Columbia IEN #6, practicing]*

Among midwives, even those with plenty of experience are confronted with conditions:

*I've got quite a lot of experience as a midwife in the U.K. I've been a midwife for 12 years so I've covered a lot of what they wanted you to do so I've just got the minimum conditions." "...after I trained, there was no continuity of care that I could demonstrate and so lo and behold the College decided to give me 30 continuity of care requirements which is the highest number that anybody has to do even though I had been... I was the oldest trained midwife in Vancouver at the time. And I thought to myself when I found out 'What? This is absolutely crazy.' But I couldn't demonstrate to the College's satisfaction that I could meet any continuity of care requirements. [British Columbia ITM #6, no longer pursuing integration]*

Others found work in the health care field, but in jobs which require a much lower skill level such as *infirmières auxiliaire*. Both the OSFQ, and many community organizations established to assist new immigrants, directed ITMs to these lower skill level and lower status jobs. Many immigrants had to spend time and money retraining for these positions.

*Elle m'a dit oui, oui, après je lui donne le nom de l'école, donc elle m'a donné le nom de l'école, je devais payé 300 \$, donc j'ai payé 300 \$ et puis j'ai fait la formation des préposés.*

*[She told me yes, yes, then I gave her the name of the school, and so she gave me the name of the school. I had to pay \$300.00, so I paid \$300.00 and then I took the support worker training.] [Québec ITM #3, no longer pursuing integration].*

While generally dissatisfied with this work, many ITMs do not feel they have any real alternatives, due to personal family and financial responsibilities, as well as the current systemic restrictions to midwifery.

**In sum**, while many of the barriers that individual IEHPs experienced were specific to their profession, many – including the skills-based language, cultural competency, and the structurally based financial, bureaucratic, and time constraints – were similar in nature even if not in scope. Although we only briefly touched upon the consequences here, it is important to note that their impact was great. In the next section we reorient the discussion to focus on facilitators which help us to better formulate policy and program recommendations that emerged from our discussions with these IEHPs.



## **SECTION 5: FACILITATORS TO INTEGRATION**

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Immediately prior to and during the conduct of this study, it was becoming clear that several different Canadian stakeholders had become more interested in the issues facing IEHPs attempting to become integrated into the health care workforce. This change can be partially attributed to the local political pressure from the IEHPs' lobby groups as well as broader concerns with shortages of certain health professionals in particular sectors. As a result, a number of provincial and federal policy initiatives had been employed to facilitate the integration of IEHPs into the health care sector. Among them are: 1) the standardization and improvement of information on the licensing process and retraining in health related fields; 2) the establishment of a number of bridging programs and language courses designed specifically for IEHPs; 3) improvements in inter-provincial and federal-provincial communication between ministries and regulatory bodies; and 4) communication with potential employers regarding the benefits of hiring IEHPs (Baumann & Blythe 2009). Continuing to streamline the process of integration of IEHPs (which includes effective communication of information, profession-specific requirements by CIC, and the standardization of the process of accreditation by all Canadian provinces) and further work with potential employers (to ensure that they understand the benefits of hiring IEHPs) were identified in a recent report issued for the Ontario Hospital Association as major facilitators for the successful integration of IEHPs (Baumann & Blythe 2009).

In this section, we highlight the facilitators to integration that were most salient to the IEHPs that we interviewed. We first address how pre-immigration arrangements made while an IEHP is still in their country or origin can reduce some of the barriers to integration. Several of the IEHPs also felt that appropriately targeted information sessions available at the outset and throughout the immigration and integration process facilitated their success. The bulk of this



section is, however, devoted to the various bridging programs that have been established, which not only help to upgrade skills, but also assist with the amorphous cultural competency problems we outlined above. Finally, we discuss how alternative routes to utilize health professional skills can be both a facilitator to integration, as well as an end in and of itself for those deciding to redirect their efforts.

### **Pre-Immigration Arrangements**

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Those who had the opportunity to start the process of obtaining their license even before receiving their permanent residency status here in Canada reported fewer difficulties than those who didn't take this route. Many IENs, for example, described travelling to Canada prior to making the final decision to move here; they sat the CRNE exam - one of the biggest barriers to obtaining their license – or they found a prospective employer before moving here:

*When I was in UA I went through the paperwork and applied to [the College of Nurses here in Canada] and they said you need to pass the exam [CRNE]. So I came to Winnipeg in 2004 June to appear for the exam. I came as a visitor to appear for the exam only and then when I went back... I got the pass and then I started paperwork... Then in one or two couple of months I got everything cleared to come to [Canada]. [Manitoba IEN #12, practicing]*

*That was one reason I started working with the College almost a year before I had my permanent residency because I did not want to take the exams ever again. [Ontario, IEN #3, practicing]*

In Quebec, on the other hand, nurses are allowed to practice their profession for two years before being taking the OIIQ nursing exam. Depending on their country of origin and the evaluation of their credentials, they are required to take either a twenty-day orientation period or a six- to eight-month updating course (i.e., bridging program), which includes both a theoretical and practical component. Once this obligatory exposure to the Quebec health care system is successfully completed, they are awarded a one year temporary permit to practice, renewable once, allowing them two years of practice before being obliged to pass the equivalency exam.

*La première année je pouvais travailler comme infirmière sans qu'il y ait de problème, ils se sont rétractés par la suite, pas avec moi mais pour d'autres. Au début les premières infirmières qui sont arrivées elles avaient le droit de travailler deux ans et au bout de deux ans si elles voulaient rester fallait qu'elles passent l'examen.*

*[The first year I could work as a nurse without a problem, and then they retracted, not for me, but for others. At the start, the first nurses who arrived were allowed to work for two years and after two years, if they wanted to stay, they had to pass the exam.] [Quebec IEN #1, practicing]*

Physicians who migrated to Québec generally had a much easier time obtaining their license if they began the equivalency process before leaving their home country. In fact, RSQ strongly

encourages IMGs to go as far as they can in the process of obtaining their license while still in their home country before even starting the immigration process. There are a number of countries in which IMGs may take the Canadian equivalency exams for medical practice in Québec.

*Dans le monde aussi c'est très organisé, sur le Collège ils vous marquent les endroits où vous pouvez passer, c'est sûr que pour l'Europe il y avait Londres, il y avait Paris, il y avait l'Italie, je crois qu'il y en avait en Espagne aussi, un peu partout.*

*[In the world, too, it's very well organized. At College they show the locations where you can go. Sure, in Europe, there was London, there was Paris, there was Italy, and I think there was Spain too, almost everywhere]. [Quebec IMG #4, practicing.]*

There are also ongoing discussions between the *Collège des médecins du Québec* and the *Ordre national des médecins de France* with a view to reaching an agreement on mutual recognition of physicians. (CMQ 2009b). Similarly, MCC provides a list of 73 countries where physicians wishing to practice in Canada can write the evaluating exam – the first step for obtaining their license (MCC 2010)

Although physicians are allowed to take the evaluating exam without permanent residency status, this exam is but one small step on the way to professional integration. Residency positions, however, cannot be obtained without having permanent residency status in Canada. Similarly, the option of doing as much as one can prior to immigrating is limited in the case of ITMs, because to be eligible to attend an assessment process where their skills will be evaluated, they usually have to have permanent residency status. Therefore, while nurses do get a chance to find employment in Canada prior to the actual migration, IMGs outside of Quebec and ITMs across Canada have to be physically present in Canada to go through the process. As a result, many IMGs and ITMs postpone their preparations for professional integration until they enter the country.

### **Formal Information Sessions and Informal Support Groups**

Some respondents had access to information sessions provided either by Citizenship and Immigration Canada or MICC (Ministère d'Immigration et de Communautés Culturelles). These sessions are designed to provide information to new immigrants about Canadian or Québec culture, language and the working environment:

*Il y avait une séance gouvernementale de temps en temps parce que le ministère Immigration surtout offre de temps en temps des services pour groupe communautaire. Et il y avait une séance de avoir des services pour garder les enfants, c'est quoi le système éducatif ici, vraiment une séance d'information. Il y avait une séance psychologique pour garder l'estime de soi, c'est intéressant, moi j'étais impressionnée, le gouvernement mais surtout québécois est conscient de fragilité des immigrants comme ça, moi j'étais très impressionnée, j'ai assisté parce que j'étais très curieuse. C'était un psychologue qui est venu, c'était un monsieur qui était très sympathique et il a fait formation très impressionnante.*

*[There was a government session now and then. Mostly the Department of Immigration sometimes offered services for community groups. And there was a session on childcare services, that's the education system here, really an information session. There was a psychological session on self-esteem. It was really something and I was impressed. The government but especially the Quebec government is aware of the vulnerability of immigrants like that, I was very impressed; I attended because I was very curious. It was a psychologist who came, a man, he was very nice and the training he gave was very impressive.]*  
*[Quebec IMG #2, practicing]*

Similarly, information sessions with some specific content for IEHPs were available to some of our participants in Manitoba:

*Like we have some kind of it's not the same kind of ... communication course. That is a free course at like every college and the government pays for that that IMG doctors do in Winnipeg. My husband actually did that. And that like doctors come over there and like they do cases and it is really a good course but the thing you were talking about it would be okay but people cannot go like every day. Like one or two sessions would be okay. But in that course ... which the government provides in Manitoba it is from the Red River College and like it's free for immigrants... It was for everybody else but mainly IMGs... And it was not for like just the English. It's kind of communication skills with patients...I didn't take it but my husband took that course and a lot of doctors go over there and most of them get benefit with that. [Manitoba IMG #1, practicing]*

This was considered to be particularly important for IMGs, who come to learn that the number of physicians available for supervision is very limited, and thus their chance of getting a residency spot is very low.

*Actually it's kind you know I was not very informed. I would say so because I thought to purchase my license here it's almost impossible. And everybody told me it's so hard. So I kind of [got this feeling] from the newspaper, from the friend, from the people around you. Everybody around me. ... actually. Okay, so as I started to look at those information about the doctors when I was in China. Before I came I started and that give me also kind of impression that it's hard, that it's almost impossible. This information all comes from the websites. [BC IMG #7, in progress].*

*Doctors working here, in Canada all were sort of trying to... you know... to... cool off my enthusiasm saying "this is extremely difficult", "this is highly unlikely to happen", "remember this is highly competitive, even Canadian graduates cannot get residency training". "You rather try in US. If you continue trying in Canada you would rather waste your time and money". So all three doctors I talked to tried to discourage me from trying. Not supportive at all [Ontario IMG #1, practicing].*

That said, there were respondents among all professional groups interviewed who were not interested in participating in information sessions, largely because there were not specifically targeted to the situation of IEHPs. For example, one of our IMG participants noted:

*Respondent: Il y avait un séminaire comme ça à l'Ambassade du Canada en France.*

*Interviewer : Est-ce que vous l'avez pris ce séminaire?*

*Respondent : Non, non, je ne l'ai pas eu, j'étais pas allé parce que bon c'était quelque chose générale, c'était pas spécifique pour les médecins.*

*Interviewer : O.K. puis vous ne pensez pas...*

*Respondent : Pour les applicants, pour les immigrants. Pour les immigrants en général, les immigrants en français qui voulaient immigrer au Canada.*

*Interviewer : Pour vous ça n'aurait pas été utile ce genre de séminaire?*

*Respondent : Non, non, parce que pour la médecine c'est quelque chose de spécial, c'est spécifique*

*[Respondent: There was a seminar like that at the Canadian embassy in France.*

*Interviewer: Did you attend the seminar?*

*Respondent: No, no, I didn't, I didn't go because it was a general kind of thing, it wasn't specifically for doctors.*

*Interviewer: O.K. and you don't think ...*

*Respondent: For applicants, for immigrants. For immigrants in general, French immigrants who wanted to immigrate to Canada.*

*Interviewer: That kind of seminar wouldn't be useful to you?*

*Respondent: No, no, because medicine is special, it's specific.] [Quebec IMG #8, practicing].*

Indeed, some IMGs who attended information sessions offered by CIC or MICC were dissatisfied with the information provided and were left with many unanswered questions about health

care in Canada. Furthermore, they complained that participating in the information sessions did not open any doors to them.

*Actually the reason why I did not attend those seminars and those kind of stuff because most of my colleague(s) who are senior who came earlier than me, they attended all these thing and they said it is useless. They are not working for you. They are just telling you do this and this. And we did. We took the exam. We did this, we did this. But nothing is happening. What is the use to go there and waste your time? [Ontario IMG #1, practicing]*

*Honestly? I do not think it would make a difference, 'cause I do not need someone to tell me what I already know. I already know why I cannot make it and bridging program would not help me to solve the problem with residency in the future. [Ontario IMG # 6, no longer pursuing integration].*

Finally, others argued that due to financial, time and family constraints, they would not have been able to take part in any information sessions. Many opted to gain important information from their colleagues:

*Actually it happened by chance. Just my husband had a meeting with someone in the United Way. He was telling them that, you know, 'My wife is a doctor. She is living in Canada and what she should do.' And they told him okay, she should go. There's the ... World Skills. You know, go talk to people. There's doctors that can provide you with some information, help you how to apply for the exams and, you know, just other people study together. So this is actually what I did and, uh, I started connecting with some other immigrant doctors, uh, took some workshops. I took almost three workshops, three programs I should say with many workshops. It was very interesting, very helpful. They made introduction for the Canadian workplace. We did some workshops on resumes and interviews. How it works in Canada. And what they did is like a profile book for each of us. We were like 24, 25 people. Some of us doctors. ... And they were introducing us to the employers and they sent us as well some job ads. We sent them our resumes for review. And so it's been helpful. [Ontario IMG #20, practicing].*

### **Bridging Programs**

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Bridging programs aim to assist IEHPs in overcoming the perceived discrepancy between their knowledge and experience and Canadian standards of professional practice and knowledge so as to facilitate professional integration (Lum 2009). Bridging programs vary and can serve multiple purposes, including the assessment of existing education and skills to identify any additional training needs, and where possible, profession-specific language training; preparation for licensure exams; provision of both clinical or workplace experience; and improving familiarity with the social and cultural context of the Canadian health care system (Lum 2009). Completion of bridging education programs is usually one of the components necessary to secure licensure for IEHPs.

In each of the provinces we studied, and for each of the professions, there were bridging programs to assist in the professional integration process of IEHPs. We have already described (in Section 3) the Prior Learning and Experience Assessment programs and International Midwifery Preregistration Program (IMPP) that ITMs have to undertake, as they are both the ways in which ITMs become integrated and follow bridging programs simultaneously. For IENs, there are programs designed to upgrade their language, nursing skills and knowledge, and prepare for the licensure exams in BC at Kwantlen Polytechnic University, and in Manitoba, at Red River College in Winnipeg (CRNM 2010). The OIIQ requires that all IENs complete a 'professional integration program' which provides them with background on organizational, legal, ethical and socio-cultural aspects of nursing in Quebec, plus guidance regarding adaptation to the Quebec context and clinical skills (OIIQ 2006). In Ontario, the program is specifically called the Creating Access to Regulated Employment (CARE) for Nurses bridge training program. First announced by the Ontario government in May 2001, its aim is to provide profession-specific skills, including relevant English skills, along with education in nursing culture, to prepare IENs to meet the nursing baccalaureate degree requirements.

For IMGs, residency training acts as a form of bridging, but this is particularly the case for residencies that are specifically targeted to IMGs, such as those in Ontario and B.C. In Quebec, the only programs available to assist IMGs applying to obtain their license through the regular route are information sessions made available before each stage in the licensing process. Recently, the MICC in Québec joined forces with AMEQ to organize sessions to assist IMGs in their preparation for the examination portion of the licensing process. For IMGs applying for licensure through the restrictive permit route, on the other hand, three months of orientation and evaluation must be completed. This clinical introduction to Quebec health care is undertaken by the teaching hospitals in the province, and acts as a bridging program of sorts. This program is not available to IMGs applying through the regular equivalency route (CMQ 2009a). Manitoba, for example, has a program for IMGs, the Medical Licensure Program for International Medical Graduates (MLPIMG) where they can prepare for future practice.

### **Benefits of Bridging Programs**

Bridging programs were often regarded by our respondents as a facilitator for integration. This was perhaps most salient for IENs who were recruited and expected to enter practice quickly:

*And actually in the courses, they were kind of going for all other nurses as well ... in that they were learning nursing that how you are going to deal with patients and lots of scenarios about this. So I really, that was very, very useful. And I was glad that they make me to not just write the exam. Take some courses. Some other people was [unintelligible] an eye opening. And I am so glad to the College allowed me to do that course [Ontario IEN #21, practicing].*

Many commented on the benefits of the formal structure that a bridging program offered:

*Like I could choose the courses I want to take. I just do the most important thing just to refresh my memory because it's no way I can just sit home and study everything on my own every day. It's no way. There's just so much information. Like I'm glad I did it. I'm glad I did it cause if won't take the program I won't pass the exam for sure. In my opinion everybody should take these course,s even if they are eligible to go and write the exam, cause ... your chances to pass the exam is so low without the proper preparation [Ontario IEN #1, no longer pursuing integration].*

Others noted the important content of the course – such as ethics or culturally appropriate communication – but also how it provided information on the best way forward in the professional integration process. As one IMG in Manitoba mentioned:

*In terms of medical training, I did not [know] where to go, because we did not know anyone and it was quite difficult. There was a very good program in Red River College CCPTA - communication for physicians trained abroad and it was a really good program, 'cause they taught culture and ethics and some language and it was very useful. Another thing is good about CCPTA that it gave a sense of direction on what to do next. It became clear where to apply and when. ... it was really good. [Manitoba IMG #2, no longer pursuing integration].*

### **Challenges with Bridging Programs**

When asked about existing bridging programs, our interviewees raised concerns about three major issues that need to be improved: (1) accessibility of bridging programs in terms of available spots, geographic availability and financial hurdles; (2) the coordination of those programs in terms of the design of the program and who is in charge, and (3) the content of the material in terms of a requirement to be more adequately tailored to the needs of IEHPs.

#### Lack of Availability/Accessibility

There are bridging opportunities for professionals but unfortunately, the number of bridging programs is extremely limited. Not all health care professionals who are willing to participate in a bridging program can get access to one. This is due to three major problems that our respondents identified over the course of this study: (1) limited spots for participants, (2) accessibility of existing bridging opportunities; and (3) the financial burden that participation in the bridging program can create for the family of an IEHP.

The problem of limited spots was especially salient among IMGs who are looking at the possibility of getting into medicine through existing bridging programs. Usually, the spots available for IMGs in provincial bridging programs are far lower than the actual numbers of IMGs eligible to participate. As noted earlier, for instance, MLPIMG – a bridging program in Manitoba – on average recruits 25 to 30 IMGs, but applications number over 150. In Québec, an IMG with a sponsoring employer waiting in the wings (the best case scenario possible for an IMG) may wait as long as 18 months before getting access to the orientation and evaluation program.

While programs for IMGs exist in all four of the study provinces, there are fewer bridging opportunities for nurses, other than those in Québec. Nurses from Manitoba, for instance, constantly complained about the lack of bridging opportunities available for IENs who entered the province. In fact, the local Filipino Nurses Association in Manitoba started to offer courses for IENs to improve their chances of finding work and address the lack of refresher courses. The IENs themselves took the initiative to actually establish bridging opportunities for local immigrant nurses:

*When I was in Manitoba and I was preparing for this examination [CRNE] there was a shortage [of nurses] here in Manitoba... So what happened is there are lots of Filipino nurses here in Manitoba that are not licensed but they are already Canadian citizens. They live here in Manitoba. So what we did is we looked for somebody, like we approached some politicians here and asked for their help: "You know what, you are short of nurses here. We have lots of nurses who are in Winnipeg right now and they are willing to do extra review courses or study more so that they can get their license and practice as nurses." ... So anyways we were lucky enough that [they said] "okay, let's see what you can do". We had a meeting with the Red River College. We had a meeting with the licensing body. We had a meeting with the Minister of Health to get some money and recruitment and retention and things like those. But anyway in short sentence we were able to acquire... these nurses were able to get the licensure because they offered them some review courses. [Manitoba IEN #1, practicing].*

IENs even had concerns with the model CARE program:

*The time wasn't really, uh, it wasn't suitable for me. It was at night and since I have a family to look after myself, my husband is very busy, I didn't consider it. [Ontario IEN #9, no longer pursuing integration].*

The availability of bridging programs is especially limited for people coming to cities which are far from the provincial "centres" of concentration of immigrants. Availability of courses online was regarded by our respondents as an excellent opportunity to gain access to information. Finally, availability of financial assistance for IEHPs participating in bridging programs is a crucial factor: there is a need for loans, bursaries and scholarships to allow IEHPs to study and to prepare themselves for the licensure exam instead of working as health care aids, waitresses and gas station workers.

#### Program Coordination

Another problem that IEHPs identified is the manner in which the bridging programs were coordinated or administered, the lack of navigation inside each program, and the inability of IEHPs to raise concerns or to complain about unfair treatment. A number of concerns were raised about the IMMP program which provides bridging opportunities to midwives in Ontario. For example, some of our participants felt that the assessment of their eligibility for the



program was not based solely on an objective assessment of their qualifications, and their progress in the program was sometimes unfairly evaluated. Instances of unfair treatment while attending the bridging program were also reported by nurses and physicians. Usually IEHPs do not know how to navigate through the educational system and are unaware of how (or even if) they can make complaints. In the bridging programs designed for IMGs, for instance, the success of a physician can be evaluated by a mentor assigned to an IMG by a program coordinator. If, for any reason, the communication between the IMG and their mentor is disrupted, there is little can they can do to complete the process:

*The only reason I think I survived this assessment [part of the bridging program] was because there were two doctors who were assessing me. I worked with [one of them] for just two days, and then she went on vacation. In the first four hours she observed me and I didn't know that she was my boss... And suddenly she introduced herself to me and she said 'Okay, my name is this and you are working under me.' And, you know, I said okay. And she said that 'I have seen you working and I just want to tell you that you will have no problem passing this assessment. You are very good.' ... And then my bad luck that she went on her vacation just two days after. Now I had no choice but to work with other doctor who had a lot of personality issues... Now what should I do? You know... I thought that I will not pass this [assessment]. So I called my program director and I said 'I am going to lose it not because I am not competent. I'm going to lose it because somebody just don't like me.' ... So the human error thing is there. The remedy is that they should have two or three assessors. [Manitoba IMG #2, practicing].*

The bridging program for nurses in Québec requires that some IENs undergo between six months and two years of retraining. As indicated below, some respondents feel that they were pegged for failure before even finishing the bridging program. Furthermore, they believe that the program was designed to test their capacity to endure stress more than to teach them how to work in the Québec health care system.

*Respondent : ... la première session que j'ai réussi et après il m'informait que j'avais réussi, la prof m'a dit [nom] je crois que tu dois travailler comme préposée [PSW]... À la deuxième session j'avais monté un peu de catégorie, parce qu'à la deuxième session quand j'avais réussi, la prof m'a dit [nom] tu as réussi mais je te recommande fortement d'aller travailler comme infirmière auxiliaire [LPN], parce que tu es excellente comme infirmière auxiliaire. Mais madame qu'est-ce que vous faites ici, vous êtes supposée de former des infirmières, ça veut dire que vous ne réussissez pas votre travail, votre tâche. Non j'ai pas dit, non je ne pouvais pas dire ça mon Dieu...C'était parfait mais non j'ai juste dit on dirait mais on n'est pas, on n'est pas capable de dire rien parce que c'est une formation, je dis maintenant, je peux le dire après six sessions, basée sur la porte...En cinquième session, la prof m'a dit qu'il faut que je parle de l'Ativan, parce qu'elle m'a dit [nom] tu as pas fait ça, oui, pourquoi si tu sais comment le faire. Je sais comment le faire mais le stress ne me permette pas de le faire.*

*Interviewer : Donc elle vous recommande de prendre un anti-anxiété?*

*Respondent : Mais c'est une pratique commune, il y a beaucoup de collègues qui ont commencé à prendre l'Ativan pour arriver à réussir le stage.*

*[Respondent: ...I passed the first session and after they told me that I had passed, the teacher said, "[name], I think you should work in personal support [PSW]"... In the second session, I moved up a notch because in the second session, when I passed, the teacher said, "[name], you passed but I strongly advise you to work as a licensed practical nurse [LPN] because you would make an excellent licensed practical nurse." But lady, what are you doing here? You're supposed to be training nurses, and if not, you aren't doing your job, your duty. No, I didn't say it; I couldn't say that, my God. It was fine. No I'm just saying, but we aren't, you can't say anything because it's a training program. I say it now, after six sessions based on how things went ...In the fifth session, the teacher told me that I had to talk on Ativan because she said [name] you didn't do that. Yes. Why, if you know how to do it? I know how to do it but the stress stops me.*

*Interviewer: So she advised you to take anti-anxiety medication?*

*Respondent: But it's common. A lot of my colleagues started taking Ativan to get through the training.] [Quebec IEN #3, in progress].*

Thus, many of our participants felt that the assessment process developed by their bridging program was in some cases poorly managed or poorly coordinated.

#### Program content and target

Finally, some IEHPs also raised concerns with of content of bridging programs, in terms of variability and what kind of target it had in mind. This was a challenge not prevalent among all the professions, because of the variability in the IEHPs that came to Canada. As was noted in the report, *Navigating To Become A Nurse In Canada* (2005, p. 6), "Some provinces offer specific bridging programs for IENs but they are not all similar in content, length or cost and only some incorporate language and communication training."

The following ITMs argue that this variability in bridging program participants made it redundant for some, although appropriate for others:

*I think it's aimed at people like me [ie. with degree]. I think it's for people who have clinical skills and just need a little bit of like okay, you know, this is how the relationships are different, this is how you have to approach the doctors. [Ontario ITM #1, practicing]*

*And in that way actually the IMPP program that we did is very poorly designed for us. It was designed for the immigrants. Fair enough. ... and have more time to be developing their cultural awareness and language skills... [Ontario ITM #2, in progress]*

Many felt that bridging programs should pay more attention to the culture of Canadian practice rather than to the care issues:

*Respondent: Childbirth is not different from country to country. It's not maple syrup is coming out of the breast here and that we need to know then what breastfeeding is all about. I'm sorry, but that's just how it comes across... I made those jokes. I said, like 'What? Canadian women deliver upside down? So we need to learn the skill again?' Honestly, give me a break.... I've worked in different settings and different hospitals and I know that protocols can be different and I said, pharmacology's completely different and I think it is fair that people from other countries go through that ...*

*Interviewer: Would a program that focused on working in the Canadian context be more interesting?*

*Respondent: Yes, absolutely. And, I think, don't make it a seminar, make it part of that process of becoming licenced... That's very fair and I think I would have really enjoyed that. I really would have enjoyed to hear more about the history of midwifery, for example. These were things that I learned in my placement. How the Association worked and how the college worked and so on and so on, how we can be protected as midwives. [Ontario ITM #5, practicing].*

Since many of bridging programs are just in their early stages of development and delivery, there are often inconsistencies or ambiguity about some parts:

*I think there are some gaps in between. I have my personal example. It was obvious that IMGGO and Royal College didn't have proper negotiations about this particular new stream that I got enrolled in and almost admitted this in conversation with me that they sort of didn't have time to discuss this because they really wanted to start one of them... they were in a rush to do it in Spring 2004. They didn't want to delay it for half a year. And I agree they did a good job but there were some drawbacks in particular. They didn't negotiate it properly with Royal College and as a result I am doing the residency longer. [Ontario IMG #2, practicing]*

### **Alternative routes of entry and utilization of skills**

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Alternative routes to utilize health professional skills can serve as a personal bridging program, that is, a possible facilitator to professional integration or possibly professional redirection. To facilitate integration into their future work environment, many IENs choose to work in a lower skill level position in health care before obtaining their license to work as a nurse in Québec. For instance, in Québec, many IENs work as patient care attendants or *préposés aux bénéficiaires* (PAB) while going through the licensing process, and numerous IENs in the other provinces work as Personal Service Workers (PSW).

*Respondent: Yes. After three months and a half I found this job. At the McGill Health Centre, and I start work.*

*Interviewer: What are you doing again? I'm sorry, I forget what you said? What are you...*

*Respondent: I'm a patient care attendant.*

*Interviewer: Patient care attendant. So you're at least getting familiar with how hospitals work here in Quebec....*

*Respondent: In the same time I learn language, medical language, that type of thing. It's a good practice for me. [Quebec IEN #1, in process]*

When the prospects of getting employment in their own profession seem slim, many IEHPs consider getting into health care in Canada by finding some other position which would offer a way into the system, but which would be easier to obtain. For example, the inability to get into residency motivates IMGs to look at other options of gaining employment in Canada. Others travel to other provinces to work as clinical assistants (in Manitoba) or medical assistants. This way, they hope to get Canadian medical experiences and thus to become more attractive candidates for provincially run bridging programs for IMGs. Indeed, one of the biggest concerns raised by IMGs is that they could not get a position in Canadian health care, which would be (at least partially) related to their medical past:

*I am also making some alternative arrangements. Not too far from medical practice. Because there is an area I am quite interested in. That is biotechnology. Very, very interested in it... While I am in this process [of getting medical license] if I get opportunity [to work in biotechnology] I have to move on. [Manitoba IMG #1, in process].*

Many choose to apply to research programs where they can work as research associates:

*And I'm looking forward just, you know, maybe if there's something worth it to maybe start a new career in something like related to health field. As I mentioned the CRA, like a research associate, I would love to because like I'm very organized. I can find myself doing this... So I might consider this path [Ontario IMG #20, practicing].*

Other IMGs decide to retrain as nurses, because nursing is a shorter program than medicine. In this way, they will be integrated into the health care system, but not as physicians.

*Oui, oui, je ne suis pas le seul donc dans ma formation il y a je ne sais pas, il y a nous sommes 4, 5 médecins étrangers, il y a deux femmes qui viennent d'Algérie, un du Liban, il y a une dame qui vient de la scène des pays soviétiques. Donc il y a la dame qui vous avait donné mes références qui venait de la Roumanie. Donc nous sommes nombreux puis nous ne sommes pas les seuls au cégep à avoir fait la médecine.*

*[Yes, yes, I'm not the only one in my training program. There are, I don't know, there are four or five foreign doctors, two women from Algeria, one from Lebanon, a woman who comes from the Soviet countries. There is the woman who referred you to me, from Romania. There are a lot of us, and we are not the only ones in Cégep who studied medicine]. [Quebec IMG, no longer pursuing integration].*

But those initiatives are taken by IEHPs individually. Many think that the system could offer retraining programs in order to utilize IMGs in other health care related positions:

*I wasn't expecting to get directly into the medical system [in Canada]. [I thought that if] I am not able to work right away in the medical system I can work as let's say a paramedic. I can work as an instructor for a tourist training center. I felt I can work for biomedical companies... I felt I can get into the universities and do my PhD or Masters which was something that I was interested in as well. After getting into Canada I figure out that all this paths are much more complicated than what I thought and some of it is considerable... Immigration in Canada is not a new phenomenon and you're expecting the system... to be much more organized and widely designed. This part was a little far from expectations [Ontario IMG #1, in process].*

Therefore, one of the recommendations given to us by IMGs is to establish bridging programs which would allow them to practice in a health-related field:

*You cannot bring people from overseas to here and make them go through the system which is absolutely designed for people who are trained and who have been living here, you know what I mean? You cannot take people as immigrants to Canada and right after arriving in Canada asking them to offer Canadian experience and Canadian credentials. It doesn't make sense. If the system believes immigration is contributing in any ways to the society it's supposed to do something to fix these problems... As an immigrant you have to get out of the square sometimes... This is the responsibility of the government and the high rank[ing] decision makers are supposed to fix these problems. They have to make bridges based on different sectors. And they know what's the impact of immigration on these different sectors. But somebody in a higher position needs to look from higher position [how] to bridge the systems, bridge these gaps. A physician if he is not able to get in practicing medicine could do something useful instead of driving cab [Ontario IMG #1, in process]*

*There should be some kind of programs. Even a lot of people are so desperate they are like I also did some work, I worked with some doctor in Toronto for some time for no money you know. Volunteering. And my husband did for at least six months in Winnipeg for some time. This is not right. There should be something for the doctors you know [Manitoba, IMG #1, practicing].*

**In sum**, our participants overall felt that they should have more information about the Canadian work environment, the structure of the health care system and other things which are unique to Canada. This knowledge would also help them once they are integrated into the local health care force. But before we turn to mapping out some of the key policy recommendations that emerged from our discussion with IEHPs, it is important to turn to a theme which began to emerge from our data analysis: this is the question of whether the success of an IEHP is due to being *proactive or just to fate*.

Some of our participants who were ultimately successful in their professional integration process identified two activities key to their success: professional *networking* and personally being *proactive*. Being “proactive” denotes self-initiative, determination, and self-confidence. One IMG summarized the situation succinctly:

*From the beginning I understood that it's the most important thing is to have connections, the networking. I know many people took the workshops. Nothing. I mean other people, you know, help them to find a job but it's not through the government. [British Columbia IMG #9, no longer pursuing integration]*

*I called people. I sent my resume. I met with people who agreed to meet with me. I spoke with them and everybody understood, ... And finally, finally when I think that somebody already know that there is such guy here and he is looking for work, they called me. [British Columbia IMG #1, in progress]*

Others, however, when asked why did you get the job, obtain the residency, or make it through, did not answer “luck” or “a miracle”, citing many examples of people who were highly proactive yet they still didn’t make it through. So for many it was really more of a question of “fate” (i.e., I was just lucky to get in touch with person, to meet a person, to get into a program). It was a like a miracle, like winning the lottery. Thus, being proactive was seen as being necessary but insufficient – because many who were not yet integrated exhibited a great deal of initiative and proactive measures.

In the next section, we expand upon this discussion of facilitators with some clear recommendations and promising practices highlighted by the IEHPs we interviewed. Table 5.1 provides a summary of the barriers and facilitators discussed and provides an outline for the recommendations and promising practices of the following Sections.

**Table 5.1 Barriers, Facilitators and Recommendations/Promising Practices**

| BARRIERS                            | FACILITATORS   | RECOMMENDATIONS & PROMISING PRACTICES   |
|-------------------------------------|--|---|
| <b>General</b>                      |  |   |
| Language                            | Profession-specific language training  | Improve access to health sector/profession-specific language training<br>e.g., scale up the language training component of the CARE for IENs in Ontario   |
| Financial costs                     | Access to student loans and alternate routes to utilization of high level skills | Address financial difficulties through a IEHP-targeted loans program and counseling to improve the labour market positions of IEHPs while undertaking the professional integration process<br>e.g., scale up accessibility to the type of loans offered through the Maytree Foundation in Ontario & labour market counseling of the Access Centre for IEHPs in Ontario                            |
| Time frame & Bureaucratic processes | Pre-immigration Activities and a case management approach post-immigration       | Information should be available from <i>multiple sources</i> and at multiple points in the integration process – but with a <i>consistent</i> message about the process and likely outcomes<br>e.g., scale up the case-management approach such as that employed by the Access Centre for IEHPs in Ontario to help navigate and negotiate the bureaucracy of the professional integration process |

|  |  |   |
|--|--|---|
| Cultural competency                          | Cultural components of bridging programs & 'on-the-job' training | Increase opportunities to gain cultural competence, formally and informally<br>e.g., scale up the cultural components of existing bridging programs, such as the one in CARE; also enable alternate entry routes which both enable IEHPs to earn money and gain culturally appropriate experience in the health care system.              |
| <b>IMG Specific</b>                          |  |   |
| MCCEE  |  | Increase accessibility of this exam in the pre-immigration period to better inform IMG of chances of success/rather than use it as a screening device for IMG already here in Canada<br>e.g., scale up the accessibility of like what is done for the CRNE exam   |
| Residency Placements                         |  | Better match the likelihood of a residency position for those who pass MCC exams, better approximating chances of Canadian medical grads who successfully pass exams<br>e.g., scale up specifically targeted residencies for IMGs, as has been done in several provinces (ON, BC, etc.) but also including a cultural bridging component. |
| <b>IEN Specific</b>                          |  |   |
| Level of Education                           |  | Explore a more of a competency than 'one-size-fits-all' examination and credential-based approach<br>e.g., like the ITM assessment/bridging programs  |
| <b>ITM Specific</b>                          |  |   |
| Newness & Insufficient Numbers/Critical Mass |  | Share resources where possible<br>e.g., IMPP simulation lab is shared with IMG education and assessment programs  |
| Model of Care                                |  | Expand range of modalities for midwifery practice and allow on-the-job shadowing to gain insight into the model   |

**SECTION 6: RECOMMENDATIONS FOR MOVING FORWARD**

To better map out a way forward, we asked our participants to suggest recommendations for changes to key policies or programs. Most of these relate directly to the barriers and facilitators we discussed in the previous two sections (see Table 5.1), but some address issues which were not identified. Similar to what we outlined for the barriers and facilitators, some of the recommended changes are profession-specific, and some cut across professional boundaries. Where possible, we outline whether the suggestions made by the IEHPs we interviewed resonate with those identified in the policy literature reviewed in the introduction. We also highlight practices identified as some of the most promising that could be scaled up to make better use of human resources of IEHPs. We begin, as did many of our participants, with recommended changes for some of the more *proximate* barriers they experience and then *broaden* this out to the seeming mismatch between the present health human resources shortage and the paradoxical processes that do not enable IEHPs to help meet the growing need for their services.

**Improve Access to Profession-Specific Language Training**

As noted in the IEHPs experiences in the barriers section above and in the reviewed policy literature, comfort and ease with English or French is critical. But it was not just any kind of

language assistance that the IEHPs we interviewed suggested was needed, but rather that which was specific to the health care domain and the practice of their particular profession:

*Definitely a language course with specific terminology would help a lot. And it's not just medical terminology because a lot of these words are new but there are other terms that are specific to this country that could mean something different in the States and something that again, it's not the only thing that immigrants have to learn so it could be very overwhelming to have to deal with this language barrier [Ontario IEN #1, practicing].*

Some of the IENs we interviewed in Manitoba recounted how they lobbied for just such a course and were successful in having one created:

*These students I think will benefit from giving them a course which is specifically dedicated to nursing only, like terminologies, you know, the languages. What are the common terms that the patients are using inside the hospital? So that's what they did. They opened this English for nursing purposes here in Manitoba. So before you can go for a refresher course you have to pass that course first and then you go to the refresher course. But that is after we have talked to politicians. But before that, there is nothing. [Manitoba IEN #1, practicing]*

Another promising practice, highlighted by one of our participants, is avoiding the use of acronyms so as to better enable the integration of those educated outside of Canada:

*We don't abbreviate stuff. So you know, you'll hear a lot of people within the work force talking about certain abbreviations and you're kind of like 'Well what does that mean?' So that was one of the things. [Manitoba ITM #1, practicing]*

Several of the bridging programs, like CARE in Ontario, incorporate elements of profession-specific language training which our participants noted as being important. Keatings (2006, p. 64S) also describes how independently, the College Nurses of Ontario (CNO) has developed a program that "focuses on helping internationally educated nurses understand specific health care terminology." Such programs, as we have already noted, are few and far between, making this a critical area for which to scale up services and benefit from lessons learned.

### **Help Address Financial Difficulties through Multiple Routes**

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A major stumbling block to licensing cited by many IEHPs, is the cost of the process. Indeed, while expected to pay thousands of dollars to complete the examination process, many, and IMGs in particular, do not ultimately get to practice in their profession. This in turn, limits their ability to pay back these costs. As mentioned above, there are some who decide not to embark upon the process, for they feel that they will only be wasting time and money.



Where IEHPs are reluctant to attend bridging programs and other integration initiatives, their reasoning is often related to the lack of financial support they face while being enrolled in the program:

*But in our case our future is, you know, it can be very bright and it can be very dark. So we have no guarantees there so nobody will give us any kind of OSAP [Ontario Student Assistance Program] or any kind of student loan because they don't know where we will end up. So we have to take regular loans with high interest rates, 18.5 and things like those. So that's why we had to pay \$3,300 in a month. [Manitoba IMG #2, practicing]*

Many IEHPs raised the issue of lack of access to student loans. Many IEHPs are not eligible for student loans in the provinces that we studied and among those that are, many may not realize their eligibility. A promising practice implemented through funds from the Maytree Foundation in 2006, was the Immigrant Education Loan Program (IELP). This was kick-started with funds from the provincial government through its Foreign Trained Professionals Loans program, which provided loans of up to \$5,000 per person to cover assessment, training and exam costs. None of our participants had availed themselves of these loans. Since we conducted the interviews, however, the IELP has ceased. The Maytree Foundation now redirects those interested to the Royal Bank's Skilled Immigrant Education Loan Program which provides short-term financial support for training programs through a credit line of up to \$10,000. This, unfortunately, does not allow for an interest free period during training which is a critical component of a student loan program. Hence, exploring the possibility of establishing student loan eligibility for at least some IEHPs (who meet particular criteria – good language, near practice ready) would be a promising approach to address the financial barriers that face IEHPs.

Another promising route to help address financial difficulties is to help improve the interim labour market positions of IEHPs, either while they are in the process of gaining professional integration, or as an end in and of itself. A promising model for IEHPs is employed by the Ontario Ministry of Health funded Access Centre. The Access Centre provides comprehensive information about the requirements for integration into one of the over 20 regulated health professions in Ontario, including standards of professional qualifications and the licensing and registration processes. The Centre provides on-site reference materials and resources, including an on-site library, links to education and assessment programs, self-assessment tools, and information sessions focused on various aspects of the registration process for internationally educated health professionals (IEHPs). Its truly value-added components include ongoing counseling and support, alternative career options, referrals to relevant organizations and community resources, information and referrals for retraining, and bridge-training programs.

### **Improve Access to Clear and Concise Information about Integration Processes**

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As we have seen above, many IEHPs complained that they don't have sufficient information, nor do they have sufficiently clear and concise information, about the process of integration into the Canadian health care system. Indeed, the experiences of our own research team of Canadian-trained doctoral students and graduates largely corroborate the experience of the complexity of the professional integration processes across the Canadian provinces we studied. This is a

particularly important point, given the amount of funds devoted to the streamlining of processes and the creation of 'one-stop' websites (Bourgeault 2006).

As a result of the concerns about the lack of information, a number of policy initiatives were developed to provide incoming health professionals with information about the process of integration into the system. Mainly offered through various internet portals, the regulatory Colleges put information on their websites regarding integration of IEHPs. Some even warned them not to come before they have their credentials assessed, noting that this process can take a long time.

One of the common recommendations is that the IEHPs need this information before they come to Canada. Our interviews with some IEHPs, however, demonstrated that many of them did not plan professional integration (for a variety of reasons) until their actual arrival. For others, the sources of information accessed were the internet and the embassy. Those who contacted licensing bodies directly, or who had personal contacts already in Canada, were better prepared. Those who were contacted by recruiters had mixed experiences, some being aided and expedited through the system, others feeling they had been misled or even lied to.

Given these findings, it would be best to distribute this information via *multiple sources* and at multiple points in the integration process with *consistent* messages. In addition, in the absence of general knowledge about the Canadian health care system, difficulties (for some IEHPs) accessing the web and in reading English or French, many choose to start looking into alternative professional integration here in Canada. Some of our respondents suggested that, rather than having a lot of information booklets, it would be more useful to have a personal, case manager-like approach:

*There should be an individual counsellor, but that counselor has to have the knowledge of the system and it would be very difficult to find a person who has the knowledge of the system, because the system is constantly changing and even if that person knows the system it doesn't mean that they're going to be helpful ... So this is where the gap is. Once they, like this case manager, has to have some communication with maybe a special division of the College of Nurses that deals with immigrant issues and says wait a second, our system does not allow this person to practice. That's ridiculous. It's unfair. It's unconstitutional. It's, you know, not good for anybody. It's just simply stupid... So there has to be a person designated by the College who would notify the requirements, the entry requirements according to that specific case and be on top of things and eventually, you know, they should deal with it maybe on a case by case basis [Ontario IEN #1, practicing]*

*Well I would recommend to have some sort of case manager for a person like me. Because what is happening now, I don't have anyone to talk to. And this is not only about documents, but it is also about this type of negotiations and these instances where the advice is needed, so I think it is critical. [Ontario IMG #3, practicing].*

It is easy to get lost in the myriad of information pieces available on the web and it is really hard to navigate the system solely on the information provided by booklets and websites. Having a person who can suggest the path to navigate on an individual basis would really help IEHPs in the process. This is the precisely the model developed by the Ontario Access Centre

Another facilitator in obtaining relevant information comes from professional associations of IEHPs. Our IEHP respondents often talked about gathering information and, although they did consult websites and information brochures, their primary source of information were fellow IEHPs who had been through the process. It could be assumed, therefore, that they have not only official information, but also “unofficial” information such as rumours and tips that would help them to get through the system more effectively.

### **Box 6.1: Suggested Information Sharing and Content Improvements**

Study respondents suggested that information distributed to potential IEHPs should:

- Be offered before immigration in the IEHP’s home country, and in the language(s) of that country;
- Provide an accurate portrayal of IEHP’s chances of obtaining a license to practice;
- Strongly encourage IEHPs to go as far as they can in the Canadian licensing process before leaving their home countries;
- Talk about the culture in the chosen province of destination and the patient/health care provider relationship.

Suggested services and information to provide once IEHPs are in Canada should include:

- A forum for IEHPs to share their knowledge and experiences;
- Detailed explanations of the licensing process, including:
  - Exams and their content;
  - For IMGs, the residency matching system (CaRMS);
  - Program requirements;
    - Individual evaluation and coaching for IEHPs who require such assistance(i.e., the Ontario Access Centre for IEHPs provides an individual case management approach)
- Information about where to seek emotional support and counseling throughout the licensing process.

Finally they suggested a need to provide these types of assistance and support for IEHPs throughout this process.

Many of the points raised in Box 6.1 also relate to our next point of improved transparency.

### **Improve Transparency, Reduce Bureaucracy & Address Policy Gaps**

Perhaps the real issue is not so much the clarity and accessibility of information itself, but the complexity of the system. The changes that the majority of the IEHCPs interviewed would most like to see in terms of the immigration and licensing processes are improvements to transparency and simplification:

*"...transparency... Be honest 'cause it's not a transparent system at the moment." [British Columbia IMG #2, no longer pursuing integration]*

*Uh, you know, I just wish there was more organization. In a way this still was good, was okay, but I think if there was a little more centralized information involved for doctors, you know, the government could organize it province by province, you know, what's the process to come? [Manitoba IMG #1, practicing].*

One of the gaps in the system that was identified by IEHPs is the lack of communication between individual provinces and between the provinces and federal ministries. For instance, one of the nurses decided to move to Ontario after five years of practice in Manitoba. Despite many years of Canadian practice and a nursing license from the Manitoba College of Nurses, she had to undergo the process of verification of her credentials once again. Since verification of credentials required communication with the nursing school in her home country, it significantly slowed down the process of accreditation.

Other IENs were not pleased with the work of the nursing Colleges/Ordres. We heard many accounts of documents being delayed or lost and it was perceived as almost impossible to receive any response to queries. The following excerpt explains the situation one IEN faced:

*The College of Nurses would tell me that I needed verification from [my state], then I would call them and basically they would [put me] on hold on long distance, and they would say, you aren't registered here so we will not give you anything. You haven't written anything here, you're not registered here; we won't provide you with anything. Then I would go back to the College of Nurses and say, I can't get anything from them because I'm not registered there. So, I had a lot of trouble trying to figure out what paperwork I even needed... [The College was very] disorganized and I'm hoping that maybe... things are better now, but I know you still get that 1-800 Call Centre type of filter... It's very hard to get through to someone there... It's just such an aggravation and nobody knows what you need and you're going back and forth and you're wasting so much time and it's just frustrating, I guess, when you know that there's an employer that wants to hire you, they want you to work, they want you to start like yesterday, and you have to go through all this red tape. [Ontario IEN #1, practicing].*

Similar problems were identified by ITMs. They were really looking forward to having one governing body which would assess midwives' qualifications:

*Actually when you decide which province you want to go to you have to go through the PLEA, which is the Previous Learning Experience Assessment. You have to go through the governing body for that province. So each province has a College of Midwives, Registered Midwives. So mine was the College of Registered Midwives in Manitoba. And it was entirely on their stipulation that I went through the whole process. They set the exams. The problem in Canada I think, and this national exam is going to stop this, but each province can basically set up their own standard of exams without having to follow a national guideline. So every province is different, you know. And depends on which province you go to. It depends on how tough the process is. Well Manitoba is particularly tough for some reason. [Manitoba ITM #1, practicing]*

*Well you know, I think we've made a major step forward with this national exam being formulated because that was always my kind of grievance was you can't assess midwives at provincial level without there being a national guideline to follow because what one province might deem as appropriate, another one might not. And then that affects the reciprocity across the whole of Canada. So the fact that they've brought in this national exam now I think is good [Manitoba ITM #1, practicing]*

ITMs in particular express frustration with changing standards and requirements, and many of these changes are attributable to a relatively young and evolving professional association in Canada. But even among professions like nursing and medicine, who have nationally standardized exams, there were another set of concerns, as discussed in Section 4 above.

### **Better Connection of HHR Supply and Demand to Achieve Self Sufficiency**

One of the sources of a great deal of frustration among IEHPs who participated in our study was the apparent disconnect between their difficulties in obtaining a license in Canada and the perceived (and indeed, in some cases, conveyed) feeling that Canada is in need of health professionals:

*Voilà mais j'avoue que ce qui ne m'a pas plu c'est que, je me dis mais on a besoin de former des agents de santé, le Québec ça crie partout oui il y a manque d'agents de santé, il y a manque d'infirmières, il y a manque de médecins...*

*[Okay, so here, I admit that what I didn't like, I tell myself, but we need to train healthcare professionals; in Quebec, everybody's complaining that there's a lack of healthcare professionals. That there is a shortage of nurses, a shortage of doctors.] [Québec IEN #4, in progress].*

*For instance, since I came here I can find out from all indications, interaction whatever, there are a shortage of doctors here. As I said earlier the most important thing about the whole thing is to ... make the system a little easier for foreign trained doctors to get into the system ...because if some of these measures are relaxed there are certain fundamental objective ways you could assess a foreign trained doctor to really find out if*

*he is competent. I think that the ...measures are so rigorous and difficult. [Manitoba IMG #1, in progress].*

One source of disillusionment among IEHPs is an inconsistency in the message being given regarding licensing opportunities between immigration representatives at the Canadian embassy or national level, and licensing bodies at the provincial level. Many have experienced both inter- and intra-institutional inconsistencies in terms of requirements, costs, labour market realities, and even lifestyle.

This issue of the misleading belief that IEHPs are indeed in great demand in Canada and would thus have no trouble finding a job, resonates with many policy stakeholders (Bourgeault 2006). Many argue further that this is a result of the disconnect between the immigration policy and health professional regulatory policy – which is exacerbated by being a federal and a provincial jurisdiction, respectively. Thus, IEHPs fare well in our points-based immigration policy system but then face the seemingly paradoxical situation of the professional regulatory world.

*If Canada doesn't need us, why it opens so many centers for assessment? Somehow Canada sells illusion. So I don't know, this is my... you know, when you see okay, there are so many centers around the world for those exams, that means they really need physicians, they are really looking so much to hiring us which is not true. ...Who opens those centers? Medical Council of Canada, yeah? Those centers for assessment are under Medical Council of Canada. But if Medical Council of Canada doesn't want physician why they open so many centers for assessment? This is my biggest question. [Ontario IMG #2, no longer pursuing integration]*

Moreover, the belief among some stakeholders that Canada will likely always rely (at least partially) on the supply of IEHPs and that effective HHR planning should also include the accommodation of incoming health professionals (Bourgeault 2006), is shared by many of the IEHPs we interviewed:

*Well what I said to you there has to be a regulatory body as World Health Organization or something like that that would penalize this country because this country is doing two kinds of damage. Like is draining the poor countries of doctors. How many dollars that country has spent in training that physician for that physician to come here for example to Canada? The second damage is to the person. They are not allowing that person to practice medicine. ...We are bringing physicians here to deliver pizzas. This is nonsense. So somebody has to penalize Canada and say well, for example, we poor countries [want] some compensation. [Ontario IMG #5, no longer pursuing integration]].*

In terms of recruitment, the consensus is that IMGs should not be actively recruited from developing countries. If they are, they should be given access to their profession in Canada.

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### **Increase Opportunities to Gain Cultural Competence**

Many of the IEHPs we interviewed sought out opportunities to gain cultural competency and identified some important exemplars. These ranged from the informal to the formal:

*Buddy up with somebody and just sort of shadow that, have a shadow person with you and just watch and as they feel more comfortable they are allowed to do things as well. Just like I had done with my student, she basically watch me for a period of time and now she is doing things hands on and by the time she gets the job, on the job then she should up to speed or at least almost up to speed in terms of... and less likely to fail in terms of integrating herself and be able to cope with the job [Manitoba ITM #3, practicing].*

*Why don't you solve the problem properly like allow these doctors who have passed the LMCC to work under somebody for some months before even you can apply. ..And then we will have first hand Canadian experience. ...I passed LMCC. Now let me, allow me to examine the patient, work under the supervision of a doctor, you know, I reach my plan and then the doctor can countersign my management if he is satisfied. [Manitoba IMG #2, practicing]*

More formally, the cultural components of bridging programs like CARE were identified by some of our participants. Others, however, noted that cultural competency was not something that could be taught in a course, but rather was only gained by experience, which ideally would be gained on the job:

*In my opinion people who have been able to fulfill this level of education are smart enough to learn these items, to learn these subjects, in a very short time in the real life context. ... but nobody says we are not letting you in because you don't know how to deal with cultural issues in Canada. ... I believe culture is not something to be trained in a course. You know, you need to get the system to bring these people in and this is something that Canada needs to think about. ...But I don't believe you can teach culture in professional courses [Ontario IMG, in progress].*

A combined formal and informal approach would enable both quick uptake, to hit the ground running, so to speak, and an opportunity to more fully flesh out 'crash' courses with some practical experiences.

### **IMG Specific Recommendations for Access to Residency Positions**

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Some respondents suggest once in Canada, IMGs who have invested in the examination process and succeed in passing all of the exams should have some form of guarantee of obtaining a residency position. While they are not asking to be guaranteed a license, they wish to be guaranteed a chance to obtain a license:

*But this process, I'd like that this process would be a little bit easier than... I'm ready to pass all these exams. I'm ready to pay my money. But I want to have guarantee that the final of this process I will have a place ... in residency. [Québec IMG #3, in progress]*

If Canada is unable or unwilling to provide this guarantee, then respondents argue that we should tell IMGs that there is no need for them here, and if they want to work in their field of practice, they will not be able to do so in Canada.

*S'ils ne veulent pas, je ne peux pas parce que je comprends, comme je leur ai dit, OK, moi, je suis ici, je suis un médecin formé. J'ai 50 ans. J'ai mes vieilles habitudes. Je te donne un exemple. Et si le Canada veut avoir des médecins jeunes, pour les former qu'ils connaissent le système, qu'on ne connaît pas, c'est le droit du Canada. Mais au moins qu'ils soient clairs au début.*

*[If they don't want to, I can't, because I understand, as I told them, okay, me, I'm here, I'm a trained doctor. I'm 50 years old. I have my ingrained habits. I'll give you an example. And if Canada wishes to have young doctors, to train them so that they know the system, that we don't know, it's Canada's right. But at least they should make things clear from the outset.] [Québec IMG #6, in progress]*

This, they argue, is something that Canadian medical graduates are almost assured of – if of course they pass their exams.

### **IEN Specific Recommendations for a Competency-Based Approach**

There is clearly a variety of perspectives and expectations among the participants in our study regarding the integration process for IENs. To allow for this variance, one respondent suggested that a system be set up to test the knowledge and experience level of IENs, and create several levels of re-training – shorter for those who are close to being ready-to-practice, and longer for those who are not – instead of accepting or rejecting applicants based on credentials or test scores. The respondent suggested that everyone's goal should be to work together to get IENs working in Canada, not simply to test their knowledge and set up barriers.

*It's for the person who trains here needs to be more open, you know, because the person who is coming probably has a little bit of knowledge that it's going to be a struggle. But people over here they don't have it. They think 'Oh, go back from where you came.' That is not the answer. So what I feel is it's not immigrant nurses who need to be taught. When they immigrate they are already prepared but they're going to face a lot of challenges. But the people from here need to know that when the immigrant nurses come they're going to ask a lot of questions so they have to be ready for the challenge. [Québec IEN #2, in progress].*

Some respondents went as far as saying that the equivalency process felt like a weeding out process – rather than a process to recognize, upgrade and finally use the abilities and competencies of IENs.

*Bien dans ce sens que la formation c'est comme un championnat, oui, la formation c'est comme un championnat, je prends un peu l'image où est le championnat du soccer, on*



*commence par le huitième des finales, il y a des équipes qui tombent, qu'on élimine et puis bon on va en quart de finale, il y a des équipes qui tombent, ensuite en demi-finale et puis bon la finale c'est lui qui est champion quoi...Voilà parce que moi je me dis que si on a plusieurs véritablement agents de santé, il vaut mieux former correctement ceux qui sont dévoués, ceux qui veulent vraiment faire ce travail. Il vaut mieux les former correctement pour que, vous savez la formation il faut mettre l'accent sur la formation pour que les gens puissent sortir pour qu'il y ait assez d'agents de santé, parce que tant qu'on se basera sur le côté sélectif vraiment il en manquera toujours.*

*[So, in this way, training is like a championship, yes, training is like a championship; I'm using a bit the image of a soccer championship, you start by the Round of 16, there are teams that lose, that are eliminated, and so you move on to the quarter finals. There's teams that lose, then you move to Semi-Finals, and then the Finals, and... where the champion wins. So there, because I tell myself that if we have many real healthcare professionals, it would be better to correctly train those who are committed, those who really want to do this type of work. It's better to train them correctly so that, you know training, you have to put the emphasis on training, so that people can make it out of school so that there are enough health professionals, because as long as the system is based on the selective aspect, honestly, there will be a shortage of healthcare professionals.][Québec, IEN #4, in progress]*

In terms of cultural competence, it is clear that immigrant nurses often have difficulty adapting their practice to the Canadian approach. The flip side of the coin is that nurses with experience in their home countries understand what patients from that same country of origin who are living in Canada, are looking for and expect. IENs knowledge and experience in terms of cultural competence can be put to use rather than be discarded. Some respondents went as far as to suggest that there be an exchange program whereby nurses from Canada go to the countries where most IENs come from to see what type of nursing practice and conditions IENs who come to Canada have experienced.

### **ITM Specific Recommendations for Building Greater Integration Capacity**

Capacity is clearly the biggest issue for ITMs. ITMs in all of the provinces where we conducted interviews called for an increase in the number of clinical placements by increasing the number of preceptors available. Some components of the integration process would not necessarily have to be taught by midwifery preceptors. Indeed, some aspects of the Canadian midwifery education programs are taught by faculty in other professions. This would release time for the midwifery faculty to focus on teaching core midwifery skills. Another example of the sharing of resources exists at the IMPP at Ryerson University. To keep costs low for the relatively small number of ITMs it assesses, it shares some of its simulation lab resources with other IEHP programs in the area. This is a win-win situation that not only increases integration capacity of its own profession but that of other health professions.

As for the existing bridging program, many participants had no idea what to expect, and were generally surprised at the demands of the program. To correct this lack of understanding of how the system in Canada works, they suggest that observation opportunities be made available to ITMs. Such opportunities provide a clear understanding of the work performed by midwives in Canada prior to an ITM choosing to go through the licensing process. Furthermore, ITMs would like to have access to others who have been through the process, who could act as mentors to help guide them. Finally, some feel that they need more time than the bridging program provides to adapt to the Canadian model of practice.

## COMPARISONS & CONCLUSIONS

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In conclusion, many of our findings and recommendations are consistent with earlier research and policy briefs. This should be taken as an indication of the stability of some of the key issues, and that our participants are not unique in any particular way that would limit the transferability of our findings. Our comparative approach, however, does allow us to make some important and unique contributions to this policy literature. Below, we present some of the key conclusions reached by comparing our IEHPs across provinces, professions, integration status and country of origin. We conclude with a description of some directions we are pursuing in follow-up analyses and suggest some promising future directions for research and action.

### Interprovincial Similarities & Differences

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Our data analysis suggests that, when it comes to integration of IEHPs, there are a lot of similarities across the provinces studied. Despite some variations in procedures for the three professions, such issues as, lack of spots in bridging and integration programs (especially for IMGs); difficulties in navigating through the integration process, in obtaining information, and in finding an organization that can coordinate or consult about the process of integration; and finally, the time consuming and money draining nature of the process of integration, were raised by virtually all of the respondents.

At the same time, it should be noted that interprovincial differences exist across Canada and many IEHPs are well aware of that. As one of our ITM participants explained:

*But, you know, as I say every province is so different that that's the same with Canada that I've learned since I've been here. Each province has its own way of doing things. It's not like a national, you know, it's not like a theme that runs through everything in Canada nationally. It seems to be each province is a rule unto themselves. So how effective that would be when things are so different in each province I'm not sure. I guess you'd have to kind of draw from each province on what their practice is and adapt once you know where the immigrants are going to, kind of be able to adapt that to the provincial culture rather than a national culture. [Manitoba ITM #1, practicing]*

The majority of our respondents suggested that each province's culture is unique and that integration into Canada must be done by way of assimilation into a provincial culture. However, it is difficult to objectively qualify these cultural differences, and how they affect IEHP integration, particularly when the IEHPs in question have generally only applied to one province. We can, however, look at the effects of policy on the experiences of IEHPs in the four provinces. The most significant differences between the provinces under study were in the number of provincial programs that are available to IEHPs who wish to integrate and practice in their chosen profession. Whereas Ontario, for example, during the time of the interviews, reserved about 200 residency spots for IMGs, BC had only 18 residency positions available and other provinces had none. Ontario provides the greatest number of bridging opportunities for all IEHPs. However, IEHPs residing in Ontario did not feel that the provincial health authorities were

willing to integrate them or that an effort was being made. This is probably due to large number of applicants and large numbers of IEHPs willing to attend those programs.

Many of the programs available in Ontario were not available in Manitoba. The small number of midwives residing and practicing in Manitoba, for example, means that there was insufficient demand to justify a program similar to IMMP for ITMs living in Manitoba. In addition, at the time of the interviews, there was no formal bridging program available for Manitoba IENs (*this has more recently been resolved*). Nevertheless, the openness with which regulators and health policy makers in Manitoba demonstrated in facilitating integration, was noted by many of the respondents. For instance, the Filipino Nurses Association worked with regulatory bodies to establish refresher courses and language courses for IENs and this initiative was met positively by the stakeholders. ITMs in Manitoba were also able to organize their efforts to push for a more unified assessment process and received a positive response from the authorities. They were not kept on the outside of the process, but participated in it, and were thus able to take credit for some of its success.

As mentioned above, shortages of health care personnel in all four provinces necessitate recruiting IEHPs from abroad. Respondents' experiences reflect the above policy findings that Manitoba appears to engage in recruitment more aggressively than the other provinces. Respondents in Manitoba note that the province not only invites IEHPs to practice their professions there, but also works hard to retain its own trained professionals and to recruit local nurses and physicians to work in rural and remote areas. Respondents generally believe that it is easier to immigrate to Manitoba than to Ontario and Manitoba IEHPs report making use of the Provincial Nominee Program. Moreover, respondents found that Manitoba has very welcoming websites and does direct recruitment for remote and rural areas. Although those same opportunities are available for people willing to move to Ontario, migration pathways are more clearly supported in Manitoba than elsewhere, and Manitoba was seen by our respondents as more welcoming than Ontario.

When comparing the situation for IEHPs in Québec to Manitoba and Ontario, the consensus among respondents from all three professions is that Québec is the least organized to welcome health professionals who are educated outside of Canada and had the least supportive integration initiatives when compared with the rest of the provinces under study. The support structure for these professionals simply does not exist, or is not readily available for those seeking licensing in Quebec. In general, the licensing processes for IMGs, IENs and ITMs is perceived as being longer, more stressful, and more costly in Quebec than elsewhere in Canada. Furthermore, there is far less assistance with exam preparation for IEHPs in any of the three professions in Quebec than in Ontario.

There was no consensus among our British Columbian respondents regarding the ease or rapidity of the immigration and licensing process there compared to the other Canadian provinces. Some argue that British Columbia is quite easy to migrate to, while others complain that it is more time-consuming to obtain a license there than elsewhere in Canada. For example,

British Columbia was seen as welcoming to IENs and ITMs but less helpful in integration of IMGs. The opinions are reflective of initiatives set out by each profession individually, with midwifery and nursing being more organized to accept international professionals than medicine.

Finally, social networks and close proximity to ethnic and cultural communities also had a great impact on the process of integration. The support from social networks (or the lack of it) was perceived as crucial by the respondents. It was also often cited as the source for informal information from other IEHPs, which helped them to integrate more quickly and more successfully. Not surprisingly, the IEHPs who resided in the GTA and other Canadian metropolitan areas were more likely to receive such support than IEHPs who were living in more remote areas.

To summarize, British Columbia, Manitoba and Ontario had relatively similar requirements for obtaining licenses. However, IEHPs immigrating to each of these provinces had somewhat different integration experiences. The availability of bridging opportunities, the perceived willingness of health authorities to integrate IEHPs, and the availability of informal social networks made each province unique in its perceived willingness and readiness to accept IEHPs and integrate them into the local workforce. IEHPs both recognize and denounce some of these jurisdictional differences. They call for simpler, standardized and nationally based licensing requirements, so that they can share their precious skills and knowledge with the population, and so that they can choose where to live in Canada, based on factors other than whether or not they can work in their field of expertise in a particular province. Interestingly, the conference of Deputy Ministers of Health launched the Advisory Committee on Health delivery and Human Resources (ACHDHR) in 2002 began to address, among other issues, those of immigration and workforce needs. The ACHDHR came to the same conclusion as Canadian-based IEHPs and implemented the Pan-Canadian Health Human Resources planning initiative in an attempt to forward the notion of standardized and nationally based licensing requirements for internationally trained health workers; however their goals have yet to be realized. IEHPs still face great variance in licensing procedures and the existence of support structures established to assist them during their integration period. There appears to be no accountability either from province to province, or on a national level, giving IEHPs the impression that there are few structures in place to ensure fair treatment. If those provinces with successful integration programs could be held up as an example to those who lag behind in terms of established support structures for IEHPs, the lessons learned could be invaluable and have far reaching impacts for the health care system in Canada as a whole.

### **Interprofessional Similarities & Differences**

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We have already highlighted how there are similarities in the barriers, facilitators and recommended changes across the different professional groups we interviewed. Here, however, we try to pull together how, and along what dimensions, the IEHPS in their profession group experience the integration process differently. Briefly, although many similarities between professions were found, the logistical structure around licensing varied from one profession to

another. While IMGs and ITMs reported the greatest difficulties around licensing, IENs also had their share of struggles, which varied in complexity according to their country of origin and their destination province.

**IMGs:** Although all IEHPs face challenges on the way to professional integration, IMGs probably face the most significant difficulties. The lengthy and complex licensing process for IMGs means that these professionals often take several years to complete all of the required steps. There is a timeframe between the end of active practice and eligibility for licensing in Canada within which IMGs are deemed acceptable candidates. Because the licensing process often takes longer than this allotted timeframe, many IMGs are effectively eliminated by the requirements of the process itself. This situation creates a great deal of frustration and outrage among the IMG community in Canada.

The strongest barrier to professional integration of IMGs is in the limited number of residency positions available to them. There is a general sense in the IMG community of not being in control of their integration and having to rely on fate rather than on their personal skills and abilities to get through the system. IMGs are also most likely to demand some retraining in the health care field that could give them the ability to integrate into the system in some other capacity than a physician (either on a temporary or permanent basis). At the same time, IMGs in general, have more social and financial capital than IENs and ITMs. Usually, they are coming to Canada as primary applicants under the category of skilled migrant. They usually have money to start the process of integration and to support themselves and their families financially, even if for a short period of time.

Thus, the case that most clearly represents the 'brain waste' issue is the issue of integration of IMGs. Indeed, recently available data from the Access Centre for Internationally Educated Health Professionals in Ontario, indicate three quarters of the over 10,000 clients that they have had since their inception in 2006, are IMGs.

**IENs:** It is generally true that nurses have higher chances of integrating into the system than do IMGs, in large part because they are more likely to be recruited from abroad than IMGs. IENs, who were recruited to practice in Canada, had the highest likelihood of being integrated into the Canadian health care system. But at the same time, they are most likely to be working in positions that are below their level of qualifications and experience. For example, some IENs who had experience and training as a Registered Nurse have been recruited to work as LPNs. Another factor which compounds the situation for IENs across Canada is the misunderstanding surrounding the different titles in nursing. Many countries have only one title for nurses and one job description. In Canada, there are three titles with three corresponding job descriptions and three pay scales.

**ITMs:** For ITMs, the different model of practicing midwifery in Canada posed the biggest challenge on the process of professional integration, followed closely with challenges associated with its newness, such as lack of developed programs, especially outside of Ontario, and

capacity limitations. Once integrated, many ITMs felt that they were not ready to face the demanding schedule of Canadian midwifery practice.

**In sum**, despite those significant difficulties in the process of integration, successful professional integration for all three professions was highly related to availability and accessibility of bridging assessment and orientation programs for IEHPs. While IMGs were not able to obtain their license in Canada without attending a bridging program (i.e., residency), some IENs and ITMs did not feel ready to practice without attending a bridging program or orientation. Therefore, some of our respondents chose to attend a bridging or an orientation program even after passing their licensure exams. Many midwives and nurses who started practicing immediately upon their arrival to Canada, reflected on the enormous confusion and problems they experienced during this time.

### **Different Stages in the Integration Process**

Interviewing IEHPs at different stages of the process of integration gave us a unique opportunity to assess the differences in the experiences of IEHPs being at these different stages.

**IMGs:** Issues varied, depending on what stage IMGs were at in the integration process. For example, it was often the case that newcomers to Canada were mostly concerned with passing the MCC examinations. Those who already passed the examinations were experiencing difficulty in deciding what to do next – to continue hoping for a residency placement, to try their chances in other provinces (as IMGs, clinical associates or as physician assistants), or to abandon medicine altogether.

**IENs:** Despite the fact that IENs reported their frustration with their regulatory bodies and had difficulties in navigating through the bureaucracy related to credential recognition, they had a clear sense of the process of integration. Those IENs who were still in the process of obtaining their license, were usually the IENs who were preparing for CRNE and attending language courses. At that time, passing CRNE was seen as the most difficult step on the process of integration. Once the exam was passed, those IENs who were not directly recruited to practice in Canada, encountered another barrier of which many of them had been unaware of, that of finding an employer who would be willing to hire an IEN. Many of these IENs, therefore, had to agree to work in jobs that were less than satisfying, where the full extent of their skills were not utilized. Although some of our respondents continue to work in these jobs due to personal reasons, many IENs were able over the years to adapt to the system and move up the professional ladder. We found, however, that their satisfaction with the job was mostly attributed to the facility in which they practice and to the quality of their personal relationships with other staff members.

**ITMs:** Unlike IENs, for the most part, ITMs were relatively satisfied with the efforts of their regulatory bodies. Attendance at the required bridging program prior to commencing practice helped them to feel better prepared to establish their practice in Canada than IENs. For the most part, once integrated, ITMs defined their work as rewarding yet very difficult – largely

because of the model of practice – but this is not dissimilar from the experience of Canadian trained midwives. They also reported the least tension between the members of their health care team, but this may be more due to the somewhat more independent nature of their practice.

**In sum**, each step in professional integration was associated with specific difficulty or a barrier. When the process of integration was seen as clear, with defined step-by-step navigation, it helped IEHPs to integrate faster and better and to feel more satisfied with their job. Clearly, some of the differences we found by profession need to also be viewed with a lens sensitive to the level integration process.

### **Future Analyses**

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We have opted in this report to present the breadth of responses from the IEHPs we interviewed. We intend to supplement this with more in-depth analyses of particularly interesting themes which emerged from our comparative analysis. Some of the analysis that we will be pursuing include the following:

#### **What are the gendered dimensions of the experiences of IEHPs?**

Although it is hard to come to a definite conclusion from our sample, it seems that the process of integration needs to be understood as a gendered process. Female IMGs often decide to give up during the process and find alternative fields for employment (as midwives, nurses, or practitioners in the field of alternative medicine) due to the uncertainty of the process. Those few women who succeeded in getting into practice reported that this process put a strain on their personal relationships. Some lived apart from their families or partners and felt that the effort that they put into becoming licensed negatively impacted their personal life. This theme was not apparent in the interviews with male IMGs who were practicing.

Although IMGs are less likely to be integrated into the system, the gender composition of nursing and midwifery highlighted the specific difficulties for IEHPs practicing those professions, too. Many IENs and ITMs had to juggle their family responsibilities with pursuing professional integration. Taking care of their families meant that they often had difficulties in attending full-time bridging programs. If they were primary applicants, they also had to take the leading roles in integrating their families in Canada. If they were travelling to Canada as dependants, their mobility was restricted to their husband's place of work. Those who were pregnant, or became pregnant during the process, found a challenging situation even more difficult. Thus, by analyzing the process of professional integration as a gendered process and comparing the experiences of IMGs (mixed-gender profession) with the experiences of IENs and ITMs (predominately women's profession) we plan to see how gender intersects with the process of professional integration.

#### **How does the integration process for IEHPs represent a kind of professional resocialization?**

While the sociological literature provides a rich understanding about the professional socialization process experienced by medical and nursing students, it rarely deals with the process of *re-socialization* experienced by professionals who move from one workspace to



another. Neither has it paid attention to the process of re-socialization which immigrants have to undergo to adapt to a new professional culture in their host country. By drawing upon the experiences of the IMGs, IENs and ITMs in our study, we intend to demonstrate how the differences in professional cultures can be a major barrier for professional integration, and how this is addressed to a greater or lesser extent in the context of bridging programs and other integration initiatives which aim to facilitate the process of integration of IEHPs into the local workforce. We hope to reveal how current educational settings designed for integration of IEHPs may not be paying sufficient attention to the process of professional re-socialization.

#### **How do the work experiences of fully integrated IEHPs differ by professional category?**

Despite significant differences in the countries of origins of newcomer professionals, they experience remarkably similar process of struggling to get into the local system upon their arrival. They also often feel alienated from other members of their profession when integrated and report discrimination at their new workplace. We intend to compare the experiences of the culturally diverse groups of IMGs and IENs we interviewed, and examine in particular, how their differences in professional status shape their experiences of workplace discrimination. Specifically, we plan to explore how the instances of discrimination and racism to which IEHPs are exposed at their workplace differ among physicians and nurses and how the status of the profession can serve as a shield of protection from the experiences of racism and discrimination.

#### **How does the experience of IMGs in particular reflect a professional diaspora?**

We intend to apply the concept of *diaspora* to the analysis of the creation and maintenance of an ethnically diverse community of IMGs, by drawing upon those we interviewed in this study. Traditionally, the research on diaspora concerns ethnic communities that preserve their homeland ties while residing in foreign countries. We suggest, however, that ethnic roots are not imperative for the analysis of diasporic communities when other forms of shared values and meanings can become a basis for creation of collective identity. Reconfiguring both the homeland and host country as places of geographic and professional belonging provides opportunity to conceptualize an ethnically diverse group of immigrant physicians residing in Canada as professional diaspora. Though examining the interviews with the IMGs in our study, we hope to demonstrate (1) how they create medical diaspora, (2) what myths and sensitivities they share in constructing their professional and geographic homelands, and (3) the relationship they develop with their hosting society. We suggest that in spite of the increasing mobility of internationally-educated health care providers, the analysis of professional diasporas could become a useful tool for analyzing complex relationships between home countries, hosting countries, and international travelers.

**In closing**, we hope these analyses highlight the complexities of the process of professional integration which is linked to immigration and shaped by gender, ethnicity, country of origin, the status of profession and globalization of health care market. We are grateful to our respondents for sharing their personal experiences with us and we hope that future research will allow for a better, simpler and more welcoming process of professional integration. It is important to

convey the overwhelming message we came away from our interviews with: IEHPs wish to be productive members of Canadian society and to bring their skills and knowledge to their new home. Knowing about the perceived shortages in health care creates a great deal of confusion to these professionals when they face insurmountable barriers to obtaining a license to practice and respond to the health care needs of the Canadian population.



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## Appendices

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### Appendix A: Abbreviations

|          |   |
|----------|---|
| AIMG     | Alberta International Medical Graduates   |
| ACHDHR   | Advisory Committee on Health Delivery and Human Resources                         |
| CAM      | Canadian Association of Midwives  |
| CaRMS    | Canadian Resident Matching Service  |
| CARE     | Creating Access to Regulated Employment ( <i>Nurses, Ontario</i> )                |
| CFPC     | College of Family Physicians of Canada  |
| CIC      | Citizenship and Immigration Canada  |
| CMQ      | Collège des médecins du Québec  |
| CMRC     | Canadian Midwifery Regulator's Consortium   |
| CNO      | College of Nurses of Ontario  |
| CRNE     | Canadian Registered Nurse Examination   |
| CRNM     | College of Registered Nurses of Manitoba  |
| GTA      | Greater Toronto Area  |
| IELP     | Immigrant Education Loan Program  |
| IENS     | Internationally Educated Nurses   |
| IEHP     | Internationally Educated Health Professionals                                     |
| IMGACL   | Assessment for Conditional Licensure  |
| IMGs     | International Medical Graduates   |
| IMGACL   | Assessment for Conditional Licensure  |
| IMPP     | International Midwifery Pre-registration Program ( <i>Ontario</i> )               |
| ITMs     | Internationally Trained Midwives  |
| LMCC     | Licentiate of the Medical Council of Canada                                       |
| LPN      | Licensed Practical Nurse  |
| MCC      | Medical Council of Canada   |
| MCCEE    | Medical Council of Canada Evaluating Exam   |
| MCCQE I  | Medical Council of Canada Qualifying Exam I                                       |
| MCCQE II | Medical Council of Canada Qualifying Exam II                                      |
| MICC     | Ministère de l'Immigration et des Communautés Culturelles ( <i>Quebec</i> )       |
| MLPIMG   | Medical Licensure Program for International Medical Graduates ( <i>Manitoba</i> ) |
| NAS      | National Assessment Strategy ( <i>Midwifery</i> )                                 |
| OIIQ     | Ordre des infirmières et infirmiers du Québec                                     |
| OSCE     | Objective Structured Clinical Exam  |
| OSFQ     | Ordre des sages femmes du Québec  |
| PAB      | préposés aux bénéficiaires  |
| PLA      | Prior Learning Assessment   |
| PLEA     | Prior Learning and Experience Assessment  |
| PSW      | Personal Service Workers  |
| QE I     | Medical Council of Canada Qualifying Exam I                                       |
| QE II    | Medical Council of Canada Qualifying Exam II                                      |
| RCPSC    | Royal College of Physicians and Surgeons of Canada                                |
| RN       | Registered Nurse  |
| RPN      | Registered Psychiatric Nurse  |
| RSQ      | Recrutement Santé Québec  |
| TFWP     | Temporary Foreign Worker Program  |
| UQTR     | Université du Québec à Trois Rivières   |

**Appendix B. Specific Paths to Registration in Selected Canadian Provinces**





